University of the
West of England
BRISTOL

Creating partnership by aligning the support needs of the neophyte registered nurse and the healthcare organisation: An Appreciative Inquiry

Jenny Caroline Child

A thesis submitted in partial fulfilment of the requirements of the University of the West of England, Bristol for the doctorate in Health and Social Care

Faculty of Health and Life Sciences, University of the West of England, Bristol

June 2015

Dedication

I dedicate this thesis to three precious patients who inspired my nursing philosophy.

They taught me to nurse with respect and dignity and to value the authentic self within the individual.

For this I will be forever grateful.

To

Winnie, Kenny and Mamushka

Acknowledgements

Abstract

The transition from neophyte registered nurse to staff nurse can be a challenging stage in an individual's career. There has been much discussion on the process and the effect that it can have on the individual's performance, however less consideration has been given to understanding the nature of required support and how this can be realised in the practice arena. This study focuses on the nature and concept of that support and investigates how six neophyte registered nurses and nine senior nurse managers from one healthcare organisation experience the transition. It examines what they perceive as desirable support and identifies what organisational features contribute to effective support when achieving a successful transition.

The study adopts the affirmative action-orientated approach of Appreciative Inquiry, a methodology which is new to the research area but one which seeks to discover and build on what works well in existing systems. In particular, appreciative inquiry methodology engages with participants as co-collaborators to envision a future reality. The research employed a single mini-summit event structured by the 4D framework which engaged the participants in storytelling, drawing and generative thinking. Thematic analysis of data revealed four main themes which encapsulated the notion of support from participant perspectives: safe environment, strategic environment, learning environment and emotional environment.

The concept of support is complex however the findings suggest that a high quality of contributing factors such as professional learning, social competency, guidance and a favourable workplace environment are essential to the process. This thesis further suggests that the transition from student to neophyte registered nurse requires good quality leadership from the organisation and senior nurse manager. A person-centred transition plan assists in aligning the individual needs with those of the healthcare

organisation and creates the potential to enhance the individual's experience, practice performance and organisational efficiency.

Findings from this study have enabled the development of a conceptual model. This illustrates that the transition is a shared experience which needs to be shaped and informed through education, with the provision of organisational containment, to enhance good practice in order to facilitate professional growth.

TABLE OF CONTENTS

CHAPTER 3: METHODOLOGY, DESIGN AND ETHICAL ISSUES

CHAPTER 4: PRESENTATION OF RESEARCH FINDINGS   93

LIST OF FIGURES

LIST OF TABLES

Chapter 1: Introduction

In this thesis I examine the concept of support for both the neophyte registered nurse (NRN) during their transition from student to staff nurse, and for the senior nurse manager who oversees and co-ordinates the process. I explore the nature of this support and how it can be aligned in meeting the needs of the NRN and the healthcare organisation to achieve an effective transition. The subject of NRN transition into the workplace has been explored since the 1970s and is recognised as an educational and organisational concern following the move from the apprenticeship model of learning to Higher Education (HE) in the 1980s. Recent research has primarily focused on the transition from education to service, workplace stresses and preceptorship needs (Johnstone *et al*., 2008; Scott *et al*., 2008; Whitehead *et al*., 2013). However, there has been minimal exploration into the expectations of those undergoing transition and those involved in facilitating transition and what support means to them. Within nursing, transition involves NRNs working through a process of learning, adjustment and socialisation into the professional workplace. Support from the employing organisation is pivotal as it is acknowledged that early experiences in the workplace can influence future job satisfaction and future workplace productivity (Jamieson *et al*., 2012). Therefore, understanding the nature of the support required and the expectations of the surrounding workplace are fundamental to informing a successful transition.

The exploration took place within the field of human science, appreciating the positive experiences and perceptions which, when considered in collaboration, can inform a potential new future. The qualitative methodology I have chosen for this doctoral thesis takes the affirmative action-orientated approach of Appreciative Inquiry (AI) (Troxel, 2002). This method enables the researcher to both study and to influence social systems (groups, organisations, communities), utilising collective inquiry to explore 'the best of what is', in order to imagine 'what could be' (Bushe, 2013). This means that the research focus will be an appreciation of the strengths of positive organisational stories (Whitney and Trosten-Bloom,

2003) to inform future action in developing meaningful and tailored transition to NRN.

My interest in AI was heightened following attendance at a three day international conference and workshop, where I had the opportunity to work with originators, critics and experts to understand the underlying theory and application of the methodology. This experience fuelled my desire to engage with AI to explore how this lens could help understand the nature of support and transition of NRNs. This would further encourage the opportunity it brought to examine and value the positive experiences, and how these could inspire a new approach. The emphasis on notions of 'appreciative' and the 'affirmative' within the methodology introduces a new approach to view the process of how support and transition are generally conceived. Specifically AI moves the focus from the exploration of the problems to the action related stories that have brought value to the NRN and to the employing organisation. Research evaluating post registration support suggests that it brings value to the individual and to the employing organisation (Whitehead *et al.*, 2013) making it pertinent to explore and to build on these areas of recognised value.

This research approach invites two key groups, NRNs and senior nurse managers, to explore their experience and perceptions of the transition and the available support within it through an AI lens. The data will describe aspects which were identified as enhancing a successful transition experience and how these could be built upon and adopted within the future workforce. The study is conducted in a unique healthcare setting which is founded on the National Health Service, and is the single acute healthcare provider for the small island community. Further discussion on methodological orientation, research design and ethical issues are provided in Chapter Three.

1.1 Chapter context

This section begins by sharing my personal motivation and intellectual curiosity driving this inquiry and the reasons for choosing the research methodology. Additionally, I will explore the significant policies informing

the national and local context of the nursing workforce, while providing a brief dialogue on the educational and practice preparation of the NRN.

The concepts of 'socialisation and transition' are inter-related and key within the literature examining how individuals become integrated into the workforce (Duchscher, 2009). These will be defined and adopted throughout the thesis.

1.2 Personal context and research questions

My interest in this subject has developed throughout my own career transitions and workplace roles against an ever changing organisational and national landscape. I am conscious that the notions of transition can evoke a range of emotions for many, with some viewing it as an opportunity and others a challenge, with various feelings in between. I relate to this, having experienced a number of career transitions. Personally I view them with interest, relishing the opportunity for new understanding and development. However, the process itself has occasionally generated feelings of uncertainty, vulnerability and isolation, with a sense of starting at the 'bottom' once more, with each transition reverting me to a sense of being the 'novice'. I have experienced a range of inductions, from being 'thrown' into the role to being gradually immersed into the environment. Each has brought difference to my immediate performance and confidence, leaving me often thinking:

- What am I doing here?
- What are they wanting of me?
- Have I got anything to offer?
- Who should I trust?
- When are they going to start using my skills?

These experiences have raised my anxiety and at times made it difficult to follow my intrinsic desire to contribute and to add value to my workplace. My experiences have made me appreciate how fundamental the workplace is in helping to contextualise the transition process for those undertaking it. I have found that there is an expectation of the workplace for the

newcomer to take the weight of responsibility for the transition, 'to fit in', bringing an immediate sense of imbalance to the process. These personal transition experiences have culminated in an interest in workforce development.

My own experience over the last 25 years either as a NRN, nurse manager, workforce development manager and university lecturer have greatly influenced my interest in the transition of student to registered practitioner. Recollections of joining my first professional nursing team as a new staff nurse are surprisingly clear. I entered the new community with trepidation, unsure of what to expect, and of what would be expected of me. On reflection I realise how valuable my peer group were in their support, and the kindness of some staff members in their care and attention to my needs as a new practitioner. As a lecturer I observed the mounting stress felt by many students approaching their registration, and their mixed emotions when immersed within it. I was able to recognise the influence that the practice community had on building (or weakening) an individual's practice. I was also witness to the stress the nurse managers were under and the increasing responsibilities and needs that they had. I was conscious of the tensions that they were experiencing between clinical and managerial responsibility. These observations focused my interest to the preparatory needs of the NRN and into the leadership and management of senior nurses.

My career has exposed me to the numerous years of change in healthcare policy, education and practice, which have introduced different priorities and expectations of and to the nursing workforce. This dynamic activity potentially complicates the transition process with established practitioners managing varying agendas based on their career experience and practice needs. During this time the Department of Health (DH, 2008b) and the Nursing and Midwifery Council (NMC, 2008) have advocated the introduction of support processes to aid the NRN into their new professional role. This 'support' has been interpreted by healthcare organisations in a number of ways, and has a tendency to introduce an agenda of learning to meet service need, rather than individual transition needs. In addition the variability of transition processes and service

expectations of NRNs is neither consistent nor congruent even within higher education.

It is within this context that I have been motivated to continually improve the support that I offer NRNs and practice environments, mindful of the challenge that the transition process can bring to both. My desire to smoothly align the skills of the new workforce with the needs of the healthcare organisation is to build confidence in the NRNs ability, enabling them to actively contribute to the new community. Nursing teams are powerful and can unnerve the novice nurse (Evans *et al*., 2008; RCN, 2012), making the alignment of the new with the established a potential challenge for an individual. The team expectations can be taxing, creating uncertainty and distrust in individual knowledge and values. My previous experience has illustrated the different ways and varying degrees of success through which student's transition to NRNs takes place. It is this, coupled with the outcomes of my MSc in 2003, which have been the main inspiration to explore the subject of support.

The aim of my Master's study was to examine the effectiveness of a structured preceptorship programme for the NRN. I explored NRNs and senior managers' perceptions of the effectiveness of a structured programme for the individual and for the practice arena. Data were collected through semi structured interviews asking NRNs and senior managers' for their perceptions on the outcomes this programme brought for individual progression and integration within the workplace. The results from the study indicated that the practice environment had a profound effect on the NRN, which was not always conducive to job satisfaction or reduction of stress. However, the benefits of the programme were apparent from both the NRN and nurse managers' perspectives, indicating the importance of the two groups having a thorough understanding of the transition needs for successful integration and practice competence. This process not only appeared to enable participants to share their knowledge and learning but also positively engaged with organisational goals. This enabled NRNs to synthesise their theoretical and practice learning, fast-tracking the integration process, bringing mutual benefit to both groups studied. The shared goals and inclusive working encouraged employee engagement which contributed to organisational performance. These findings energised

my enthusiasm for organisational development and my interest in challenging the inherent view that NRNs must *'hit the ground running'* and *'fit in'* to already formed systems (Levett Jones and FitzGerald, 2005). It is from this context that my Doctoral study aimed to explore the successful transition stories from the perspective of six NRNs and nine senior nurse managers from one healthcare organisation. My objective was to understand the nature of the support required to achieve a successful transition for the NRN and the organisational needs to provide this.

Throughout my professional roles I have always valued individuals, conscious of the diversity and the potential each has to influence and develop practice. I like to engage people, believing that in using a democratic and collaborative style, an inclusive and dynamic working environment can be created. This aligns with many of the aspirations and expectations of qualitative research, and in particular AI which intrinsically mirrors my approach to workforce development. I have been motivated to generate a holistic understanding of how individual NRNs and senior nurse managers experience and perceive the transition process. To consider this the following research questions are explored in this thesis, through the theoretical and philosophical lens of AI:

- What constitutes *support* in meeting the needs of neophyte registered nurses and the healthcare organisation during the transition period?

- What factors are perceived by the neophyte registered nurse and the senior nurse manager of most value in achieving an effective transition into the professional workforce?

- What can we learn from professionals' experience of support to guide education policy and practice for neophyte registered nurses and senior nurse managers in relation to transition and in aligning new staff into healthcare organisations?

The overall aim of the study was to examine positive experiences of support during transition for NRNs and senior nurse managers recognising

that the team is also influenced by the transition while similarly experiencing a role transition of their own.

It is important to highlight my own professional transition during the course of this research which inevitably influenced the study. I moved from an established university senior lecturer role in England to an island community where healthcare was provided independent of UK governance. This generated a new learning environment and moved me into a relative novice state, which introduced differences in organisational and pedagogical cultures, learning the island and organisational norms and the healthcare framework. The acknowledgement of this assumed novice position in a new environment was a powerful and challenging experience which caused me to question my expectations of the role (Forbes and Jessup, 2004; Dellasega *et al*., 2009). This juxtaposition of my transition with that of the NRNs I was researching made me conscious of the uncertainty that the situation evoked. However, the key difference was the knowledge and experience gathered during my career, being a professional, leading others, teaching others and observing others undertaking their own transition. I was therefore able to use this understanding to make sense of my experience and to manage my transition needs within it.

I was also conscious that my role would make me an insider researcher within my workplace, however, my lecturer role gave me a degree of detachment from the practice environment, making this less apparent. Although my introduction and position gave me insider knowledge of the organisation and workforce, it was obtained from a relatively hierarchal stance. This did not enlighten me with the history of the organisation, teams, or individuals which enabled me to enter the research study without insider knowledge. In addition, being new to the research site I was viewed with a degree of intrigue, with practitioners endeavouring to find out more about me. I was keen to maintain this intrigue, finding that it revealed the unexpected and took discussion in less obvious directions (Holloway, 2005). I was mindful of these various factors throughout the research process, aware of the risk that personal inquiry can bring and the assumptions that can be made (Coghlan and Casey, 2011).

Defining transition and socialisation

It is necessary to examine the issue of terminology as words such as 'transition' and 'socialisation' are interrelated terms throughout the literature (Duchscher, 2009) and thus through this study. The concept of transition is well reported; with Meleis (1985) valuing its role within nursing theory, due to the influence it has on the individual, carer, organisation and society. During this transition, an individual's behaviour changes in relation to their ability, identity, role and relationships. Thus the transition demonstrates an acceptance of change.

Socialisation is the process by which individuals become adjusted insiders, gaining appropriate skills and adapting to their organisational role (Mackintosh, 2006). According to Jayne *et al*. (2005) it involves three stages with the separation from academia; the transition into practice and forming an identity while integrating into the new professional role. It involves a process of knowledge acquisition, skills, values, roles attitudes and norms relating to the professional position (Merton *et al.,* 1957). The complexity of this process is further challenged by the influence of an individual's past on the expectations of self and environment (Lacey, 1977). Socialisation therefore, plays an influential role within this study and so will be explored further in chapter two.

Educational and cultural influence

University learning and values acquired at a personal level shape the NRN through a process of individual professionalisation. When entering the healthcare workforce, this process affects both occupational change and the organisational control governing it (Evetts, 2006). Furthermore, the environment and cultural elements involved are not static, as both the individual and the surrounding community continually re-create and influence them and the wider organisational culture (Senge, 1990). The environment and the people within it influence the relationships formed and thus the development of the individual (Brim and Wheeler, 1966). Equally influential are the values and actions of the people in that environment, as they will contribute to forming and sustaining a sense of identity for the practitioner (Race and Skees, 2010). Developing and sustaining

relationships enhances role acquisition and learning through sharing tasks, sense can be made of situations (Vygotsky, 1978), making it a necessary element of the transition. For a NRN to feel supported, all these cultural elements, including those from the individual professionalisation process and those of the wider organisation, need to align with each other.

1.3 Support: a professional concern

The transition from student to registered nurse is internationally recognised as a potentially challenging stage in an individual's career (Kramer, 1974; Lavoie-Tremblay, *et al*., 2008; Duchscher, 2009; DH, 2010a; Bjerknes and Bjork, 2012; Kaihlanen *et al*., 2013). It has the potential to ignite organisational and individual concern about competency and confidence to perform effectively within the practice arena (Casey *et al*., 2004; Higgins *et al*., 2010), resulting in recommendations being made for a period of support to assist the NRN through the transition process (DH, 2008b; NMC, 2008; Wangensteen *et al*., 2008; Duchscher, 2009; Chernomas *et al*., 2010). Therefore it could be argued that the successful facilitation of transition carries the same importance as preparing students at pre-registration level (Hickey, 2009).

In the UK, national policy regarding support for the NRN during their first four to six months of post registration is commonly provided through preceptorship (NMC, 2006; DH, 2010a). Although this is neither prescriptive, nor mandatory (UKCC 1993, 1999, Maben *et al*., 2006), it is considered sound professional practice (DH, 2001; DH, 2010a). The essence of preceptorship is to allocate an experienced practitioner (preceptor) to a NRN within their practice setting, aiding their development and consolidation of knowledge and skills (Ashurst, 2008; NMC, 2008; DH, 2009; NNRU, 2009). According to the DH (2009) benefits to NRN receiving preceptorship include: enhanced confidence; professional socialisation into the workplace; increased job satisfaction leading to improvement in delivery quality patient care; feeling valued and respected; and a sense of investment and commitment from and to employer's strategy and objectives. Policy guidelines from the NMC (2006) recommend that during the first year as registered nurses, individuals should have protected time to develop, learn and meet with their preceptor. It is therefore recognised

that the preceptor has the potential to be a strong influence on the NRN's self-perception and adaptation into the practice culture (Rush *et al*., 2009; Park *et al*., 2011) and thus plays an important role in the support process (Procter *et al*., 2011). Understanding the role of the preceptor and the commitment given, therefore, requires major consideration within the service ethos.

The emphasis has been for employers to manage transition experiences in order to support and retain the NRN (Ferguson and Day, 2007). However, the lack of policy guidance regarding the content given to preceptorship (DH, 2008a; NMC 2008) has resulted in it being modelled in a number of formal and informal ways. In creating bespoke models, healthcare organisations have developed a diverse range of programmes which have been shaped by individualised organisational understanding of preceptorship and their experience/expectations of NRNs (Higgins *et al*., 2010). This lack of policy guidance can challenge organisations to operationalise how the NRN can be supported in a practical and realistic way that enables the goals of the individuals and health service to be accomplished (Whitehead, *et al*., 2013).

Guidance on the content and the delivery of support programmes can promote organisational engagement and an evidenced based approach to the implementation of preceptorship. The relevance of enhancing the staff experience has continued to be on the national agenda, with the government report 'A High Quality Workforce' (DH, 2008b) outlining recommendations for healthcare organisations to concentrate resources on nurse education, preceptorship and continuous professional development. This demands organisations to continue to address the needs of its workforce in creating a culture which maximises on the skills and needs of its staff to perform effectively. The lack of guidance can also potentially create further disparity with the NRN having preconceived expectations of what this support can offer while the organisation may view it with a different priority and different content. What is understood, is that from an organisational perspective a successful socialisation increases job satisfaction, organisational commitment, identity within their role, professional performance and their retention (Bauer *et al*., 2007; Yang 2008; Walker *et al*., 2013).

The successful integration and professional competence, therefore, carries equal importance for both individual and organisation when generating a sustainable and effective professional workforce, making the quality of the support available for NRNs an organisational priority (Whitehead and Holmes, 2011). In order to achieve this, a collaborative approach with HE will further align the understanding and expectations between novice nurses and service employers (Hickey, 2009; Wilson *et al*., 2009).

There is debate within the nursing profession that 'mothering' of NRNs is commonplace in their first post, however Moreton-Cooper and Palmer (2000) argue that learning support (a structured process) benefits the nursing profession by building relationships of value, nurturing and sustaining the profession both personally and professionally. They give some compelling reasons for this:

- A defence against feelings of disorientation, disillusionment and burnout
- A framework for clarifying human values
- A way to recover meaning in to social relationships
- An access to role models in the workplace (personally and collegially)
- A device for evaluating and disseminating best practice in healthcare
- As acquiring 'emotional literacy' (constructively managing emotions in a mutually beneficial way)

However, insufficient support for the NRN continues to be an on-going research theme in relation to the NRN workforce experience (Cowin and Hengstberger-Sims, 2006). Johnstone *et al*. (2008) and Cubit and Ryan (2011) agree that dedicated support plays a crucial role during the transition period but claim that little is understood about its nature and concept when aligning the needs of the NRN and the healthcare organisation (Andrews and Roberts, 2003). Johnstone *et al.* (2008) view this form of support as critical to enable registered nurses to become safe and effective practitioners within organisational processes and systems. However, a key recommendation that comes from their work is that the nature of what support entails has been largely under-investigated, this

makes it difficult to both create an evidence base for its content and to regulate its provision. Therefore a working definition of what support is and involves would be useful for benchmarking and practice initiatives. This would enable future research to identify the optimum support length, delivery and provider.

While the need and the rationale for providing support for the NRN is recognised (Kramer, 1974; UKCC, 1986; Lathlean, 1987; Johnstone *et al*., 2008; Cubit and Ryan, 2011), and carries a plethora of international and national evidence identifying its benefits (Whitehead *et al*., 2013), what it means and involves for the NRN and senior nurse has not been articulated (Johnstone *et al*., 2008). This creates a challenge for professionals and organisations to understand and to deliver the support needs when balancing the organisational needs against the individual agenda in an already complex healthcare climate.

Although NRNs have achieved academic merit and a 'Fitness for Practice' standard (NMC, 2004), demonstrating their competence, they do not necessarily have the self-confidence to perform in a new practice environment (Kelly and Ahern, 2009). This can be challenging for an organisation and a clinical team to prioritise when there are increasing practice and workforce demands and diverse agendas which result in continuous change (Morley, 2009). This workplace pressure can increase the NRN's responsibility and the expectations of their autonomy within the inter-professional team (Morley, 2009; Bjerknes and Bjørk, 2012). It is also recognised that this pressure influences job satisfaction (Chang and Hancock, 2003) and attrition (Tourangeau *et al*., 2010). The multiple agendas may make it challenging for the manager to observe the impact of the workplace on the new member (Walker *et al*., 2013). Equally these agendas could also result in limited resources being invested into support processes (Draper *et al*., 2010) and influence its content and availability (Mooney, 2007a; Drury *et al*., 2008; Dyess and Sherman, 2009); even though senior nurse managers, NRNs and educationists agree that they are required (Wangensteen *et al*., 2008; Duchscher, 2009).

The senior nurse managers, together with members of the team, carry a key responsibility for a smooth and safe transition of NRNs into the workforce. However, there is limited empirical research examining senior

nurse managers' expectations and understanding of the transition process (Walker *et al*., 2013) and the support needs to realise this. Understanding the perceptions and expectations of the senior nurse manager is relevant when establishing if these align with those of the NRN. Where there may be differences there could be a negative influence on the support relationship, learning opportunities and progression of the NRN. This could further complicate the smooth integration for this workforce group, making this worthy of exploration. An effective transition holds importance to policymakers and to employers, who need to both retain and develop their nurses (DH, 2006; DH, 2008a). Therefore the issue of achieving a successful transition for NRNs carries great importance not only financially but also to the safety of patient care and to enabling a productive team culture.

The culture of an organisational workplace is recognised as vital to the effective transition of the NRN (Walker *et al*., 2013). A work culture can, for example, have a profound effect on shaping the attitudes and behaviours of the new workforce (Henderson *et al*., 2006), and how these manifest to those joining it can determine an individual's loyalty, commitment, performance and engagement (Thrysoe *et al*., 2012). While socialisation and transition are on-going processes (Mackintosh, 2006) the initial phase can introduce real challenges around role stress, differing expectations and values, and moral integrity for the NRN (Morrow, 2009). The interaction of the established team with the new appointees can influence degree of integration and participation in work related activities (Wenger, 1998). This prioritises the importance of a team approach to the transition process, and the need for clarity regarding the expectations of those undertaking it, recognising that where this is not present the challenge increases (Thrysoe *et al*., 2012). Thus the collegial workplace cannot afford to be complacent towards the process even though they may be encountering it on a regular basis through staff recruitment and student placements. Each episode will inevitably influence the team dynamics changing individual responsibilities and shifting roles. Although this holds importance within the transition process, it has continued to receive limited exploration. However, the transition and the socialisation of a new member introduces further responsibility for the practice community, and challenges

them to balance the needs of the individual with the increasing practice and workforce demands and diverse agendas.

1.4 The changing professional landscape

With experts predicting the impending nursing shortages as a national and international concern, the importance of the effective integration of the NRN into the workforce becomes important. Nurses are the largest single profession within healthcare making up nearly 30% of the workforce (Hyde *et al*., 2006), with nearly 60% of these being newly registered (Higgins *et al.*, 2010). These figures serve to illustrate the contribution of this group to the workforce (Duffield *et al*., 2011) and a need for employer investment in developing long term support strategies (Whitehead and Holmes, 2011). Studies exploring the attrition identify that ranges between 20-50% within one year (Winfield *et al*., 2009; Hillman and Foster, 2011) increasing to 35-65% within three years of employment (Giallonardo *et al*., 2010; Whitehead *et al*., 2013). Explanations for the high attrition rate for this group include role ambiguity, role insecurity, role overload, inadequacy and instability (Maben and McLeod Clarke, 1998; Chang *et al*., 2006; Kelly and Ahern, 2009; Duchscher, 2009; Kramer *et al*., 2013a; Marom and Koslowsky, 2013). Overall, how NRNs are welcomed and supported play an important role in staff retention, and when not successfully implemented risk a negative influence on both NRN attrition and performance. The aging population, and projected shortage of qualified practitioners (WHO, 2006; Buchan and Seccombe, 2011), consequently are concerns high on the national policy workforce agenda, in a climate where the delivery of quality care is evermore essential (DH, 2013).

Meanwhile nursing has evolved alongside law changes encouraging entrepreneurship (DH, 2006) and career movement within and between inpatient healthcare provision, independent and third sector working. This brings great opportunity for the registered nurse, but also carries high expectations, professionally and publicly, of their role. The 'public-eye' is scrutinising the delivery of care, with standards and organisational cultures being questioned (DH, 2013). This makes the provision of high-quality care and assessment of that quality increasingly central in the present

healthcare environment. When preparing a nurse to practise the NMC requires generalist skills, competencies and abilities which transfer their knowledge into today's diverse healthcare needs (Longley *et al*., 2007). The NMC and the Department of Health (DH) are responsive to public and service needs and introduce new initiatives to manage this. Examples include the 'essential skills clusters' competencies within the pre-registration nursing curriculum (NMC, 2007) and 'Essence of Care' (DH, 2010b) to benchmark standards. The registered nurse is expected to provide care that is efficient, effective and of a high evidence-based quality (DH, 2008a). These factors put an ever greater demand on the student during their journey to registered nurse to perform these standards in line with professional, public and service need.

Nurse Education has undergone numerous changes over the last few decades. Student nurse education has moved from an apprentice model, working within the workforce, to a Higher Education (HE) model as part of the introduction of Project 2000 (UKCC, 1986). This move introduced supernumerary status for the student learner and required them to achieve diploma status as the minimum academic level. Since its introduction, concerns have been voiced regarding the competence of NRNs (Carlisle *et al*., 1999; Runciman *et al*., 2002). In response to these concerns, a review of nurse education was undertaken culminating in the Peach Report (Fitness for Practice (UKCC, 1999) and 'A Vision for Nursing, Midwifery and Health Visiting' (DH, 1999) both of which highlighted the importance of the practical and academic learning required to be a registered nurse. Recommendations were made for placements to start earlier in the programme and of longer duration. The reasons were to enhance clinical skills, and to encourage a collaborative relationship between education and healthcare. Some argue that this change in approach has separated the hospital needs from those of HE (Anderson and Kiger, 2007), which has influenced the integration of the NRN. Authentic partnership although complex (RCN, 2012) is essential in bringing the combined needs together to provide a curriculum which does not compromise the student experience and competence. Giddens (1987) suggests that collaborative working is advantageous in its ability to generate new working styles which can also change the powerbases within the partnership. Thus collaboration changes the ownership and the inherent blame culture related to this on-going

research theme, sharing the challenge between the partners to appreciate individual and corporate needs to generate a 'fit for purpose' approach.

The curriculum developments inevitably generate a different approach to each HE programme design which is standardised and authorised by the NMC and EU directive processes (NMC, 2010). This can create difficulties for the NRN when starting their registered role as the professional community may be unfamiliar with their programme content and refer back to their individual training. This can be confusing and potentially isolating for the new recruit, with limited appreciation of their knowledge and experience. Further educational change has been implemented with the introduction of an 'all graduate curriculum' (September 2013), which aims to bring nursing in-line with other professional groups and to develop a more knowledgeable workforce (cited NHSEO, 2009). This creates further diversity in registrant preparation, and therefore requires the practice community to understand the NMC objectives and the individual's needs, to ensure that an informed and a knowledgeable approach is taken when supporting the start of the NRN's career (Regan *et al*., 2009).

Employability is now a core metric within the HE sector, with a responsibility of producing graduates who are ready and able to be integrated into the workforce seamlessly (Berntsson, 2008; DBIS, 2012). Healthcare organisations want nurses who are competent, knowledgeable and skilled, and the public expectation of the professional role is rising (DH, 2012). This, coupled with the continual change within healthcare, makes it ever more important that the NRN is effectively aligned with organisational expectations and service needs.

> *'Higher education is considered vital for developing a productive and dynamic labour force to meet the demands of the global economy' (Bardhan et al., 2013, p.1239).*

This introduces various challenges for HE and healthcare in preparing the NRN for employment. Aligning practice preparation with practice need is recognised by Levett Jones and FitzGerald (2005) as a practice conundrum. Despite two decades of nurse education delivery within HE, the research themes continue to suggest that the NRN does not quickly or

easily fit into the practice environment (Johnson and Preston, 2001; Burns, 2006; Morrow, 2009). Cowin and Jacobsson (2003) question how an education system can prepare nurses when they and the healthcare workplace are not in alignment with regards to nursing care philosophy. This highlights the importance of having a collaborative working relationship between service and HE.

The above indicates that *support* is not a simple practicality in managing expectations, experience and organisational skill. The context of *support* also needs to make sense of, and take account of, the ideals and values within the healthcare culture (Halfer and Graf, 2006). This infers that *support* must address the practical issues and the complex growth of a professional identity within an organisation, whilst also helping to develop generic skills and attributes (Kelly and Ahern, 2009; Caballero *et al*. 2011). The literature helps the reader to understand the NRN's experience of transition and the complex challenges presented within organisations; staff attrition, aging workforce and evolving healthcare needs. However, this does not illustrate the understanding of the support processes needed to aid socialisation.

1.5 The local context

The research setting was on a small island community which operates a healthcare system fashioned on the National Health Service. Secondary care is provided through one hospital site which employs a registered nursing workforce of about 900 staff. Similar to other healthcare communities, the organisation is experiencing challenges in that they have an aging workforce and difficulties in recruiting and retaining to nursing positions. To address this need, the organisation was working creatively to attract new registrants which made the study timely in helping to understand what constituted support of appointees during their transition. I had been appointed to an educational post and was able to develop my thesis in line with initiatives.

A preceptorship model was well established at the study site. A bespoke workbook was available which required NRNs to work through a set of

locally developed competencies which were signed off by the preceptor and senior nurse manager. This process was incorporated into a probation period, for which successful completion determined tenure status. This introduced pressure for those working through the preceptorship process and additional responsibility for their preceptors. This model was regarded as appropriate for local circumstances by the organisation, however, there were anecdotal concerns about its relevance to the NRN transition needs.

1.6 Chapter summary and outline structure of the thesis

In this chapter I have highlighted the challenges and the opportunities which influence the provision and the effective delivery of tailored support for NRNs during the transition period. This is at a time when emerging governmental and professional policy developments emphasise the importance of ensuring the appropriate support mechanisms are embedded for this workforce group so that they can be effective in responding to an evolving landscape of clinical practice.

In chapter two, I examine debates from research and theory in relation to the concept of support and the transition process. It reviews key themes related to support processes identifying what is currently known and the influence that it holds on the research question.

In chapter three I explore the methodology, research design and ethical issues.

In chapter four I present the findings from the mini-summit data.

In chapter five I provide a discussion of the key findings emerging from the study and illustrate the transition as a shared event through a conceptual model.

In chapter six I conclude the study by sharing the key discoveries regarding the meaning of support and linking these to the organisational development opportunities. I will also address the value the research

findings have on healthcare employers, nurse practitioners, and education. Finally recommendations and suggestions will be made for further enquiry.

Chapter 2: Literature review

In this chapter I discuss my literature search strategy and critical review of selected published studies examining the perceived support needs, practices and influencing factors associated with a successful transition for the NRN. The critical analysis of the literature aimed to identify gaps relating to existing research and theory concerned with the nature of support. It also explored the factors which both NRNs and senior nurse managers perceived as of most value to a successful transition. This collective analysis aimed to inform the future education and practice needs for the NRN and manager in aligning new staff into healthcare organisations.

Chapter one illustrated the diversity of factors which influence the study, resulting in the literature connected to the subject being substantive. It is for this reason that a conventional approach has not been taken to the literature review. Terms associated with 'transition of nurses into the workforce' identified a substantial quantity of papers, often with a limited focus on the intricacies of the nature of support. Therefore a conceptual model has been developed to embrace emerging themes within the literature and to help frame the review in an attempt to both organise the literature and to address the study questions. A snowballing like technique was adopted allowing me to connect to relevant citations to enhance my search.

My approach to the literature review was to use a traditional web-based search which was further enhanced with relevant citations found through reference lists. In order to manage the complexities of overlapping and diverse discourses relating to support during NRN transition, the structure of this chapter has been framed by the research questions identified in chapter one. Prior to the literature review I will explore the context of transition and socialisation, and examine any issues raised with regards to NRN support needs.

2.1 The search method

The aim of the literature review was to identify and analyse the evidence relating to the subject of support in the transition from student to registered practitioner. To ensure rigour the review was initially conducted systematically to reduce publication and selection bias. To enable this, I gave clarity to the inclusion and exclusion criteria. The review included only primary/empirical studies which used English-language and that were published between 2003 and 2013. This was to ensure that recent and relevant evidence was incorporated to establish what is already known about the area of inquiry.

The search strategy

The initial literature search incorporated a wide range of databases to capture the wealth of related evidence exploring the subject of support with the transition. In addition, key journals such as Nurse Education Today, Nurse Educator and Nurse Practitioner were searched manually to add to the comprehensiveness and locate other studies which might address the research questions. Additional references from retrieved publications were examined for other relevant sources.

Search terms

Key words, relevant synonyms, and associated truncations that were used in the search included 'support in transition', 'preceptorship', 'student nurse transition', 'new graduate nurse', 'new registered nurse', 'nurse manager' or 'leaders'. These terms were also combined with others including 'socialisation', 'integration', 'orientation', 'stress'; and 'job satisfaction', in response to the diversity of issues raised in the literature. Terms were inspired from published papers. A manual search of key UK and US nurse educational journals was also conducted to determine further key words to enhance the process.

Databases

The databases used were BNI, CINAHL and Medline, each were chosen due to the wealth of available citations which use the English language and focus on nursing. The search introduced a variety of challenges, with terminologies such as 'orientation', also being written as 'transition'.

Additionally the term 'preceptor', an accepted term in the UK, meaning 'mentoring newly qualified nurses', is understood to be a 'mentor' in countries such as Ireland and USA. The term 'mentor' is also associated with a range of educational and developmental roles which creates additional challenges to the search.

Selection criteria

Studies focusing on pre-registration students and patient related transitions were removed, as were duplicate citations, leaving a total of 339 original pertinent citations. Citation abstracts were systematically reviewed and those not meeting the inclusion criteria were deleted, leaving seventy four papers for potential inclusion (Figure 2.1). The 74 articles were then evaluated and filtered through the following criteria: based on empirical research; included an abstract; focused on secondary care; focused on transition support processes for NRNs' integration to the workforce. Publications that were removed were for the following reasons: focused on clinical competence; studies exploring specialist areas or rural communities; editorial or grey literature. The final number of articles included in this study was twenty-one.

Sample of studies selected for analysis

The twenty-one primary studies were critically appraised to ensure that a consistent and systematic approach was taken to critique the chosen articles. The tool used in the review was the Critical Appraisal Skills Programme (CASP), Briggs, 2006)) and Figure 2.1 illustrates the strategy taken.
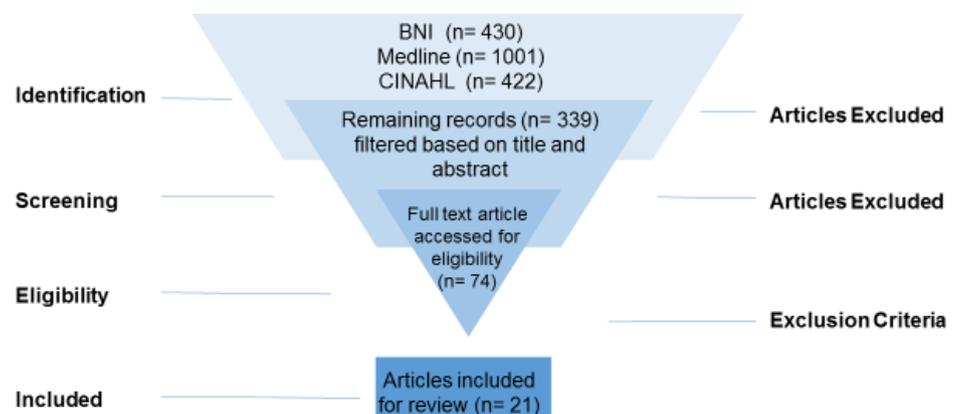
Figure 2.1 Database search strategy

Sample sizes of study populations in the research papers reviewed ranged from 9 to <6000. Methodological designs are identified in Table 2.1. The majority employed a qualitative study design (n=12), but mixed methods (n=6) and quantitative (n=3) were also employed to address specific aspects of transition and support. The majority of the literature was of US and Australian origin.

Research method	Authors
Phenomenological (interpretative)	Thrysoe *et al.*, 2012
Grounded Theory	Mooney, 2007a
Ethnography	Bjerknes and Bjork, 2012
Broad qualitative approach	Clark and Holmes, 2007; Dyess and Sherman, 2009; Chandler, 2012; Feng and Tsai, 2012; Cleary e*t al*., 2013; Horsburgh and Ross, 2013; Olson, 2009; Randall Andrews, 2013; Walker *et al*., 2013
Mixed methods	Casey *et al.,* 2004; Halfer and Graf, 2006; Johnstone *et al.,* 2008; Maben *et al*., 2007; Parker *et al*., 2012; Scott *et al.,* 2008
Quantitative approaches	Cho *et al*., 2006; Ulrich *et al.,* 2010; Kramer *et al*., 2013a

Table 2.1 Methodological approaches employed in selected studies (n=21)

I will now address the concepts of role transition and occupational socialisation. These theoretical perspectives help guide understanding and conceptualisation of the transition on the NRN. The theoretical perspectives explored were: situated learning (Lave and Wenger, 1991), social learning (Wenger, 2000) communities of practice (Wenger, 1998), role transition (Meleis *et al.,* 2000; Duchscher, 2008) and socialisation (Scott *et al.,* 2008).

2.2 Transition and occupational socialisation - context

The transition period of student nurse to registered nurse is well documented as a time of heightened stress for new staff; in particular, NRNs. This is in part due to the move from the structured university learning environment to the act of practising as a registered professional. The new role is multidimensional and interlinked with complex personal and professional values and practices. These will have been influenced by educational background, practice environments and peers (Maben *et al.,* 2006). In addition the variance in programme structures and the individual learning taken from these will influence the transition process. However, Benner's novice-to-expert model positions the NRN as novice or advanced-beginner (Benner, 1984), seeing them at an early stage of applying clinical skill and reasoning. Organisational orientation programmes are recognised as supporting the move from novice to advanced beginner (Bjerknes and Bjork, 2012; Dyess and Parker, 2012; Kramer *et al*., 2013a). But despite this, programmes vary in content and intensity, length and structure, and in their use of preceptorship, adding additional uncertainty to the transition (Scott *et al*., 2008; Whitehead *et al*., 2013). However, the findings from Scott *et al*. (2008) who used a mixed methodology study design with a sample of 329 participants confirms that NRNs who received extensive orientation were more satisfied with their job, illustrating the importance of the transition process for both the individual and long term success of a stable workforce.

The transition naturally involves more than one person, by nature, it refers to both the process and the outcome of complex person-environment interactions (Meleis and Trangestein, 1994; Kralik, *et al*., 2006; Thrysoe *et al.,* 2012). These have significance on both the individual and the organisation, with the NRN entering the profession with the high of achieving registration while faced with the enormity of the practice reality (Dellasega, 2009; Caliskan, 2010; Lee *et al*., 2013). In turn the organisation has change introduced through the introduction of a new member and the challenges that this can bring. This emotional matrix can result in the new professional having (in)appropriately high expectations of self in their desire to perform well, seeking an environment which can facilitate this, while the organisation has diverse agendas competing with its time. This can lead to the NRN experiencing feelings of self-doubt and

overwhelming stress (Delaney, 2003; Wieland, *et al.,* 2007; Walker *et al.,* 2013). This reaction is often referred to as 'transition shock' (Duchscher, 2008) where the NRN moves from the security of learner status to accountable world of professional practice. Individuals enter with the excitement of achieving the goal of registration with academic merit, to the challenge of becoming a registered professional within an organisation. This introduces a different structure to their pre-registration life. This change could be mistaken for discomfort and uncertainty which could affect anyone experiencing difference in their work. However, there is a plethora of evidence which links it particularly to the NRN experience, finding that they do not always encounter the supportive environment needed for a successful transition. In addition they can find that their practice expectations do not align with their established practice colleagues (Randall Andrews, 2013; Walker *et al*., 2013).

Literature covering the last four decades has produced various theories that enhance understanding of the complex and challenging experience of the transitioning NRN (Kramer, 1974; Benner, 1984; Duchscher, 2009). Duchscher, (2008, p442), an eminent researcher in this area, proposed three distinct stages of development: 'Doing' (first three months); 'Being' (months four to seven); and 'Knowing' (how individuals explored the complexities and interplay of the "emotional, intellectual, physical, sociocultural and developmental issues") which take place during the transition (Appendix 1). This framework appears relevant to the context of transition and therefore has been incorporated into my conceptual framework to help inform understanding regarding the nature of the support needs on the transition from student to registrant.

The change in environment

Change is a significant feature in the literature exploring transitioning of student nurses into the workforce (Kralik, *et al.,* 2006). A concept analysis of transition has addressed key areas such as **awareness; engagement; change and difference; time span and critical points, and events** (Meleis *et al*., 2000) provided both a perspective and a framework for understanding the concept of transition**.** The theoretical framework

originated from an exploration into the patient transitioning through ill health, linking this to the concept of the vulnerable patient. Meleis *et al*. (2000) correlated this to the NRN experience, connecting individuals' experiences of uncertainty and vulnerability. Their framework emphasises the influence that the transition has on the NRN feeling connected to, and interacting with, their situation and people around them. When a NRN feels situated in the work setting, this enables them to reflect and interact, and develop increasing the confidence to manage change, gaining new skills and a new approach to their work and identity (Meleis *et al.,* 2000). When exploring these properties further, the NRN may be **aware** of the change that role transition brings, but they may not fully recognise how this affects them in reality (Parker *et al.,* 2012). It is therefore difficult for them to understand the potential the experience carries when they have no practical knowledge to assist their understanding. It is, however, essential that the preparatory support facilitates both discussion and shared experience. This support enhances awareness, as expressed by Gadamer (1979, p271-3):

> *'Conversation involves working to bring together the insights and questions of the different parties; it entails the fusion of a number of perspectives, not the entering into of one.'*

This **engagement** is essential. It necessitates active participation within the transition process. Commencing a new role alone is not enough; there is an individual responsibility to engage and be active in the transition process. Senge *et al.* (2004, p.13) believes this is about being present:

> *…'to appreciate presence as deep listening, of being open beyond one's preconceptions and historical ways of making sense.'*

This may challenge an individual's knowledge, prompting their ability to see and think. The NRN develops expertise based on integrating professional experience with formal knowledge (Engebretson and Littleton, 2001). To this they bring their personal understanding, based on their cultural, experiential, and formal knowledge. The individual and the organisation each have their own culture, holding beliefs, values,

expectations and language which influence their practice interpretation (Mooney, 2007b). The cultural influences will be constructed through the team relationships. For the NRN to be active within these relationships, they need to gain knowledge and understanding through their performance and engagement (Bandura, 1977; Thrysoe *et al*., 2012; Bjerknes and Bjork, 2012). Therefore this cannot be achieved through cognitive attainment of knowledge alone (Lave and Wenger, 1991).

The transition properties **change** and **difference** view learning as change, which occurs naturally when gathering and applying new skills and knowledge and so changes behaviour (Twycross, 2002). However, change does not happen solely through registration but also through exposure to the complex healthcare arena (DH, 2010a; Cleary *et al*., 2013; Little *et al.,* 2013). This inevitably influences the function of the established team and increases practice demands (Hardy *et al.,* 2009), which requires leadership consideration and planning (Morrow, 2009; Haggerty *et al.,* 2013). Illeris (2003, p169) views learning in the workplace as;

> *'… both an individual and social process, comprising both ordinary everyday learning and more complex personal development'.*

The **difference** is viewed by the authors as the perceptions of others, with some feeling that the NRN has achieved their goal (family) and others seeing that there is more to learn (employer), demonstrating the diverse expectations and interpretations of the individuals situation. This process can generate personal and professional isolation (Hall *et al.,* 1994; Morrow, 2009), as the individual does not want to disappoint or let people down. Therefore true emotions may not be shared at home or work about the reality of their experience, creating further distance and isolation. This is evident in a recent phenomenological study (Lee *et al.* 2013, p793) where NRNs spoke of '*masking themselves'* hiding their *'true self'* to protect themselves from negative attitudes or behaviours from those around them.

The final properties of transition are **time span, critical points** and **events**. Meleis *et al*. (2000) suggest that transitions can be unending with

27

learning and professional growth evolving throughout their career. Life-long learning is an essential aspect of professional working. In chapter one I alluded to the potential variance in the education and practice, interpretation of the pre-registration curriculum, and how this affects the knowledge and skills that the individual has. Therefore there may be an element of bespoke need to the transition process (Dellasega, 2009; Bjerknes and Bjork, 2012) which may not fit within the designated timeframe. Transition models from authors such as Duchscher (2008) can inform programme timelines and map out development stages but still the theories do not smoothly underpin the policy guidance from the NMC (2006) who advocate 4-6 months and the DH (2010a) 12 months, although Duchscher's (2008) transition model states that the individual's development and growth is not a static process. As the needs become apparent, the skilful eye of the preceptor and the nurse manager are required to facilitate the NRN's progression (Dyess and Parker, 2012; Haggerty *et al.,* 2013). Critical moments are significant to both the NRN and to the nurse manager because they signify their awareness to the new levels of engagement in the learning process. Critical moments are powerful scenarios which stay in the memory due to their relevance to the individual (Brookfield, 1995). The relevance and new understanding taken from the event potentially brings deep learning and future awareness (Ramsden, 1988, Ghaye *et al.,* 2009). This may happen as registrants start to feel confident in making decisions about patient care, and communicating within the team. Mooney (2007b) identifies this as metamorphosis, where the NRN becomes visible, moving from the shadow into responsible practitioner.

Although it is acknowledged that the transition process is not a challenge experienced by all NRNs (Lee *et al.,* 2013), change alone can induce uncertainty when entering a new community of practice. The term community of practice has been adopted from Lave and Wenger's (1991) work as it characterises the practice setting explored; 1) different levels of expertise presenting throughout, 2) movement throughout team from novice to expert, 3) authentic tasks and communication (Johnson, 2001). The desire to be accepted within the clinical team is an important element of the transition process (Hunt, 2004; Morrow, 2009; Bjerknes and Bjork, 2012) which affects both the new member and the established team. The

transition process tends to introduce two themes; the reality of being a registered nurse and the socialisation process of entering the professional workforce. The NRN enter their professional role with recognition that they are accountable for actions, decisions and omissions relating to the management of the patients in their care. This may precipitate anxiety and disappointment for some, particularly when individuals find that it is not solely a process of applying knowledge and skills, but the adaptation of this within the bounds of the professional community (Clark and Holmes, 2007). These themes will be explored in more detail in the literature review.

There is a plethora of research dedicated to the transition from the NRNs perspective (Kramer, 1974; Benner, 1984; Kelly, 1998; Chang *et al*., 2006; Morrow, 2009; Martin and Wilson, 2011; Lee et al., 2013; Kramer *et al.,* 2013a), but minimal work examining the nurse manager or organisational perspective (Walker *et al.,* 2013). However, when examining human-adaptation the change in the event/non-event, affects relationships, routines, assumptions or roles (Schlossberg *et al.,* 1995), which will inevitably have an influence on those connected with the individual undertaking the transition. This makes the effect of the transition more than solely an individual activity, but becomes a process which ripples out, challenging surrounding colleagues to respond to the change that any one person can bring when entering an established practice community. Thus the transition is potentially a shared experience.

Organisations have the responsibility to manage the workforce, to ensure that the budget is efficiently managed and that public, policy and professional needs are met. When employing a new registrant they are introducing a new skill and value set into the workforce. This will bring with it a period of change for the established nursing team. Given the employment pattern of the NRN identified in chapter one and the effects that this has on the employing organisations it is timely to understand the expectations of both the NRN and the senior nurse managers (Randall Andrews, 2013; Walker *et al.,* 2013). Understanding these expectations may influence education and healthcare organisations in facilitating an effective socialisation and supportive experience.

2.3 The literature review

Conceptual Framework

This section presents a critical analysis of selected studies to identify key debates and gaps and which also aimed to inform the development of research questions and methodological direction. To help make sense of the complexities associated with NRNs' entry into professional practice, a conceptual framework has been developed (Figure 2.2) to focus on key ideas and their relationships (Polit and Beck, 2008). A simplified version of Scott *et al's*. (2008) socialisation framework has been used because it helpfully stages the perspective of the NRN undergoing the socialisation process, incorporating the pre-work experience, actual work experience and work adjustment. Although it acknowledges the organisational influence on the new recruit it does not overtly consider the team socialisation. However, the stages provide a strong framework for discussion regarding the influence the socialisation process has on the NRN and the healthcare organisation. The stages, '*Anticipatory socialisation'*, '*Organisational socialisation'*, and '*Socialisation outcomes'* are used to structure the next stage of the review. Figure 2.2 gives a simplified interpretation of the conceptual framework using the significant elements to address the research questions. Additionally, Duchscher's (2008) transition stages - 0-12 months - are incorporated, as Scott *et al's*. (2008) framework was originally designed for the first two years of the NRN's career. This timeline is inconsistent with many researchers who believe that socialisation is usually successfully achieved within 12 months (Delaney 2003; Duchscher, 2008; Anderson and Edberg, 2010; Kramer *et al*., 2013b), with the '*reality shock'* apparent one month into practice (Thompson, 2011).

It is therefore reasonable to assume that these two models might fully represent the process as a linear activity and not the multifaceted phenomenon that the literature suggests (Maben *et al.,* 2006). To acknowledge this I have incorporated Wenger's (2000) work on social learning where he observes the modes of belonging, (**engagement**, **imagination** and **alignment**). This ecological approach may add further insight into understanding the expectations of support and what it means in the transition process. Ecology is defined as:

'a set of social interactions between multiple elements that are neither fully constrained nor fully independent' (Abbott, 2005, p.248).

With this approach the influence of the healthcare organisation on the transition support can be considered. The purpose of this conceptual framework is to apply the concepts by critically examining the selected studies comprising the literature review to answer the research questions posed.

Redacted due to copyright

Figure 2.2. Adaptation of Scott et al's. (2008) Socialisation model incorporating Stages of Transition Theory 0–12 months (Duchscher, 2008) and Modes of Belonging (Wenger, 2000)

What constitutes support in meeting the needs of NRN and the healthcare organisation during the transition period?

Support

The Latin phrase for support is Alo, meaning to nourish, cherish, support, sustain, maintain and keep. The last point holds great resonance for the attrition figures within this workforce group (Winfield *et al.,* 2009; Giallonardo *et al.,* 2010). However, each word plays a pertinent part in developing and engaging an individual in their professional role and

resonates with the findings in the studies reviewed. It is recognised that support and guidance play an important part in managing the transition from student to NRN (Johnstone *et al.,* 2008; Wagensteen *et al.,* 2008; Duchscher, 2009). To address the extent of this issue Johnstone *et al.* (2008) studied the concept of support, using mixed methods, with a sample of NRN (n=11) and stakeholders (n=34). Interviews and questionnaires were given to NRNs (in their first year) and key stakeholders. The findings upheld the notion that the NRNs are vulnerable in the early stages, but that support in the form of positive constructive feedback aided their resilience. Additionally, it was identified that NRNs' performance improved in a shorter timeframe (3-4 months) when there was a structured support framework in place. The study highlighted the individual nature of the transition process, indicating that although there are generic themes within the NRN experience in the stages of transitioning, there are also individual needs which require consideration. This study demonstrates that providing certain support structures can maximise the integration of NRNs, their resilience and performance. Individual needs require acknowledgment as does the process of socialisation.

Maben *et al.* (2006) acknowledge the valuable role of positive support has in shaping self-esteem and attitudes to post registered practitioners. The NRN's self-esteem was initially challenged by the newness of the culture, systems and environment. Feng and Tsai (2012) observed this in their qualitative study of 24 NRNs and 63 stakeholders, where their aim was to explore the socialisation experiences of NRNs. Data analysis revealed that although individuals needed time to fit into a system, the greatest challenge was building and maintaining interpersonal relationships while learning the cultural rules. Their study identified that it took five months of working in the environment until NRNs' stress levels became less evident. Their stress appeared to be in part due to the fear of colleague reprimand rather than their professional ability. So although the timeline correlates with Duchschers stages (Doing), the findings attribute this to self-esteem and acceptance within the team as being the important support factors. When understanding the ward culture and norms, the NRN was more able to perform competently. Duchscher (2008) would suggest that this is a natural process in which the NRN is learning to understand their role in the hierarchy; matching their values against their colleagues' to identify safe

and ethically aligned practitioners to approach for support (Maben *et al.*, 2006; Thrysoe *et al.,* 2012). A period of orientation is discussed in four of the selected papers (Casey, 2004; Bjerknes and Bjork, 2012; Chandler, 2012; Feng and Tsai, 2012) with transition programmes spanning one month to twelve months. Each identifies orientation as an important feature of support, and this is generally interpreted as preceptorship (Casey, 2004).

Preceptorship may be delivered formally or informally, through structured teaching programmes and or 1:1 support (Kilpatrick and Frunchak, 2006; Kimberly, 2007; Price, 2009). Although its provision is considered good practice and a potential incentive to NRN recruitment (Anderson and Edberg, 2010; DH, 2010a) there is no consistent approach given to its content or delivery (FitzGerald *et al.*, 2001; Rush *et al.*, 2013). Many studies suggest that nurse managers should be leading and motivating the process (Halfer and Graf, 2006; Morrow, 2009; Omansky, 2010; Dyess and Parker, 2012; Haggerty *et al.,* 2013), however, this is not a practice pattern. This may be a result of the competing priorities experienced by the nurse manager role or a lack of awareness of the issues relating to the transition process.

Preceptorship is discussed in a variety of ways from the how it is delivered (Kramer *et al.,* 2013a), the need for guidance and preparation for the preceptor role (Henderson *et al.,* 2006; Parker *et al.,* 2012), and acknowledging the importance of the preceptor role (Haggerty *et al.,* 2013). The more recent studies discuss the need for guidance and preparation for the preceptor role (Chandler, 2012; Harrison-White and Simons, 2013), appreciating its importance (Cleary *et al.*, 2013; Rush *et al.,* 2013) and the need for it to be better acknowledged. The allocation of preceptor to preceptee is often based on availability and if they are considered as 'good clinicians' rather than good preceptors (Henderson, 2006). The studies indicate the need for a structured approach to the preceptor role.

Emotional support for the NRN features in Walker *et al's*. (2013) qualitative study of NRNs (n=69) and nurse managers (n=25), where they identify the importance of its provision in the workplace. In addition, the findings also

report the relevance of the organisation in being active in the support process, establishing that this assisted the NRN in both building their confidence and in enabling a successful integration. When not actively involved it was found that this had a negative impact on the confidence and competence of the NRN. These workplace findings correlate with earlier research by Johnstone *et al*. (2008) and theory by Duchscher (2008), indicating a pattern of importance regarding the relevance of the emotional experience in achieving effective support.

This theme was explored in a further three papers linking lack of emotional support to stress and a poor transition experience. Marked themes included the sometimes insensitive nature of the preceptor role, where the needs and the anxieties of the NRN were not fully met (Casey *et al.,* 2004; Randall Andrews, 2013). Findings from Maben *et al's*. (2007) mixed method study (n=26) revealed that emotional support was particularly pertinent when in an unreceptive environment. The quotations used generated unique meaning adding value to the findings, however, there is minimal detail given to the methodological process. In Horsburgh and Ross's (2013) qualitative study (n=42), participant data suggests that support in the practice environment was viewed as 'luck of the draw' and dependent on the willingness of individuals working with NRN's rather than a cultural norm.

The subject of support attracts much interest, however, efforts to explore what it comprises of to enable NRNs' effectiveness is less clear. However, what is evident from this review is that the provision of support is dependent on individual practitioners rather than a cultural norm. The evidence highlights the importance explicit support has on the development of the NRNs self-esteem, improved performance and their team integration. The nature of support appears to be a combination of emotional, physical and learning activities which involves orientation, positive feedback and team engagement.

Considering the research question further Scott *et al's*. (2008) first stage, **Anticipatory socialisation** (Doing, engagement), will be used.

Expectation

International literature spanning four decades has considered the debate relating to whether the new registrant enters practice prepared, and still HE and healthcare do not share the same view (Bendall, 1975; Melia, 1984; Bradby, 1990; Regan *et al*., 2009). Data from the Innovations Centre Staff (2008) record that only 10% of healthcare managers consider the NRN to be ready and able to provide safe and effective care. Registration liberates the opportunity to live out the collective learning and ethical conduct, however, it can be felt that the team dynamics and hierarchal pressures make it hard to deliver in the practice reality (Duchscher, 2008; Kramer *et al*., 2013a). The expectation and the reality can fail to align because of factors such as: moral reasoning; vulnerability; coping with moral distress; alienation from self; coping with lost ideals; and the challenge of a new professional self-concept (Kelly, 1998; Franco and Tavares, 2013). It is recognised that the NRN can have high expectations of self (Anderson and Edberg, 2010; Parker *et al.,* 2012) and, when the reality does not conform, individuals may feel that they are not living up to their professional ideals and the realities of the workplace (Boychuk Duchscher and Cowin, 2004; Duchscher, 2008; Christiansen, 2008; Kramer *et al.,* 2013a). These issues were considered in Parker *et al's*. (2012) mixed methodology study of 282 new graduates where 26% of the respondents questioned if they had the necessary information to carry out their role, and a further 22% felt unable to meet their own expectations. The self-reported stress levels associated to role expectations was 45%, illustrating the significance of the transition effect on the NRN.

Expectations are viewed as beliefs or the anticipated outcomes of those beliefs, which are generated from the practitioners experience and values. When not communicated or realised these expectations can turn to frustration and disappointment leading to a change in attitude and an alteration in job satisfaction (Duchscher, 2001; Mooney, 2007b; Parker *et al.,* 2012). This was observed through Halfer and Graf's (2006) quantitative study (n=122) finding that where the nurse leader expectations of the NRN role were understood, the integration was more successful after 18

35

months. This was also found in Parker *et al's.* (2012) study where NRNs were seeking visibility and transferability from their nurse leaders to support their transition. This raises the relevance of the nurse leader being actively involved in the transition process, aware of the individual needs but also in ensuring that the practice community understand those needs. In order to achieve this, good knowledge of HE and healthcare was required to inform a successful transition experience for NRN and service alike (Randall Andrews, 2013). This shared understanding enabled the community to make sense of the experience and to realise the expectations, allowing a cohesive working team to develop (Haslebo and Haslebo, 2012).

All registered nurses are professionally mandated to share their expertise with their colleagues (NMC, 2008). NRNs could be conceptualised as novice nurses (Benner, 1984), working through 'legitimate peripheral participation' within their new community of practice (Lave and Wenger, 1991 p.29). Lave and Wenger (1991) define a community of practice as the relationship among people, their activity and the world that surrounds them. This term relates to professional communities to signify the way knowledge and identity are situated in practice, in this case, nursing. When joining a new community of practice the individual becomes a participant, developing their knowledge, communication and identity within that environment (Ibid).

The NRN's entry to a new community of practice involves the NRN joining a culture as well as a practice environment where relationships are fundamental to developing a shared understanding and identity with the practice environment (Wenger, 1998). The individual and the practice community need to understand and share the context of the area that the individual is entering and the knowledge that they bring (Randall Andrews, 2013).

Of the selected papers, six address individuals' expectations as significant aspects of the transition experience. For example, supportive relationships were a particular theme within Randall Andrews (2013) qualitative study whose aim was to explore the expectations of a sample of 14 NRNs joining a new practice community. The data revealed that participants believed

and expected that they would be welcomed and accepted as a professional colleague. In addition they anticipated that their practice community would value, respect and support them, working collaboratively for the good of the patient and organisation. Although it is interesting to acknowledge these participants high and possibly unrealistic expectations of their professional colleagues, it does not explore if these were born out, thus warrants a follow up study. However, it does give insight into some of the fundamental expectations that the NRN have.

This expectation was evident in Chandler's (2012) qualitative study where NRNs (n=36) conceived a supportive environment as a place where good staff relationships thrived and their needs were met. Her study identified three emerging themes: 'they were there for me'; 'there are no stupid questions'; and 'nurturing the seeds'. Importantly the themes correlate with the vulnerable nature of the NRN workforce group where there is a desire for advocacy to support, give purpose and identity to their role. Advocacy is a well-accepted aspect of the professional code (NMC, 2010) when considering patient-centred care, however, it is not so obviously recognised in the same way in clinical teams. Advocacy reduces isolation as it introduces a sense that there is someone looking out for the individual. It brings safety when asking questions, removing uncertainty and generates the confidence to pursue new knowledge and understanding. This 'safety net of support' was found in Randall Andrews' (2013, p.155) qualitative study, in which students two months from registration felt that this approach brought respect to their new role. Where this was not realised, support was considered inadequate (Hayman-White *et al*., 2007; Cleary *et al*., 2009; Chandler, 2012). The expectation therefore to have someone there for them (Senge, 2005) was strong and thus a fundamental component of support.

When engaging in a new community of practice, the technical and cognitive skills of the NRN appear to develop within the context of their colleagues. Walker *et al's.* (2013) qualitative study reveals the importance of the workplace environment in facilitating this, finding that in the absence of support and role models the NRN role became overwhelming. This study emphasised the importance of social and cultural acceptance of NRNs. Likewise Chandler (2012) observed that a nurturing environment

with effective role modelling behaviours could enable cognitive apprenticeship, supporting the NRN through task, discourse and scaffolding.

Many studies reveal that this approach to transition is inconsistent. Clark and Holmes' (2007) qualitative study (n=105) found that experienced staff had low expectations of NRNs. They linked this to the low confidence of the NRN but also identified the reluctance of the experienced staff to facilitate autonomous practice. Staff generated learning contracts, and paperwork to further assess competence. Although in some cases this approach could meet the bespoke needs of the individual, it also introduced additional hierarchal requirements and moved from discourse and coaching to teacher student. This process could bring further isolation to the NRN, potentially making them feel vulnerable about what they do know. It could also be argued that this approach to the NRN could be more about staff knowledge of pre-registration curriculum rather than the individual themselves. For example, it could be influenced by past experience and in some cases personal transition experiences (Randall Andrews, 2013).

Parker *et al's,* (2012) mixed methodology study (n=282) identified that generally NRNs were clear about their role, however, they were less clear about what others expected of them. Participants rated stress levels as high to extreme in relation to role expectations, finding no distinction between genders. Some of this anxiety generated from unreasonable expectations in relation to patient allocation, shift patterns and workload, with roles poorly defined.

Competence versus confidence

The review thus far has recognised the relevance of expectations and role definition from self and colleagues, however, these aspects are intertwined with confidence and perceived competence (Ulrich *et al.,* 2010). The literature surrounding the subject of competence is vast. According to Benner (1984), competency is the ability to successfully perform a skill within the bounds of the cultural reality. Through her continuum of nursing practice, Benner positions competence in the middle suggesting that it is a

process of progression which may initially lack speed or flexibility, but which can develop. The NRN may be deemed competent through their registration but may not feel confident to practice autonomously (Halfer and Graf, 2006; Kelly and Ahern, 2008). To underpin safe and effective practice the NMC (2010) recognises competence as skills, knowledge, attitudes, values and technical ability. However, there is a difference between achieving these competencies as a student and in carrying them forward in the reality of a workplace environment. This potential difficulty when coupled with the individual qualities and characteristics of a NRN suggests an individualised approach is needed (McMillan *et al.,* 2003).

Etheridge (2007, p.25) identifies the importance of the professional characteristics:

> *"The process of learning to think like a nurse is characterized by the emergence of confidence, the acceptance of responsibility, the changing relationships with others, and the ability to think more critically within and about one's work"*

The application of competence needs self-confidence (Bandura, 2001; Pfaff *et al*., 2013) and thus the latter requires support to develop it. This has been further illustrated through a 10 year longitudinal study (n=118) by Ulrich *et al.* (2010) who found that confidence was fundamental to safe and successful performance. Supporting Etheridge (2007), Pfaff *et al's.* (2013) review of 26 research and non-research papers found that the lack of confidence influenced NRN relationships and interactions with the multi-professional team, particularly medics, and thus how they behaved and were perceived within their immediate community.

The interactions and relationships with qualified nurses are important elements of integration, allowing the NRN to learn and develop confidence (Rance and Grealish, 2007; Thrysoe *et al.,* 2012). Franco and Tavares (2013) suggest that nurses have their own identity which differentiates them from other health professionals. However, some nurses feel that their work still lacks socio-professional recognition, which could impact on their ability to be autonomous practitioners. Pfaff *et al*. (2013) highlight that confidence could be either a barrier or a facilitator to the successful

transition process, demonstrating the influence that it could have on both the individual and the culture that they enter. Johnstone *et al's.* (2008) study identified timely emotional support as relevant to achieving competence and confidence, as this can reduce stress and ease the transition.

Culture

The behaviour of NRNs is influenced by the organisational cultures they join (Parker *et al*., 2012; Kramer *et al.,* 2013a). When commencing their new role NRNs will not necessarily have insight into the occupational systems and expectations which inform the healthcare environment (Boychuk Duchscher and Cowin, 2004; Mooney, 2007a; Cleary, 2013). As a result, the ethical codes with professional normative standards which they learnt on a formal (university) and informal level (healthcare) can be challenged. With peer relationships and practice experience come varying interpretations in language (Maben *et al.,* 2007; Thrysoe *et al*., 2012), behaviour and values all having an impact on their transition. It is recognised that through this process the socialisation can bring tension, as it also brings new knowledge and standards into an established team (Lave and Wenger, 1991). Gerdes (1998 p47) observes;

> *"Every people, every culture and every subculture, including every social group … and every individual, constructs and develops its own, in a certain way".*

This results in a period of forming, storming, norming and performing on the team development (Tuckman, 1965; Haslebo and Haslebo, 2012) and is dependent on good leadership to guide the process (Halfer and Graf, 2006; Dyess and Parker, 2012; Parker *et al*., 2012; Walker *et al.,* 2013). Support which empowers the NRN to take responsibility within the inevitable culture change and which also gives them the insight and the skills to manage their new environment (Holland, 1999; Cho *et al.,* 2006; Etheridge, 2007) is essential.

Healthcare systems have changed, as nurse education came under scrutiny in the 1980s, so too did healthcare organisations. This resulted in

the NHS Management Inquiry (Griffiths, 1983) which introduced general management to the NHS. This brought change to the senior nurse manager role, increasing responsibility for their clinical area, and budget responsibility. Nurses are encouraged to be financially aware and resource efficient. This change can induce tensions between centralising patient care and meeting organisational targets (Francis, 2013). The focus on creating a resource efficient and target driven healthcare service has inevitably influenced the ward manager role, increasing workplace priorities. This has been further intensified by public inquiries (Francis, 2013) which reinforce the vast remit and responsibility the ward manager has when balancing finance and practice targets in the clinical setting.

It is without surprise, therefore, that the ward manager is significant to the transition process, both in their ability to provide clinical leadership and the resources which facilitate a positive learning culture (Henderson *et al.*, 2012; Walker *et al*., 2013), and a healthy work environment (Shirey, 2006; Kramer and Schmalenberg, 2008; Chandler, 2012; Kramer *et al*., 2013a)**.** Disch (2002, p3) defines a healthy workplace as:

> *'a work setting in which policies, procedures, and systems*
> *are designed so that employees are able to meet*
> *organizational objectives and achieve personal satisfaction*
> *in their work.'*

This could infer a hierarchal approach, informing the workforce of the organisational direction rather than actively involving them. Manley (2004) would argue that an organisation should be responsive to the needs of both practice and policy ensuring that the expectations of both are aligned. This requires the organisation to be receptive to change.

Organisations

Organisations can be identified as social learning systems, where there are varying layers of knowledge and expertise (Messersmith, 2008). There are four generations of nurses currently in the workforce (Lancaster and

Stillman, 2002; Mensik, 2007) each introducing values and behaviours and education associated to their own era. Each generation gathers their value set through the culture in which they developed; this informs their behaviour and expectations. Chapter one mapped out the educational change that has taken place over the decades demonstrating the generational spread encapsulating the various layers of knowledge (Etheridge, 2007) within the nursing team. This will be played out in numerous ways with differing practice and managerial expectations.

Teams will have varying professional backgrounds, with changes in nurse education history, with some nurses having achieved the apprenticeship model which incorporated hospital finals; others project 2000, with recent registrants having a diploma or degree. This situation alone can create tension and differing opinions as each generation will be shaped by the world events and the relationships around them. The newest generation, identified as millennials, are reported to be technically and globally aware (Carver and Candela, 2008; Lipscomb, 2010), provided with a skill set which other generations may be less proficient in. Each generational group has different expectations and different ways of communicating. These layers of knowledge and varied approaches potentially bring value to the workforce makeup and to the delivery of care (Buerhaus *et al*., 2006). However, a period of adjustment is inevitable as the various generations understand the contribution that each is able to give.

Feeling part of a team where membership is respected and acknowledged for its contribution has been shown to influence job satisfaction and integration positively (Chandler, 2012; Feng and Tsai, 2012). Randall Andrews' (2013) qualitative study identified that students (n=14) nearing registration expected the practice community to be prepared for them and able to support their professional goals. However, previous studies suggest that this is not always the case, as workplace behaviours can leave the NRN feeling that they are being judged differently from their colleagues (Maben *et al.,* 2006; Bjerknes and Bjork, 2012; Parker et al., 2012). Randall Andrews (2013) study suggested that NRNs accepted that the integration process would be challenging, viewing it as a period of adjustment where internal and external relationships needed to be built

within the team. However, they were also concerned that any negative practice behaviour could impact on their integration and effective transition.

The need to be accepted and legitimate within a team is an important aspect of the transition process. It moves the NRN beyond the attainment of technical skills and knowledge to the accumulated knowledge of the community (Lave and Wenger, 1991). By actively participating, the NRN can understand the practice reality in relation to their knowledge. The process enables relationships to form through interaction and shared experience. This process infers the need for clarity with regards to the boundaries of the organisation which then enable the NRN to actively engage within it to form their identity in relation to it (Wenger, 1999). This is supported in Parker *et al's*. (2012) and Franco and Tavares' (2013) work found that the formation of an identity further enhanced NRNs ability to interact within the community.

Lave and Wenger (1991) studied the shift from apprenticeship to practitioner observing the part 'situational learning' has on gaining 'legitimate peripheral participation'. This concept addresses the need to feel legitimate within a community to allow trust and relationships to form. This suggests that structured programmes and models alone do not bring this change. There is a need for clarity with regards to the boundaries of the community framework which would then enable the NRN to actively engage within and to form their identity in relation to it (Wenger, 1999). This was explored in Franco and Tavares' (2013) work, finding that identity further enhanced NRNs' abilities to interact with the community. They linked the influence of the learning process with the organisational induction with regards to how knowledge is generated and understood. When knowledge is formally shared, the teacher can be viewed as 'master' rather than 'comrade' (Friere, 1970), informing rather than engaging. It can be argued that knowledge needs to be engaging, instilling safety and empowering the learner. When delivered without this balance the learner can be decentred resulting in them being led rather than making sense of the knowledge within their practice context. There is a risk that this pattern will also manifest into the NRN role, allowing the 'masters' in practice to inform their learning resulting in a 'mental glaze' which distracts from their

individual contribution (Hay, 1996, p.93). This further illuminates Wengers'
(1998) concept of the 'push and pull' when forming relationships.

It is recognised that a safe and enabling workplace were not always the
reality. Mooney's (2007a) grounded theory study (n=12) found NRNs
experienced ritualistic and rigid behaviours. Upon qualification they hoped
to be able to influence change, but found that their role was restricted by
the workplace culture. Significant barriers were identified which limited their
ability to perform in the manner that they intended finding that: tasks took
priority; care was not patient-centred; communication with patients was not
seen as working. This pattern of 'institutional negativity' was also observed
through Horsburgh and Ross' (2013) qualitative study (n=42), highlighting
how the workplace can have a poor influence on the NRN's professional
start. The workplace and the organisational ethos therefore play a central
role in providing an inspiring culture which guides and shapes the NRN
transition (James, 1992; Halfer and Graf, 2006, Mooney, 2007a; Parker *et
al.,* 2012; Horsburgh and Ross, 2013; Randall Andrews, 2013).

Many studies both quantitative (Parker *et al.,* 2012) and qualitative (Cleary,
2013) revealed the negative effect that staff shortages, patient acuity and
pressures to meet role expectations had on the NRN (Kramer, 1974,
Duchscher, 2001; Johnstone *et al.,* 2008). A non-experimental survey by
Cho *et al.* (2006) found that the causes of the 66% of 226 NRN (within 2
years of registration) for burnout were related to the lack of resources,
support and opportunities. The authors attributed these themes to poor
organisational commitment. The opportunity for a gradual development of
skills, confidence and competence in the current climate is not always
available to NRNs. Johnstone *et al.* (2008) found that the realities of the
ward work and inappropriate attitudes or behaviour of staff members were
contributory to providing ineffective support to NRNs.

Nurses are expected to deliver high quality of care that is underpinned by a
research base (Care Quality Commission, 2011; Francis, 2013). However,
with the diverse healthcare agendas this may not be the primary priority. A
formula devised by James (1992) demonstrates how the balance can be
perceived - care = organisations + physical labour + emotional labour.

Although dated, it still holds resonance with many study findings where the NRN finds that the practice environment prioritises the physical labour, by nature that the work has to be done, resulting in skills such as emotional labour not being perceived as so essential (Maben *et al.,* 2006; Mooney, 2007b; Clearly *et al.,* 2013). This can challenge the individual's moral reasoning (Kelly, 1998) in their wish to deliver care in line with their knowledge and values and yet needing to align with the cultural habitat. This can result in frustration and disappointment, as the role does not play out as easily as they may have expected. In this scenario Senge *et al.* (2004) suggest that practice can revert to habit when an individual is fearful or anxious, which could risk further misalignment with those around them.

The studies in this area identify that the expectations upon joining the workforce between NRN and experienced staff are incongruent. Although the literature highlights the importance of induction and orientation programmes, it predominantly focuses on the essential nature of 'people support' and their relevance to the NRN for a successful transition experience. NRNs are keen to understand organisational processes; however, it was not the definitive support need. Instead there was a desire for acceptance, wanting to belong and be part of the professional community. NRNs were aware of their role and their novice status in relation to the professionals around them; they saw this relationship as opportune learning and were keen to develop from the experience available to them.

The critical appraisal of the literature on the nature of support reveals that it is complex and lacking national standardisation, with varying models of provision. To achieve a successful transition it seems ever more important to focus more research into the structural and priority needs of this complex workforce need.

It is apparent that change is a significant aspect of the transition and thus requires guidance and leadership to both focus and coordinate this. To date there has been limited investigation into the senior nurse role in managing the transition process, and yet the majority of publications in this review identify their involvement as essential to the provision of support.

To explore research question two Scott *et al's.* (2008) second stage, **Organisational socialisation** (Being, imagination) will be used:

What factors are perceived by the NRN and the senior nurse manager to be of most value in achieving an effective transition into the professional workforce? (Being)

Workplace

Practice environments are fundamental factors in the successful transition of NRNs (Cho *et al.,* 2006; Cleary *et al.,* 2013; Walker *et al.,* 2013). Themes around workplace bullying, shift scheduling and team behaviours are regularly cited as barriers to NRN's fully and successfully integrating into clinical teams (Johnstone *et al.*, 2006; Kelly and Ahern, 2008; Thrysoe *et al.,* 2012). Casey *et al.* (2004), with a sample of 240 participants, identified that negative experiences related to lack of acceptance, respect and senior staff commitment to support their unique needs. However, Johnstone *et al.'s* (2006) mixed methodology study of 11 NRNs and 35 stakeholders reported that a key element of a good practice environment was the ability of NRNs to access and obtain learning opportunities. Their study revealed that established practitioners had not made the shift from viewing the 'student' as a professional practitioner, giving the NRN the sense of being an inferior member of the team. This positions staff attitudes as an important feature of an operational environment. They suggest that an effective practice environment needs to be prepared to integrate new professionals, identifying the first four weeks as fundamental to the success of the transition process. This highlights the relevance of the team and the importance of them taking an active role and responsibility for each individual transition (Ulrich *et al*., 2010; Dyess and Parker, 2012) and ensure that they are able to take an active team role and responsibility for each transition (Parker *et al*., 2012; Chandler, 2012). This involves making the team accessible to the NRN, through introduction, understanding and a collaborative process.

The workplace environment is a significant factor potentially impacting on the NRN transition, yet it is little studied in relation to formal transition programmes (Rush *et al.,* 2013). Cho *et al*. (2006) examined this in the

context of empowering the NRN. In their quantitative study (n=496), they identified the importance of bringing structured empowerment to the NRN. The provision of organisational knowledge and access to workplace structures resulted in greater work performance and engagement. NRNs less able to access this structured knowledge were more inclined to work within and to the cultural expectations. Although they were able to record this as a positive retention tool, and an important support process due to its ability to engage the NRN, there was evidence that this concept required careful management as it had the potential to overload the individual resulting in burnout. This would be an interesting area to explore further, establishing if an individual can be given too much knowledge or whether it is linked to how it is delivered and the expectations which encompass it.

Role models

Role models are influencers and can inspire change (Bandura, 1977) in the behaviour of those that choose to follow them. Their influence may be positive or negative, but either way both have the ability to shape the NRN (Perry, 2009; Ferguson, 2011). The NRN is guided by their own values and aspirations, picking and choosing the behaviours which they do and do not wish to practice, thus identifying the person that they aspire to be (Allen, 2009). This process will in part be based on their confidence in their formed value set and their sense of self within the practice community. They may equally be 'pulled' by the predominant behaviour in a bid to 'fit in'. This makes the stability and philosophy of the wider workplace culture ever more vital in ensuring that the NRN feels safe to manage the transition.

The NRN will not only be influenced by the practice role models but they will have gathered behaviours inspired by past relationships formed through HE, schooling and or friendships. These will have an impact on their practice and the subsequent relationships formed. Effective role models are defined in the literature as having a number of characteristics relating to their approachable nature, interpersonal skills and excellence in practice (Perry, 2009; Blake *et al.,* 2011). These attributes are valued as supportive processes as they engage the NRN in reflective practice,

constructive feedback and in helping them to feel heard and active within the team (Senge *et al*., 2004; Hayajneh, 2011). This not only situates the learning and enables the NRN to test out their ability safely in practice but also encourages the learning to continue. However, it could be argued that to sustain this process, knowledge and support are required (NMC, 2006; Myrick *et al.,* 2011). This may also bring recognition to the role model role (Whitehead *et al.*, 2013).

The preceptor role can often be viewed as a potential role model. There is a plethora of literature finding the role to be a fundamental aspect of a successful transition (Clark and Holmes, 2007, Duchscher, 2008; Glen, 2009, DH, 2010a; Park *et al*., 2011; Chandler, 2012). When not made available, it is found that the NRN can feel under-valued (Casey *et al.,* 2004) and potentially more likely to leave their post (Cleary *et al.,* 2013). An organisation does not have to deliver support in this recommended way; therefore the process of transition is managed locally, dependent on the individual organisation. This also relates to the preparation of the preceptor. Although authors suggest that it is needed, inclusive of teaching strategies and discussion time with fellow preceptors and educators (Chandler, 2012; Whitehead *et al*., 2013), it is not a professional priority. Cleary *et al's.* (2013) qualitative study (n=17) identified the need for good communication skills to undertake the role, recognising the preceptor as playing a vital role in integrating the NRN, and acknowledging the greater team involvement in this process. The preceptor role therefore carries great influence needing preparation and support to undertake the role.

This correlates with Whitehead *et al's.* (2013) literature review of 24 articles which relate to the preceptorship role, the importance for managerial support, for both preceptors and preceptees is highlighted (Randall Andrews, 2013; Walker *et al.,* 2013). Training and resources are identified as needed to equip the role to enable it to be effective. Where organisational resources and leadership were not apparent, the process of preceptorship could often become a paper exercise (Robinson and Griffiths, 2009; Cleary *et al.,* 2013). This also happened when the preceptor was allocated but did not have the time and/or inclination which resulted in it not happening (Mooney, 2007a).

The preceptor role can often be viewed as a potential role model. There is a plethora of literature finding the role to be a fundamental aspect of a successful transition understanding of the workplace environment which can be overwhelming when not facilitated. In situating the learning, sense can be made of the experience (Clark and Holmes, 2007; Dyess and Sherman, 2009). This process is an act of inquiry which requires the NRN to actively seek out and to create new meaning for their individual practice (Senge *et al.,* 2004). Therefore, the preceptor role encourages and develops these skills. Their role can be complex and multifaceted, as they are orientating the NRN to the profession and workplace values, whilst also taking on the role of teacher and confidant.

This introduces some very specialist skills, which were recognised in Johnstone *et al's*. (2008) mixed methods case study of 11 NRNs and 34 stakeholders. They understood the value of the preceptor and its potential influence on the NRN. Their study recommended that the support could be more effective when the preceptor was matched to the needs of the NRN, emphasising the importance of amiable relations in providing a trusting connection. In creating a preceptor/preceptee relationship, which facilitates safety the NRN is better able to test out their thinking and practice. This relationship enables informal learning opportunities such as constructive feedback building confidence and performance. To fulfil this role the preceptor would have to alter their daily routine, however, this could be beneficial to both the preceptor and preceptee (Barton *et al.,* 2005). There are cost and resource issues to consider (Scott and Smith, 2008), which require investment (Robinson and Griffiths, 2009), but which could bring long term value to the clinical team (McCabe and Garavan, 2008).

Leadership

The nurse manager is considered highly influential to the NRN experiences and to their effective transition (Evans *et al.,* 2008; Ulrich *et al.,* 2010; Walker *et al.*, 2013). This has been acknowledged in seven of the twenty-one papers, recommending that the nurse manager should promote the need to support NRN (Halfer and Graf, 2006; Ulrich *et al.,* 2010; Dyess and Parker, 2012; Cleary *et al.*, 2013; Horsburgh and Ross, 2013; Kramer *et al* 2013a; Walker *et al.*, 2013). To do this well they need the ability to

understand the individual needs of the new recruit and to provide a receptive workplace environment. Olson's (2009) qualitative interpretive longitudinal study (n=12) found that NRNs had an expectation and a desire for the ward manager to be in contact with them throughout their transition, working with them in a caring and approachable way. This attention was found to bring value to the NRN, positioning them within the workforce structure and introducing them to the workplace culture (Regan, *et al*., 2009; Parker *et al.,* 2012). McCormack and McCance, (2010) identify an effective workplace culture as one that is person-centred, considerate of all the community members. The ward manager is considered to be an important link between the local and greater organisation in communicating the various needs (Cho *et al.,* 2006; Franco and Tavares, 2013). This opens the professional culture beyond the ward environment, enabling the organisation to inform and be actively involved in the transition process (Cho *et al.,* 2006; Ulrich *et al.,* 2010). This in turn enables the organisation to recognise the potential of its members which can enhance future organisational performance (Lockwood, 2007; Ulrich *et al.,* 2010).

A large scale longitudinal quantitative study (n=468) by Kramer *et al.* (2013a), explored the expectations of the work environment and its effect on patient care. It recognised the pivotal role of the clinical manager and confirmed the relevance of the initial 4 month transition period for the NRN. The researchers found that the workplace had a significant influence on the NRN's ability to perform well as it could effect: productivity; quality patient care; and job satisfaction. Dyess and Sherman (2009) did a qualitative study of a cohort of newly qualified nurses (n=81) who elected to join a 12 month leadership programme. They completed a self-assessment of their leadership competencies on joining the programme, and then met on a monthly basis for a full day workshop. The associated ward managers met at 3 month intervals for focus group meetings to 'discuss' NRN development. Although the paper is not detailed in its methodological approach, it does signify change in the NRNs' leadership skills. However the study was dependent on both the NRNs' interpretation of 'leadership' and 'development' which would be influenced by their general confidence and self-concept. The study would have been advantaged by having a control group to establish if the NRNs would

naturally gather these skills over the 12 months and thus feel more confident in their leadership ability. Although the programme was themed around leadership, it covered information around organisational culture and safe patient practice, leading the participant into the wider spectrum of leadership issues. A key finding from the paper was how the conversations generated energy. This made it difficult to determine if it was the learning programme which developed the self-confidence or if it was the opportunity to share ideas and experiences through the forum which resulted in this outcome. In addition Duchscher's (2008) model suggests that this positive outcome would happen naturally as the NRN progresses through the stages of transition. However, the study demonstrates the relevance of leadership and the need to understand the influence of wider organisational factors when informing the translation of knowledge and skill acquisition into the workplace (Orchard *et al.,* 2005; Cho *et al.,* 2006).

It is evident from this review of the literature that the workplace has a fundamental role within the transition process. Where there has been inertia or perceived negativity towards the NRN the transition has been less successful. This highlights the need for further investigation into the team preparedness for the transition, making them fully conversant with the context of the event and their role within it. Each professional is influential to the individual and thus the transition, making them important role models and representative of the culture that the NRN is joining. This brings great responsibility for the team, representing the profession and organisational values. With the findings linking organisational knowledge with an increase in NRN performance and engagement, this makes their role ever more crucial. Thus they need to be good communicators who are able to engage in discourse and able to celebrate their role as informal teacher.

Finally to structure the exploration of the third research question Scott *et al's*. (2008) **Socialisation Outcomes** stage (knowing, alignment) will be used:

What can we learn from professionals' experience of support to guide education policy and practice for NRNs and senior nurse managers in relation to transition and in aligning new staff into healthcare?

Organisational commitment and group membership

Socialisation influences behaviour change (Meleis, 2000) in relation to abilities, identity, role, relationships and in accepting the changes that occur. This is reflected in Duchscher's (2008) transition stages, where she recognises how newly formed identity brings confidence and self-awareness which in turn enables the creation of professional boundaries. These ground the NRN in relation to others, bringing a sense of self within their group membership (social identity). McCarthy (1996, p.77) illustrates the complexity for the newcomer in understanding the organisation and its context to aid belongingness;

> *"… the self-signified as something or as someone, a signification addressed both to oneself and to others with whom one converses and where culture, in the form of language – concepts and discourses – operates at every phase of this dialogue".*

As agreed through this review, each organisation and their practitioners have their own unique subcultures (Cho *et al.,* 2006; Mooney, 2007a; Parker *et al.,* 2012; Thrysoe *et al.,* 2012; Cleary, 2013; Kramer *et al.,* 2013a), demanding specific standards (Friedson, 1986; Cleary, 2013) inclusive of language and behaviour, which impact on the socialisation (King *et al.,* 2005; Maben *et al.,* 2007). This period of adjustment challenges the NRN to align their personality and behaviour to fit into the existing norms and practices around them (Brim, 1966; Bauer *et al*., 1998; Thrysoe *et al.,* 2012). Feng and Tsai's (2012) study found that the act of sharing experiences facilitated integration of the professional activity in general and aided the adoption of the local culture.

Peer learning and the opportunity to share experiences were recognised in the majority of the publications explored as vital to this adjustment period, and as support tools for the NRN. Thrysoe *et al.* (2012) and Horsburgh and Ross (2013) particularly observed the power these activities had in reinforcing knowledge and enhancing confidence. Thrysoe *et al's.,* (2012) phenomenological (n=9) study located conversations with members of the community of practice as more social in focus, where working together and exchanging knowledge and experience enabled the team to work through conflict and establish different ways of working. This provided a strong learning culture, which was non-hierarchal and receptive to all members. The success of this approach was attributed to the middle manager, who was able to create a culture of mutual support and learning. The co-participation enabled learning to ensue, allowing individuals to take developmental steps through the facilitated team process. This enabled the team to learn and grow together as a new entity. Although this was a small study, the theme was discussed in six of the twenty-one papers, observing the influence of bureaucracy, and how negative factors such as time, workload and behaviours can impact on individual performance (Casey, 2004). This is consistent with Vygotsky's (1978) zone of proximal development where the individual and the team align their needs to those of the workplace. Chandler's (2012) mixed methodology study identifies this approach as the provision of *'a culture of inquiry', where there is discussion* around the care needs in order to achieve evidence-based care and team working. The act of working together enables positive informal learning opportunities (Ryan *et al.,* 2010). When a culture achieves this, it plays a significant role in shaping the environment for learning (Manley *et al.,* 2009).

In a quantitative longitudinal study of NRNs (n=>6000) by Ulrich *et al.* (2010), their analysis linked productivity and efficiency to 'belongingness'. They observed the importance of NRNs having an identity and involvement in their organisation. They needed to understand the organisational goals to be effective within it, having a strong desire to be an accepted member within it. In this study NRNs wanted to adjust to the perceived difficulties, wanting to be accepted, conforming to the implicit values around them (Mooney, 2007a). These practice conflicts may account for some of the variance in the expectations between established practitioner and NRN

(Bjerknes and Bjork, 2012), linking with Wenger's (2000) theory of the 'push and pull' effect.

Retention and Job satisfaction

Retention/Job satisfaction came from many positive aspects of facilitative processes such as preceptorship, supportive friendly environments and a well-established team (Scott *et al.,* 2008; Ulrich *et al.,* 2010; Horsburgh and Ross, 2013). The latter point was found to be significant in Scott *et al's*. (2008) study, where socialisation was compounded when NRNs were recruited to understaffed areas. The workplace and the relationships within it consistently played an important part when achieving the transition process and thus gaining job satisfaction. It had psychological (Parker, *et al.,* 2012) and social (Wenger, 2000) relevance, making both the environment and its membership instrumental to the support process and workforce retention. This was recognised in Horsburgh and Ross' (2013) study where the value of clinical supervision and nurse support groups were positive activities which influenced job satisfaction. Where support initiatives were not initiated, staff retention was an issue. In a climate that is already pressurised, support resources can be a challenge to provide; however, this further illustrates the organisational responsibility to support the NRN to adjust to their professional role.

2.4 The review in summary

This literature review raises several issues for education and nursing practice. Ward culture and collegial interaction have a significant influence on job satisfaction, integration and a sense of belonging. It is apparent that socialisation can ignite a change in behaviour, requiring the individual to establish a sense of who they are within the community that they join. To achieve this, NRNs value social cohesion and environments where there is a culture of collaboration to facilitate this. The literature has illustrated the lack of clarity and guidance available for this important workforce event for NRN, senior nurse manager and organisation alike.

The transition from student to NRN appears to work in relative isolation from HEs and organisations, with no mention of collaborative initiatives

found in the publications examined. This makes the transition process reliant on the interpretation of organisation and the senior nurse manager. This infers that there is scope to explore the anticipatory socialisation stage, identifying how education and practice can work together in gathering knowledge about the NRN to inform a successful transition for NRN and organisation.

The review highlights the need for all team members, in particular, the preceptor and senior nurse manager, to be prepared for and to have support to manage their role within the transition. It is evident that the environment and the membership are crucial elements of the transition process to both retain and establish an effective workforce. This suggests that there should be a move from exploring the experiences of the NRN to examining the role of the organisation and members within it to guide future transition policy and practice.

The literature has identified five themes which will inform the progression of the study:

1. While the need and the rationale for providing support for the NRN is recognised (Kramer, 1974; Casey, 2004; Johnstone *et al*., 2008; Chandler, 2012; Horsburgh and Ross, 2013; Walker *et al.,* 2013), there is minimal consensus on what it involves. The literature finds the NRN's interpretation of support to be related to the people around them, their welcome, their understanding of the transition process and to the NRN's individual needs. However, support has been identified throughout the literature as reliant on local interpretation rather than policy guidance. Although much has been explored into the experience of the transition process, little research attention has explored what needs to be considered in understanding and providing effective support.

2. The preceding research designs have predominantly explored the experience of those immersed in the transition process, rather than gaining a broader understanding of the transition effect on the wider organisational community. This literature review illustrates the influence of the NRN transition on individuals, peers, teams and

organisations, which suggests that the study design should reflect this. In widening the study beyond the NRN a shared understanding of the transition experience would be achieved. In addition, it would introduce a different perspective to the subject. A key element of the theoretical framework here is social change, making the community and expert knowledge of the participants fundamental. This generative approach would bring a sense of partnership to the organisation, encouraging a shared responsibility rather than an individual or organisational one. This follows the thesis philosophy, but also picks up on the importance of the organisational role which is recommended within the transition process throughout the literature (Cho *et al*., 2006; Chandler, 2012). An approach which builds on participant experience to develop future possibilities for an effective transition is timely (Conklin, 2009). It would bring new life to the subject, the thinking, and to the organisation involved.

3. The studies explored throughout this literature review have predominantly used broad qualitative methodologies, involving small samples and single locations. The methods have tended to use interviews and or focus groups. These two factors can make it difficult to generalise the findings to the wider population. However, the themes generated throughout the national and international studies do provide an interesting insight into the complexities of entering a new community of practice. It is evident that the transition from student to NRN introduces many challenges for the individual and the wider community. The literature cites the crucial nature of the senior nurse manager, and the need for them to have an active role within the transition process. However, there is minimal exploration into their expectations and their understanding of the NRN transition. This comes at a time when we have a diminishing workforce in which stability and competence is a priority. It is therefore timely that further exploration is given to understanding their perceptions of the support required to secure a successful transition.

4. The transition process is a long standing research phenomenon which has been explored through the literature, generating

knowledge about the experience for the NRN. The studies reviewed predominantly identified the challenges associated with the transition, creating the risk that it could be accepted and expected to be difficult. This could become a pattern in the NRN's journey, and the receiving culture. In research scenarios such as this it is recommended that new life is needed in the inquiry. Introducing a new approach could bring new insight and progression to the phenomena (Egan and Lancaster, 2005).

5. Having established that the NRN transition is recognised as a challenging process does not progress this workforce phenomenon. The literature review illustrated that studies have a tendency to explore the subject from a problem centric approach. To replicate this would further highlight the problems and not address or develop the opportunities. Using a method to observe a perceived problem could encourage further exploration of the problem embedded in its context. A flexible and strength based approach could release new opportunities and challenge tacit understandings. During this exploration no strength based studies exploring the neophyte or organisational need during the transition have been found. A new methodological approach could generate a new understanding:

> *'The most important thing social science can do, is give us new ways to think about social structures and institutions that lead to new options for action'.* (Gergen, 1978, p.1346).

Here, Gergen's generative theory suggests that transformational change should be part of the research process, producing new ways of addressing situations which can inform new actions. When bringing people together they have the opportunity to generate ideas, search for new ways of thinking which can inform a novel reality and energise collective participants. This empowers the participants to engage with ideas encouraging them to think in a different way, introducing an outcome which can come to decisions and actions that were not available or did not occur to them before.

The plethora of literature identifies the issues around *support* processes, education, and practice responsibility, but these have not stimulated change within the workforce/practice arena. Having considered the literature and identified the challenges involved in providing *good support*, with regards to the cultural, social and personal values for the NRN and healthcare organisation, a methodological approach is required to further investigate. By nature of previous inquiries and the recurring themes that come from the four decades of studies, there is opportunity to take an alternative approach to the subject. The problems have been identified and explored but the positive experiences are less prevalent. It could be argued that research undertaken has been interpreted using underlying assumptions that are limited in finding alternative ways of managing (Neville, 2008). Considering my desire to move forward and to enhance the transitional journey for NRNs and senior nurse managers, a new approach which generates change and development will be considered.

2.5 Chapter summary

There are a variety of factors which influence the success of the transition and the potential support processes which contribute to it. This review of the literature evidences transition as challenging, multifaceted and further complicated by variations in registration preparation. There are overwhelming practice demands which challenge the NRN and the senior nurse manager in balancing the professional standards with the workplace needs. The introduction of a new member brings change to the team structure and additional role responsibility to the ward manager and clinical team. This comes at a time when the healthcare environment is under pressure to stabilise its workforce and to meet diverse healthcare needs. Support for the NRN appears to be interpreted and predominantly valued when provided in person, with people being the preferred support tool, with a focus on the importance of relationships and collegial working. This indicates that the practice culture is instrumental in the provision of effective support for a successful transition.

This review raises the opportunity to ascertain the positive experiences of support throughout the transition process for both the NRN and the senior

nurse manager to address the identified gaps in our current knowledge. Therefore my aspiration for this study is to explore the following questions:

- What constitutes *support* in meeting the needs of neophyte registered nurses and the healthcare organisation during the transition period?

- What factors are perceived by the neophyte registered nurse and the senior nurse manager of most value in achieving an effective transition into the professional workforce?

- What can we learn from professionals' experience of support to guide education policy and practice for neophyte registered nurses and senior nurse managers in relation to transition and in aligning new staff into healthcare organisations?

The following chapter will outline the research design that will attempt to address the research questions. This will allow the thesis to contribute to the knowledge and understanding of support opportunities available to enhance the transition experience for the NRN, senior nurse manager and organisation alike.

Chapter 3: Methodology, Research Design and Ethical Issues

In this chapter I present a critique of the approaches considered to address the research question, and discuss why Appreciative Inquiry (AI) was favoured for exploring the perceived support needs, practices and influencing factors associated to a successful transition for the NRN. Methods for sampling, data collection and analysis are discussed together with issues of rigour and trustworthiness of the study and the ethical considerations.

The background and literature review identified an evolving healthcare culture and the influencing factors which facilitated a NRN to have a successful transition. Framing the need for this study the key issues emerging were summarised as:

- Evidence that transition has been predominantly explored from the perspective of the individual, however, the organisation is cited in many studies as a crucial component. Therefore, a broader lens which incorporates the senior nurse manager would add depth of insight.

- Studies to date have been problem orientated and relied on familiar study designs. Whilst helpful, this has also hindered viewing the topic through a new lens for examining the process of successful NRN transition.

- The evidence suggests that support is beneficial for NRN during their transition, although sparse, there is little determining what support means for this workforce group.

- Adopting an innovative research methodology could introduce new understandings and perspectives to this long standing workforce phenomenon.

3.1 Exploring the research approach

The aim of this study was to understand the nature of support, examining the positive experiences that it brought to the NRN's transition. This form of social inquiry needs insight into personal experience and stories from those involved in the transition process. This positions the research in a qualitative paradigm (Holloway and Wheeler, 2013). My beliefs, interests and view of the world are aligned with valuing and respecting individuals, and appreciating how the surrounding culture influences their ability to interpret their context. This locates my position within a constructionist epistemology (Crotty, 1998). My literature review identified a diversity of qualitative methodologies employed to address NRN support during transition, but these tended to focus around individual groups. Certainly the intricate detail of an individual's experience could not be achieved through a positivist approach (Robson, 2002).

Positivist methods have a place in nursing research and have been used successfully to explore aspects of transition. For example, when measuring the impact of the transition on NRN retention (Parker *et al*., 2012), expectations of the workplace (Kramer *et al*., 2013a) and how productivity relates to efficiency (Ulrich *et al.,* 2010). However, the literature review for this study revealed the gap in our understanding about the how professional nurses, health organisations and NRNs understand the 'nature of support'. This emphasised the need for an approach that would provide an in-depth, context-rich appreciation of the issues as experienced and perceived by key players, rather than numerical quantification of their views.

The qualitative paradigm is an umbrella term which covers a number of methodological designs, and while each provides distinctive generation of data from a particular lens, they all adopt a set of shared philosophical assumptions. In choosing a study design, Mason (2006) urges researchers to be creative within the research strategies, veering away from a passive role by embracing the unique opportunities which come from the dynamic process. This advice was used to shape the study design while addressing the need to align it with my personal values.

In chapter two table 2.1 identified the range of methodologies previously used to study the research phenomenon, demonstrating the scope of qualitative designs in contributing to developing the knowledge base. As this study aims to understand the nature of support during the transition for the NRN, it suggests a person centred approach inviting an interpretivist paradigm. This focuses on peoples' interpretations, meanings and understandings as primary data sources in a bid to understand the social world they have produced (Blaikie, 2000). I was particularly committed to gaining an in-depth understanding of participants' world using flexible and sensitive methods of data generation (Richie *et al.*, 2003), such as interviews (Mooney, 2007a, Chandler, 2012), focus groups (Clark and Holmes, 2007; Horsburgh and Ross, 2013) or a combination of different data sources. The trustworthiness and credibility of the research (Parahoo, 1997) was a key consideration observing Mason's (2006) recommendation of the importance of validating the process through participant quotes to gain individual experience. Having thought through these factors a number of approaches were considered as possibilities to address the aims of the study. These were:

- Ethnography
- Grounded theory
- Interpretative phenomenology

Ethnography is a valuable research approach in small scale social research. The methodology is both contextual and reflexive, allowing participants to share their knowledge in the context of their culture (Savage, 2000). The benefits of this would enable me greater understanding of the language, behaviours and relationships, bringing meaning to context. This suggests that an ethnographical approach would be potentially appropriate, particularly as I was based at the research site. I was familiar with the setting and could observe the workplace environment, staff interactions and the support processes employed with NRNs. Previously, Bjerknes and Bjork (2012) adopted an ethnographic design to establish the opportunities and limitations encountered by the NRN in their new role. Although the study provided valuable insight into the importance of organisational and professional engagement, it took place on one site,

minimalising its transferability to other organisations. In addition, the researcher was both a practitioner and an educator, who was well known and knowing of the study site. This provided an insider perspective which could have influenced behaviours within the observed area. Although the data collection included thirteen interviews, there were aspects of the findings which would benefit from further scrutiny where the opportunity for discourse could have provided greater understanding of participant experience and viewpoint. I wanted to establish how support was shaped, understood, agreed and delivered, which required the opportunity to elicit the finer detail from participants. In keeping with my values, I was keen to work with participants in a democratic and participatory way, ideally in a forum where I was able to embrace voices and meanings from those involved.

Although an ethnographic approach would have provided important ways to understand how support for NRNs was manifested in practice, access to the participants would have been a logistic challenge due to the different working areas and shift patterns. Ability to gain valuable insight to their experience would thus be limited. I also recognised that my position in the organisation may affect the participants in relation to the student – lecturer relationship (Lindsay *et al*., 2002). This coupled with my presence as a researcher may have been problematic for participants, who may have found observation of their practice difficult. This was particularly relevant due to the size of the organisation, where it would not be possible to work with participants with which I had previously had minimal or no contact. This would not only potentially compromise the anonymity and confidentiality of those involved in the study, but also raise additional ethical dilemmas and practicalities for the greater team and patients (Savage, 2000).

By contrast, grounded theory aims to create theory based on emerging data. In some senses, this was pertinent through my desire to better understand the nature of support. However, there can be a danger that this is analysed without consideration of wider influences such as social context (Denscomb, 2010). The context was relevant to my study, aware that the political and local environment was pertinent to the transition process. I did appreciate the pragmatic quality of grounded theory in that it

would be guided by and answer the research questions. This presented as an organised approach where the 'explicit guidelines' (Charmaz, 2006, p3) would direct the research process. However, when exploring this further, Annells (1997) cautions that the novice researcher can be hindered by the coding process embedded in the methodology, recommending that a seasoned expert be available for mentorship. This would raise further issues of confidentiality and was a resource that was not readily available to me. This could also potentially limit the methodology to being a technique or systematic process (Willig, 2001).

A key consideration within grounded theory is the debate about bringing previous researcher knowledge to the inquiry. Glaser and Strauss (1967), Glaser (1998) and Myers (2009) each advise that this should be avoided. This presented as a challenge due to the years of attention that I had given to the subject of transition. Additionally, when considering my research journey I had explored the literature to establish if my study was still relevant or of value to the research community. Charmaz (2006, p19) advocates that the rich data achieved through grounded theory can *'reveal what lies beneath the surface'*, although this has the potential to develop strong conceptual analysis of social processes (Charmaz, 1995), it would have prevented securing an insider's perspective of the experience. This is a key aspect of my research study, wanting to focus on the individual and the collective unique experiences of which, when shaped collaboratively, could be developed for future practice. I aim to understand the meaning of experiences that have provided support for individual, nurse manager and organisation; thus this approach was not deemed suitable.

An alternative approach considered was interpretative phenomenology (IP). This methodology was alluring by nature that it allowed me to draw on my personal knowledge in order to gain a deeper understanding of the participants' experiences, something that a descriptive approach would not achieve. Interpretative methods start from the position that our knowledge of reality, including the sphere of human action, is a social construction, which is formed by both researcher and participant. This negates objective reality as the duel aspects of the IP approach (Smith *et al*., 1999), combine both analysis from participant and researcher. Although the researcher interpretations are dependent on the participants' abilities to articulate their

thoughts and experiences (Baillie *et al.,* 2000) this would be true of many qualitative approaches. However, it does challenge the researcher ability with regards to their reflective and analytical skill, avoiding the trap of producing descriptive findings. Its aim is to uncover the concealed meanings in the phenomena concentrating on how participants make sense of their world. This was highly applicable for my study, concerned with the relevance of experience and meaning (Smith and Osborn, 2004). This is achieved in part due to the flexible nature of the data collection techniques allowing participants to share their rich and unique stories.

The IP approach also supports small sample sizes, furthering its relevance; however, it has a focus on the individual, allowing the individual differences and unique experiences of each participant to be heard. Although this was important to my study, it was appropriate to exclude this methodology as I wanted to examine a shared understanding of positive experiences. IP is concerned with the person's individual life events as experienced by themselves (McCance and Mcilfatrick, 2008), enabling those involved to share their personal story. Obviously this would be valuable data to the study inquiry, gaining an appreciation of what is understood to be support and beneficial to a successful transition for an individual. However, the literature review illustrated that the transition was more than solely an individual activity, it was pertinent to the wider community by virtue that it influenced their role and their responsibilities. I was therefore wanting to research beyond the individual, gaining the shared understanding and potential opportunities from their perspective, seeking a forum which would stimulate future action.

3.2 Deciding on the research approach

My search for the appropriate methodology challenged my desire for familiarity and for an approach which had been well used and accepted within the transition literature. I was reluctant to further destabilise my novice position by entering into a new methodology. It was through my search of the literature that it became evident that patterns of problem centric studies dominated the subject of transition. This energised my desire to refocus on the positive, establishing the research opportunities available to develop the subject. The literature review highlighted the

relevance of the organisation indicating the need to explore with, but also beyond the NRN. This led me to a collaborative inquiry design where the focus is on change, action, and/or improvement to a system, which fuelled my interest. It facilitated a cooperative and collaborative process which engaged participants as co-investigators, enabling research 'with' people rather than 'on' people (Reed, 2007). These collaborative approaches include Action Research, Participatory Action Research and Appreciative Inquiry (AI).

Action research (AR), is linked to action learning and reflection, and shares the process of enlightenment, empowerment and emancipation (Fay, 1987). Each AR method recognises that research has traditionally given the researcher power over the participant, establishing them as the expert therefore its focus redirects the power back to the researched. Grundy (1987, p.19) views this focus as enabling *'autonomous action to arise out of authentic, critical insights into social construction of human society'.* This further aligns the method with the design of this study in that traditional thinking shifts, allowing progressive insights to flourish. In action research the approach to, and facilitation of the inquiry are refined through an iterative process of action and reflection, by facilitator and participant. AI shares this approach through the 4D process; however, in addition participants are required to review the findings at the end of each phase, empowering them to generate the focus for the next phase. This approach not only makes them co-researchers in the research process but their involvement and influence on change ensures study rigour. This approach further embeds the change initiatives into the participants' future practice.

AI and other participatory evaluation approaches value the strength of language and the impact that it has on the process of inquiry, the method of data collection and the results reported (Preskill and Tzavaras Catsambas, 2006). The works of Coghlan *et al*. (2003, p.17) ultimately explore the shared principles of AI and other collaborative forms of evaluative practice and suggest the following:

1. emphasis on social construction, with sense and meaning achieved through dialogue and interaction. Both forms of inquiry stress the significance of asking collaborative questions and discourse.

2. both, AI and learning-oriented forms of evaluation view inquiry as ongoing, iterative, and integrated into organisation and community life.
3. similarly both, approaches reflect a systems orientation that includes a structured and planned set of processes.
4. both, AI and participatory, stakeholder, and learning approaches to evaluation stress the use of findings for decision making and action.

The actions in this AI study are ultimately anchored in the philosophical underpinnings of the chosen paradigm and developed capacity in understanding support during the transition, establishing what it means to the NRN and senior nurse manager. The design of the study was contingent on the research question, which in this case upholds a naturalistic paradigm. Thus by employing a participatory approach and through conversation participants are able to understand personal and shared feelings which influence support and culture. Through ongoing participant evaluation they are able to challenge and take risks, confident to strive for new understanding in order to meet the objectives of the study. This evaluative process is further validated through my return to participants to confirm that an accurate report of the data has been achieved, adhering to the principle of validity remaining pertinent to qualitative participatory methods of research.

I also sought to discover a methodological approach which enabled me to identify the strengths and to 'generate capacity' (Rogers and Fraser, 2003; Gergen 1978), to challenge assumptions and tacit understanding and to enable new action. Gergen (1978, p1346) defined 'generating capacity' as the:

> *'capacity to challenge the guiding assumptions of the culture, raise fundamental questions regarding contemporary social life, to foster reconsideration of that which is 'taken for granted' and thereby furnish new alternatives for social action'.*

There are many ways to generate knowledge, and the methodological approach plays an important role in knowledge production, as do the researcher and participants within the process. The concept of generative

theory challenges discourses and behavioural patterns, considering new approaches to social and cultural issues. This invites active participation in the construction of the culture (Gergen, 1990). A generative theory therefore enables new alternatives for thought and action with the process reducing stasis while challenging assumptions and energising new alternatives.

The research design aimed to bring clarity and purpose to the inquiry, bridging the theory and practice divide for the reader (Hart, 1996). It provided a framework to better understand the assumptions, design needs and context of the inquiry process (Gray, 2013). Inquiry for this study focused on the 'opportunity centric', keen to avoid the 'problem centric' approach (Boyd and Bright, 2007) which has traditionally been used in prior studies of this type (Casey *et al*., 2004; Clark and Holmes, 2007; Bjerknes and Bjork, 2012). As the research study requires the collection of rich subjective data, the qualitative approach adopted supported my epistemological belief in constructionism.

Constructionism, often associated with group dynamics and relationships, is recognised within many forms of inquiry within the action research genre (Gergen, 1999). It refers to the influence that culture has on the ability of individuals to interpret their world (Crotty, 1998). This focuses on the collective creation of knowledge as opposed that of the individual (constructivism), while recognising the knowledge and influence held within the organisation and culture. The purpose of this doctoral study was to examine the positive and to gain a shared understanding of support within the transition, therefore a constructionist epistemology influenced the research journey. This was inclusive of the research questions and data collection methods. Appreciative Inquiry (AI) was therefore chosen for its epistemological, methodological and theoretical foundations as summarised by Gergen (1990 p. 162) as:

> '....a methodology that takes the idea of social construction of reality to its positive extreme – especially with its emphasis on metaphor and narrative, relational ways of knowing on language, and on its potential as a source of generative theory.'

AI both complemented and embraced my personal values and beliefs about participants in producing practice based knowledge. The clear focus on change offered a new methodological approach for this subject area, an aspect which I was keen to achieve. In addition, AI enabled an empowering and highly inclusive approach which recognised the importance of all participants, acknowledging their expertise and their equality within the research process. Although the positive approach used by the methodology is seen by some as contentious (Egan and Lancaster, 2005; Fitzgerald *et al*., 2010), it enables participants to focus on what brings value, rather than sharing criticism of historic or current practices. This approach potentially removes inter-participant/organisational tension which could be stimulated through a problem-orientated approach.

I was excited about the opportunity to engage with a collaborative approach which could potentially make a useful contribution to debates and subject progression. However, I was mindful that this involved working with a relatively new methodology within the research community. As I explored the methodology further I became more confident of its appropriateness to my study aligning with my epistemological and ontological needs. Although its new approach to the subject provided theoretical challenges, this would be true of all processes, illustrating the messy nature of the research journey. I valued Willig's (2001) observation of the research process as the journey that lies before us. True to my nature, I viewed it with my usual optimism and sense of opportunity, however, when this became challenged I was comforted by the words of Finlay (2003, p. 209) who described it as *'full of muddy ambiguity and multiple trails as researchers (I) negotiate the swamp of interminable deconstructions, self-analysis and self-disclosure.'* I soon realised that the challenge of finding the appropriate research approach was not simply a pragmatic process but also a journey of finding out about self in terms of my values, fears and insecurities.

3.3 Appreciative Inquiry

AI is often labelled as an organisational change technique, but originally began as a research method for making grounded theory-building more

generative (Cooperrider, 1986; Cooperrider and Sekerka, 2006). Cooperrider believed that new ideas were the essential approach required for effective change, with inquiry driving the process. This focus and underpinning philosophy has allowed AI to evolve into a valued research approach (Carter *et al*., 2007; Reed, 2007; Trajkovski *et al*., 2013). Cooperrider's theory challenges the problem-solving approaches to management and change (Cooperrider and Srivastva, 1987), gaining methodological recognition as affirmative action research (Reed, 2007). Reason and Bradbury (2008, p.1) distinguish it as:

> *'…a family of practices of living inquiry that aims…to link practice and ideas in the service of human flourishing'.*

Emancipatory action research promotes a *'critical consciousness which exhibits itself in political as well as practical action to promote change'* (Grundy, 1987, p.154). This practical knowledge has been used to explore a new approach to the phenomenon. Its participant led quality gives it a person-centred approach which excites practical and theoretical outcomes from experience and understanding; it is for this quality that Reason and Bradbury (2007) believe it to be a superior form of research. AI, adopts some principles from action research (Troxel, 2002), and was chosen due to its ability to influence organisational learning and organisational change. These are significant aspects of the study, where themes from the literature review identified the importance of the organisation engagement throughout the transition process. However, AI moves the focus from a problem-based research paradigm to a positive approach to the inquiry, considering future possibilities and performance (Reed 2007).

The affirmative nature of the methodology is viewed as advancing action research (Bushe, 1995) due to its ability to bring new life and opportunity to a complex problem. This can be achieved through participant led theory and knowledge, as the process evolves so they grow towards the inquiry changing their behaviour and focus to the phenomena. This takes the participant from further exploring the problem to considering the possible, thus the affirmative within AI. Affirmation means to hold firm, the *'degree of belief or faith invested'* (Cooperrider, 1990, p120), encouraging the participants to pursue the strength through their collective knowledge.

Through this approach the participants all have a shared and equal standing in exploring what gives life to the subject. Encouraging the participants to explore the possible, energising creative thought, progresses the subject in a new way. This human engagement enables flourishing which moves *'inner knowledge to taking the right action effortlessly'* (Senge, 2005, p88-92). McCormack and McCance (2010) suggest that new relationships can blossom through this process, which further instils new inquiry. This quality is less overt in other methodologies.

Literature to date tends to offer a very positive view of AI (Carter, 2006; Trajkovski *et al*., 2013) although its affirmative approach can make it open to criticism. This is due to the risk that the underlying concerns in practice will be ignored (Reed, 2007). It is recognised that a problem or weaknesses can sometimes be easier to explore (McNamee, 2003) as the allure of what is not working indicates something needs to be fixed. However, addressing a weakness is easier to achieve when in a culture which is free from scrutiny and blame and receptive to good ideas, as this allows participants to speak freely without repercussion (Leonard, *et al*., 2001). It is important to note that in exploring the positive it does not necessarily dismiss the negative, as dreams and wishes may expose these in a different way (Mills *et al*., 2006). Or, as Cooperrider and Whitney (2001, p8) believe, that;

> *'Appreciation, draws our eye toward life, but stirs our feelings, sets in motion our curiosity, and provides inspiration to the envisioning mind.'*

AI is firmly grounded in social constructionist theory (Gergen, 1978; Gergen, 2009) in which conversation is considered influential in creating maintaining and changing organisations. Bushe (1995) believes that our ability to create new and better organisations is limited only by our imagination and collective will. Therefore, if we are not challenged to consider a scenario in a new way the organisation and the members within it will not change. This approach allows knowledge to be translated, understanding it and developing it (Kavanagh *et al*., 2010). This makes it a dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically-sound application of knowledge to improve a

situation. This echoes Einstein's (1879–1955) notion that a problem will not be solved when looked at in the same context of its formation; a new approach may offer a different perspective.

AI research is often identified as being 'research with' rather than 'research on' (Reed, 2007), consequently facilitating a more explicit collaborative relationship between researcher and participants. This values the importance of the data creation and data synthesising during the investigation as it informs the inquiry direction (Reed, 2007). The participants own and manage the process, filtering, theming and prioritising the findings. This activity is recorded in the field notes and is a significant part of the data collection process. The expectation of this methodology is that it explores the opportunity within experiences and practices, searching out the untapped possibilities within the scenario, building on its energy and potential. The methodology enables organisational groups and organisations to develop together, aligning the positive energy and open inquiry to consciously construct a more informed, improved future. This positive approach promotes success and wellbeing for the organisation and those within it (Luthans, 2002), meeting a bigger group need by introducing intergenerational inquiry to the process. In bringing participants together to share stories and to think innovatively, a level platform is provided giving shared ownership and opportunity. This removes the potential for hierarchal layers, with authority valuing the storytelling and allowing innovative thinking that comes from the group interaction and fostered energy. Cooperrider and Srivastva (1987) wanted the model to achieve discovery, understanding and fostering, generating a new meaning, believing that a deficit discourse could only tell part of the story.

3.4 Theoretical framework:

Epistemology asks questions about:

> '*what knowledge is and how it is understood. It raises issues about how individuals regard truth, what they believe is real and how they develop their understanding of the world they inhabit*' (Frost, 2011, p.193).

The theories chosen relate to my values and theoretical position, which could influence the evidence and how it is collected, analysed and understood (Crotty, 1998). The epistemology of positivism takes an objective independent view of the world that is being researched, understanding cause and effect.

The search for meaning and understanding involved the use of an interpretative model, which works with the nature of AI (Egg *et al.*, 2004). The use of such a model requires me to acknowledge my interpretation and that of the participants in order to establish the social norms. However, this approach can raise criticism that the model does not acknowledge the varying reasons for people holding particular views, which could negate the crucial role that workplace culture plays within the process (Crotty, 1998).

To explore AI further, I have adapted Watkins and Mohr's (2001) guide on the methodological philosophy addressing the theory through to the application.

Redacted due to copyright

Figure 3.1 The structure of AI – an adaptation from Watkins and Mohr (2001).

The process guides the philosophy of AI, addressing the theory through to its application. The soil of AI explores the theoretical foundations and philosophical assumptions about knowledge creation. The DNA of AI provides the essential components of the methodology with five core and four guiding principles of AI guiding the process. Finally the application of

AI directs the method used to address the mini-summit within the study design. An AI summit is a group method for accelerating positive change in organisations (Ludema *et al*., 2003). Ludema and Mohr (2003) list many reasons for the benefits of this approach such as creating an organisational mind-set, following Weisbord's (1994) philosophy that people support what they believe in, thus in getting them involved they will be better placed to embed the new practice. Due to the size and length of my study I have elected to call it a mini-summit.

The soil of AI

There are a number of ways to explore an inquiry, but as identified earlier, the question sets the methodological direction. Robson (2002) suggests that it needs to be a systematic and ethical process. I will therefore address the epistemological stance through the constructionist perspective. Constructionism or social construction of reality draws on the positivist position which appreciates that the construction of knowledge arises through the interaction of human beings and their world, redesigning and informing their social context (Gergen, 1999). It is an outcome of the scenario in which the action has evolved and is shaped by the cultural, historical, political, and social norms that operate within it at that time. The reality can be different for all involved as it is dependent on individual understandings and experience of the world around us (Berger and Luckmann, 1966). This makes each individual reality unique to the individual experiencing it. In contrast, empiricism, which is the foundation of positivism, takes the view that reality is objective and quantifiable, making the experience the same for all those involved within it. Understanding learning, cultural relationships and the recognition that cultures are neither static nor independent variables are fundamental in this process. Constructionist practice is the process of collaborative learning and deep personal reflection into one's own learning process (Brooks and Brooks, 1996).

This study understands the process of transition as a social construct in the knowledge that a workforce is constantly changing and generating new challenges as it integrates and grows producing new challenges as it evolves. Language, social dialogue and discourse are central to social

construction, conversing is co-constructing. People grow by using dialogue to make sense of what is happening (Jonsdottir *et al.*, 2004). The value of inter-relationships not only opens up a better understanding of self and individual viewpoints and understanding but also aids the understanding of why others may see something differently, offering a new understanding of the situation. This becomes an evolving process with different individuals seeing the world in varying ways and is dependent on the participants involved, however, the group dialogue will also challenge any simplistic assumptions (Gergen, 2009). When unpicking these assumptions, context and understanding can be gained which introduce new insight. This provides a platform for a potential shared understanding.

Valuing all viewpoints balances the hierarchy (Powley *et al.*, 2004); therefore having the opportunity to listen to one another can change the power relationship. As each member shares their individual and unique perspective, they become teacher, shifting the assumptions that previously informed the hierarchal roles. The dialogue can be challenged and reshaped throughout the engagement with other members; the individual experience holds individual power (Gergen, 1999). However, in the knowledge that conversation alone will not reach all participants it was important to broadly interpret language for this study, thus a variety of methods were used in the data collection, including the use of drawings.

The DNA of AI

The methodology provides an inclusive environment for those immersed in the day to day reality enabling them to construct a potential future. Barrett and Fry (2002) use the combination of five principles to move the foundation of AI from theory to practice; **constructionist**, organisational vision combined with social knowledge; **change** being inherent in every intervention; **poetic**, authored by all involved; **anticipatory**, the collective creating the potential; **positive,** meaningful experience.

This approach facilitates the engagement of participants in developing solutions to improve their individual contexts and situations. AI explores the organisational innovations, using groups to identify what is working, to

develop and implement. A common result of this approach is not only developing innovation, process and new ways of working but an increased sense of commitment to and within the organisation (Senge, 1990). AI therefore is pertinent to this research inquiry, as it embraces the positive experiences to engage both staff and organisation to create a firm informed framework. This offers potential for ownership and a feasible working model, meeting the needs of the user and organisation.

Cooperrider and Srivastva (1987) created a 4D model to manage the AI methodology process, taking the research through four aspects of inquiry. The first phase is **Discovery**, where practitioners engage in storytelling, sharing experiences which worked well, appreciating and valuing the best of what is. The second phase is **Dream**, envisioning what might be and what it could look like. Participants create a visioning statement linking the past Discovery experience of good practice to the Dream of even greater opportunity. The third phase is **Design**, identifying what is needed to create an ideal outcome to make the Dream reality. Finally, the fourth phase is **Destiny**, co-constructing the future, developing a strategy to manage the implementation. I embedded the first three phases of the 4D model to frame this study. Mini-summit interviews were used to generate inquiry; this approach enables participants to challenge one another on how aspects of their sub-culture are represented exploring and clarifying their experiences, which would not necessarily arise through an individual interview (Goodman and Evans, 2006). Enabling others to have a voice and to work from their understanding and experience may prevent the individual from feeling overwhelmed by the problems and allow them to become energised by the possibilities.

Redacted due to copyright

Figure 3.2 An adaptation of the 4D Cycle (Cooperrider et al., 2008, p.5)

The Discovery stage of the research process encourages storytelling (Cooperrider *et al*., 2008) and is considered an effective approach in generating rich qualitative data (Reed *et al*., 2002; Carter, 2006; Seebohm *et al*., 2010). It is an art which can be easily dismissed, forgetting the power that language and dialogue can have. Storytelling is an active process in making sense of something, and bringing meaning to its relevance and position. It has been used in nursing to communicate embedded knowledge, to address conflict, and to manage problem solving (Sole and Wilson, 1999). It is also well used in: action research (Mitroff and Kilmann, 1975); organisational revitalisation; building relationships (Bouterie Harmon *et al*., 2012); socialisation of new employees (Louis, 1980, 1983); and innovation (Buckler and Zien, 1996).

Storytelling provides the opportunity for intergenerational inquiry. By bringing the different participant groups from varying professional generations together, they can share personal thinking and hear the ideas of others. This takes the participant from their immediate context to understanding potential future possibilities, allowing them to make sense of difficult events (Harter *et al*., 2005). This challenges the participant

77

generations to connect the information with their own values, appreciating how this can influence them and build their expectations (Pasupathi *et al*., 2006). As this process progresses, their interpretations shift as they make sense of the situation. The storytelling of different experiences continues to change as individual values are shared. This plays an important role in motivating the process, a process which can alter their organisational identity (Boje, 2011). This makes the experience visible, providing '*a powerful pathway to creating images and building relationships between people*' (Watkins and Mohr, 2001, p130).

In creating and building transformational actions, the participants are part of an inclusive and progressive environment, creating the positive culture. This positivity is explored in Isen's (2000) research, finding that people become more flexible, creative, integrative, open to information and efficient in their thinking. Fredrickson's (2006) work develops this finding: resilience, openness, creativity and action develop from the 'positive' inquiry approach. The findings from these researchers demonstrate that the generative and positive in AI can create a more open and progressive conversation, inviting exploration for future opportunities, introducing a positive attitude therefore brings informal influence and shared responsibility (Baker *et al*., 2003).

This moves the methodology beyond simply exploring the positive events that are happening within an environment, bringing a new perspective, helping us to be conscious of and understand the relevance of what is around us (Rogers and Fraser, 2003). It is celebrating change and the people that have the ability to bring energy and focus to that change. In summary the AI method is not simply swapping the problem centric of the action learning methodology with an opportunity centric approach, but inviting different participant behaviour and generativity. The combined strength of the participants and the activation of their energy are essential to the generative momentum of the change process (Bushe, 2011).

Appreciation is not just looking at the successes (Rogers and Fraser, 2003). When bringing the novice and the experienced together, they will consider their different perspectives; their professional needs, and how

these align. Some of these perceptions may be viewed as weaknesses by the listening participatory group, or could be about what is working in the moment but becomes a transient element. The important issue here is that the insight is not lost, but explored, recognising its benefit and future opportunity by the participants, appreciating the tacit knowledge. This is crucial information in building the learning experience; giving space *'to know, to be conscious of'* (Grant and Humphries, 2006, p.408).

3.5 Researcher as facilitator

I facilitated the data collection process which involved taking responsibility for group management and for participant engagement throughout the data collection process. I was mindful that my actions, techniques and judgements could influence participants' ability to independently generate and own new possibilities and vision (Bohm, 1998). According to Denzin and Lincoln (2005), researchers can never be totally neutral and objective within a study due to the research decisions made; the methods selected and interpretation of data. I therefore sought to minimise my influence on the data collection and analysis process by being true to method, recording and reflecting on my practice through diary entries.

I was conscious that my professional identity was not constructed through technical and emotional experiences alone (Hargreaves, 1994; Sumsion, 2002), but influenced by my social, cultural and institutional experiences (Sleegers and Kelchtermans, 1999). To avoid influencing participant perspectives, whether through my professional role or researcher position, I employed strategies that would ensure my instructions were clear, simple and non-directive. I was available for discussion but made no judgments about the interactions or outputs from participants. At times this was challenging due to some contentious participant comments made about my department or the organisational hierarchy, it was here that my professional experience enabled me to facilitate a progressive debate rather than critical reporting. Therefore, rather than leading, I adopted Boyle *et al*'s. (2010) advice of using a facilitative style which sought a shared and dynamic approach which enabled co-creation and active engagement. AI was a distinctive aspect of the research process, but so

was I, in my interpretation and management of the data collection I brought a novel outcome (Rossman and Rallis, 2003). This is further explored in appendix 11).

The design of the research introduces the additional challenge of bringing two distinct groups together, NRN and the senior nurse manager. This could bring an initial tension due to the stories being told and because of how they could be perceived by the researcher and the participants. Once again it is important to identify that this methodology is searching to find the good, celebrating the possibility, rather than reciting the negative. Therefore it could be argued that this is an example of Levine and Moreland's (1998) theory of innovative thinking. Although the novice nurse might be self-conscious initially, effective facilitation will set the research expectations of the data collection, and embed the philosophy of the methodology and research aims. Boundaries within any research process are vital to a successful outcome but when there is a hierarchy of roles within the data collection group participants need to feel at ease with both their remit and their personal safety.

Having explored the methodological assumptions and philosophical framework to this study, I will now address the methods used to explore the research questions framing this study.

The application of AI

The structure of the application of AI is not fixed, allowing creativity in applying the research inquiry (Bushe, 2011). However, Ludema *et al*. (2003) identify 10 conditions for AI summit success:

- A relevant clear and compelling task
- An unconditional focus on the positive.
- Robust planning
- The whole system in the room the whole time
- Commitment to support success of decisions and outcomes
- A healthy physical and relational space

- Minimal and mindful facilitation
- Begin with appreciative interviews
- Flow through a 4D cycle
- Create a narrative rich environment

I wanted to explore the organisational perspective with two distinct peer groups and so needed to create a forum where the two groups could come together. For this reason I called this a mini-summit, in the knowledge that each AI intervention is unique and should be adapted to suit the environment and participants (Trajkovski *et al.*, 2013). Summits are often used within the methodology (Faure, 2006) to encourage the collective voice of an organisation to share and co-create. This method of group engagement is also beneficial when carrying out affirmative action research (Kitzinger, 1994) as the process endeavours to "empower" the participants as they become active within the process of analysis, moving from idea to outcome. It was possible, due to the size of the organisation, to generate large numbers for the event. The mini-summit was undertaken over one time period, bringing both the NRN and senior nurse manager together. Aware that hierarchy has the potential to impose constraints on group interactions, measures were factored into the mini-summit framework and embedded into the theoretical design. This was in part informed by Mannix and Sauer (2006) who raise concern in three areas;

- Information exchange and discussion biases in group decision making
- Conflict management and negotiation
- Creativity and effectiveness in diverse teams

Advice on bringing groups of people together for interview was followed by providing a relaxed and comfortable environment with refreshments available. This facilitated a safe and enabling atmosphere for dialogue and for relationships to develop (Kleiber, 2004; Ludema *et al.*, 2003). I also ensured that all participants understood the goals and objectives of the inquiry, providing information about the mini-summit design and expectations.

To structure the event I used the 4D cycle, setting activities to inspire each stage. As the mini-summit developed, I became more interventionist, encouraging debate and assisting in merging the two group perspectives. This occurred in part from the momentum of the event but I also wanted to inspire participants to go as far as they could with their exploration. I was mindful that the AI data collection was not aiming solely to collate themes from the findings but also aimed to generate new theory which had 'high face value' to members of the organisation and profession.

Participant Sampling

Due to the size of the organisation the pool of participants was limited, so all members that met the criteria were invited to participate in the mini-summit. This removed the opportunity to use a randomized approach making it more strategic in its development using the organisational members to shape the process. This was both purposeful (Patton, 1990) and used a snowball-like (Bryman, 2001) effect, in that having identified a number of appropriate participants they were then able to introduce me to further individuals that met the selection criteria. This supports the methodology in that it becomes a collaborative process. It could be argued that it would be appropriate to invite all members of the nursing team to take part should they wish, gaining a wider community perspective. The power to guide the direction of the inquiry should lie with them. However, I needed to work within the bounds of a small organisation, and my focus was on achieving a quality of knowledge and experience rather than the size of the sample group (Merriam, 2002).

Selection criteria:

1. Six NRNs, who have been registered for nine to eighteen months employed within the hospital setting. The time frame chosen is based on Duchscher's (2008) transition stages model. Within this the author understands the new registrant journeys through three stages of transition, **'Doing'**, **'Being'**, and **'Knowing'**. The

'Knowing' stage is seven-twelve months, moving from separateness to established practitioner. This timeframe will enable participant transition experiences to be explored at similar stages, as they will be in the 'knowing' stage of their development. The period of up to 18 months post-graduation allows the potential for reflection time of participants' professional experience to inform this study.

2. Nine senior nurse managers who are involved in supporting NRNs through the transition period, who are employed within the hospital setting working at band seven or above. These managers lead their ward and/or unit environments and are actively involved in the NRN recruitment process.

3.6 Data collection

AI allows a flexible approach, encouraging the researcher to shape the data collection process (Cooperrider and Srivastva, 1987). I therefore elected to structure the mini-summit using three of the four phases within the 4D framework. I also took advice from Bushe (2011) by including an additional D to open the event. This D encouraged the fifteen participants to **Define** the intended inquiry. Although the over-arching subject was defined pre-event, the additional D engaged participants in the subject, clarifying their understanding in relation to it. I also used it as an opening activity to *'generate an atmosphere of energy, focus, and anticipation'* (Boyd and Bright, 2007, p1029), asking the participants to work independently to explore three questions around value, support and a positive transition. Answers were written on coloured post-it notes which were displayed throughout the mini-summit. This process set the mood, began the thinking and enabled individuals to explore their own values and understandings about the subject. These questions and the mini-summit worksheet are shown in appendix 2.

True to the constructionist perspective, AI involves small-group dialogue to identify connection points and to generatively build shared meaning and development opportunities from their experiences. This collective process creates action points which when implemented, can enrich future practice

opportunities. I adopted a different approach within the mini-summit, initially asking the participants to work independently (Define phase), in peer pairs (Discovery) in small mixed groups (Dream) and finally collectively (Design). This enabled me to facilitate the participants through the processes, allowing their deliberations to work in harmony with the evolution of the AI phases and to introduce them gradually to fellow participant members, creating a safe environment for all to perform.

Whitney and Trosten-Bloom (2003) recommend that co-interviewers are trained to support the mini-summit process. This would have been an advantageous addition to the event in sharing the logistics of the process and in managing the data recording. However, this was not possible due to time and resources, meaning that I was the sole facilitator. The single 4 hour mini-summit was pre-prepared through informal conversations and used relevant literature to inform the process, which is consistent with an interview group design (Hopf, 2004). Hopf (2004) recommends that this approach is advantageous as it brings insight into subjects which have not been thoroughly understood historically, which reflected the premise of this study inquiry. It also provides unstructured time for building informal relationships, which is beneficial when inspiring ideas for potential future change (Fitzgerald *et al.*, 2003).

Each phase was recorded through drawings, audio material and/or flip chart papers which were retained as field notes (Appendix 3). AI theorists reinforce the crucial role that the question has in the inquiry process (Ludema *et al.*, 2000; Reed, 2007; Barrett and Fry, 2005). Therefore, the mini-summit questions were crafted following Reed's (2007) recommendation that AI questions should have two parts: firstly, requesting a real personal experience and a narrative story, which enables the participant to relate their knowledge; secondly, allowing the participants to work beyond the past to visualise the best possibilities for the future.

Phase 1: Discovery or *Inquire* – Identifying the "best of what is". This stage of the inquiry aimed to both undertake an evaluation of the now experience and explore the possible through the positive. Participant groups were invited to draw a picture individually of their positive experiences of being or working as/with a NRN. Drawing was used to help

participants make sense of their experiences, enabling the visual data to bring life to the experience. This approach has been used by a variety of authors when considering organisational change (Kearney and Hyle, 2004) and releasing creativity (Titchen and Manley, 2006). Anning (1997) believes that this is an underused method for discovering such information, as a drawing can express experiences and understanding which is not easily put into words: the 'not yet thought through' or the subconscious (Weber and Mitchel, 1996). This supports the notion of challenging the tacit, finding different ways to understand. Berger (1972) suggests that the way that we see things is influenced by our cultural surroundings, and the values that this brings. Events inform our opinion and observations, becoming a form of writing which can be 'read' (Weber and Mitchel, 1996). The participant can represent their experience and understanding sometimes unaware of some of the most influential aspects, using size positioning and subject(s) to make sense of their experience (Anning and Ring, 2004). This exercise helped the participant to conceptualise their experience, giving them control over the process, enabling individual thinking to inform the 4D framework. This reduced the hierarchal and peer group influences and enabled the participant dynamics to settle. Each participant was able to explore and represent their personal experience. Sarason (2004) views learning as a process which takes place in a pure interpersonal context. This activity could support the construction of their learning and understanding of an event.

During the mini-summit both participant groups worked in peer group pairs to discuss and interpret their drawings. The dialogue enabled participants to be actively and openly involved in developing their positive experience, values and wishes, generating themes as they went, exploring the variances within the shared and unshared experience. I was able to energise the groups to explore the successful achievements, unique skills/qualities and the organisational factors involved in the experience. The outcome of this phase was for participants to identify root causes for success and themes for further discussion. Carnell and Lodge (2002) describe this as a process of co-construction.

The two participant groups shared their themes and chose those that were to be taken to the next stage. This process was undertaken with a short set

of questions for each participant, which were collected for field notes. This iterative process introduced increasing depth to the quality of the analysis and reflection, building up successive layers of practice-based information and ideas. This generated a positive energy from the participants' contribution and set the agenda for the next stage of the 4D research process, using the 'power of positive strengths' (Thomas and Thomas, 2006) to achieve growth, creativity, productivity, and effectiveness from the interactions of two opposite strengths feeding one another. All material was recorded by the groups on flip chart paper and has been used as field notes. These were labelled and the group feedback was recorded (Krueger, 2000).

Phase 2: Dream or *imagine*, exploring the desirable future

> *'AI seeks out the exceptional best….to help ignite the imagination of what might be'* (Pullin, 2001, p.54).

The two participant groups explored the findings from phase 1, working in mixed participant pairs to identify how these positive experiences could be developed. They envisioned a new possible future state, recording their ideas on flip chart, taking their vision as far as it could go. This required participants to visualise utopia. Creative dreaming allows participants to think differently and builds their capacity for what is possible. Each pair used a theme from the discovery stage to explore the possibilities within it.

Phase 3: Design – Translating the vision into actionable statements
Participants were asked to use the utopia and shaping ideas achieved in the dream phase to translate the dream document into actionable statements, mapping out a project plan of the how. They were asked to create a dream document, where they shaped the theme, what could it look like, what would be involved, what would be required for it to happen and how would this align with the professional, individual and organisation needs.

The strengths of AI relate to the generative material which can evolve through positive stories (Bushe, 2011). The multifaceted and multi-layered social experience of the AI progression was fundamental in sharing the

new level of understanding that arose through the participatory process. The mini-summit event took on a life of its own which was not always linear, although each phase built on and informed the next. Tacit understanding was not always sequential as the new ideas and understandings emerged (Gergen, 1978). This process helped to identify new actionable learning which could influence future support systems. This characterised the application of the AI methodology, demonstrating that an AI summit was capable of:

> *"accelerating planning, decision-making, and innovation … crafting inspiring and generative visions of the future … forging mergers, alliances and partnerships … [and] designing or building momentum for a new initiative"* (Whitney and Trosten-Bloom (2003, p.35-36).

3.7 Informed Consent

Participants were informed about the nature of the activity and the proposed consent (Appendix 4/5/6); however, they had not been involved in a research study before. So it could be argued that they were unsure of the parameters to which they were consenting. A risk when bringing the NRN and the senior nurse manager together was introducing a superficial imbalance of power and hierarchy. However, the nature of the AI philosophy was to generate meaning and progression. The dialogue was not negatively exposing for either party, but introduced a level playing field enabling all to work within their own experience and beyond to create a new opportunity. Due to the collaborative nature of the inquiry and the evolving process of the methodology, it was essential to keep revisiting the ethical code of conduct. Throughout the mini-summit process the energy of the event brought out a variety of behaviours which needed to be managed such as dealing with dominant participant voices to episodes of criticism of current processes (These are further explored in Appendix 11).

Data analysis

While AI provides the philosophical underpinning for the study and provided guidance for the framework for the mini-summit, thematic analysis (TA) (Seebohm *et al*., 2010; Braun and Clarke, 2006; Reed *et al*., 2002) was used to analyse the data generated from each stage of the 4D Cycle. The flexibility of TA enables it to be used within a variety of theoretical frameworks (Braun and Clarke, 2006), thus appropriate to the constructionist method. The AI intervention aims to generate collaborative change, therefore it is necessary both to manage the data for independent and organisational interpretation. This makes the analysis of the AI data a slightly more bespoke activity. Bushe (1995) advocates the use of three elements to the AI intervention, Discovery (appreciating the intervention process), understanding (appreciating the insight and the analysis) and amplification (acknowledging the individual performance). To manage this, Bushe and Pitman (1991) created an inquiry matrix with organisations identifying key areas connecting the mini-summit to an organisational model and relating the data findings to the bespoke analysis template, truly embedding data findings into the organisational change. The involvement of the amplification element acknowledges the individual participant, which works outside the ethical agreement of the study; therefore, this aspect has not been adopted. However, I have been mindful of these elements and observed the generation of data and synthesis throughout the intervention and the individual voice within the research process. Therefore a broader use of amplification has been implemented. These findings also brought sense to holding a mini-summit, as the data generated from a collective organisation would be difficult to manage as a solo researcher.

When capturing the synergy within the mini-summit participants generated potential themes. This infers that the 4D cycle forms some basis for the themes which can then be scrutinised through TA. TA can be used as a foundation approach to qualitative methods, as the core skills are flexible (Braun and Clarke, 2006). However, with this comes a risk that 'anything goes' (Antaki *et al*., 2002). Therefore a transparent and rigorous process needs to be showing the 'how' (Attride-Stirling, 2001). Bushe (1995) believes that this can in part be achieved by returning to some of the participants to gain confirmation that the spirit of the meaning has been

accurately captured, validating my report of the activity and dialogue throughout the mini-summit.

The research adopts an inductive approach, which is driven by participants making it data driven with minimal pre-existing literature informing it. Braun and Clarke (2006) suggest that in applying the inductive approach, it is beneficial to avoid engaging with the literature during the early stages of analysis. Although I have an interest in the subject, I have been led by the inquiry and participant data, thus the inductive approach. Deductive analysis tends to be top-down, and motivated by the researcher. This relates better when exploring a specific question.

TA recommends that the researcher personally transcribes the data from the data corpus to allow for total immersion. Repeated readings of this material identify patterns, themes and sub-themes (Quinn and Clare, 2008). A theme represents something that is important, signifying a level of patterning or meaning (Braun and Clarke, 2006). Taylor and Ussher (2001) warn the researcher about the passive accounts where themes 'emerge' or are 'discovered' desiring the researcher to be more 'active' and able to identify patterns/themes which are of interest. My active engagement within the intervention exposed me to these themes and added value to this process. Working within my philosophical framework, I identify themes which have been produced by the group environment and which are strongly linked to the data (Patton, 1990). This inductive aspect of TA works well with the AI process (Cooperrider and Whitney, 1998) and is valued as both an accessible and theoretically-flexible model in analysing qualitative data (Braun and Clarke, 2006). Data generated through the mini-summit process has gradually been scrutinised and prioritised through the 4D cycle and the participant discussions. However, as Gergen (1999) notes, an aspect of the researcher role is to observe the synthesising process, capturing the connective ideas that inform it, to bring rigor to the findings (Bushe, 1995). Thatchenkary and Metzker (2006) identify this as a theory of "appreciative intelligence"; the ability to see the potential that is trying to emerge in people and processes. The participants in the inquiry work to locate the themes from each stage of the 4D cycle, sharing ideas for a preferred future and setting the agenda for future action. This supports latent thematic analysis which goes beyond the surface

(semantic) data and tries to examine the underlying ideas, assumptions and conceptualisations. Finding the latent themes in the data aligns more with the constructionist paradigm (Braun and Clarke, 2006 p.84).

3.8 Ethical considerations

Ethical approval from the National Research Ethics Committee was initially granted prior to commencing the study (appendix 7 with reflective account appendix 8), which was then approved by the Faculty of Health, Life and Social Sciences University of the West of England research committee (appendix 9). However, due to a career move I was working in an independent healthcare environment which worked outside UK and NHS processes. Due to their independence, I was required to undertake a further ethical application through the Local Ethics Committee where approval was granted in October 2011 (appendix 10). I had discussed the study with the chief nurse and gained her appreciation for the study purpose. In addition the Local Ethics Committee raised some interesting issues around 'insider researcher' and around methodology. I had moved from being a University based lecturer to being a hospital based lecturer, which brought me closer to and therefore more informed about the individual, the collective participants and the organisational values. Although the study commenced only nine months (May 2012) after joining the organisation, I was soon actively involved in lecturing, supervising and facilitating departmental developments and organisational conference events. This not only socialised me into the organisation and potential participants but also publicised my profile. This could have advantages but could also be contentious. However, the participatory nature of AI and AR approaches are that they are carried out in the context of practice, communicating closely and openly with the people involved to facilitate and monitor change (Meyer, 2001). I therefore used this time to build and develop these relationships, understanding the context of the organisation and the local healthcare system. Building a rapport with the participants is an important element of the AI research process, however, I was aware that if this developed into friendship it could bias the data collected (Somekh and Lewin, 2005).

My new role introduced the notion that I was an inside researcher. Staff initially viewed me as an outsider as I was new to the organisation and employed in a department that sat outside of the immediate service provision. However, staff soon appeared to value the new approach that I brought to my role and confided in me, seeking knowledge and guidance, making me feel more like an insider. Reed and Proctor (1994) discuss the fluid nature of this role, as it shifts throughout the research process. The familiarity of the site was beneficial but also difficult. I had knowledge gathered through my role, both organisationally led and individually observed. I was aware that there was also knowledge that I was unaware of, and information that I may have taken for granted whilst not fully appreciating its meaning.

The role of the researcher is to do no harm, maintaining confidentiality and safeguarding the participant's consent and allowing them to withdraw at any stage of the research study (Winter and Munn Giddings, 2001; Meyer, 2006). Due to the nature of such a small organisation and nursing community, the AI process was challenging to facilitate, owing to the close relationships involved and the insider knowledge of the community itself (Meyer, 2006). However, following the principles of good research practice professional boundaries were observed. The generative nature of the AI process made the confidentiality challenging due to the energy and action that came from the event resulting in many participants being keen to implement their ideas. Cohen *et al*. (2007) refer to the keeping of *'shared secrets'*. This notion became very real to me following the mini-summit. I appreciated the confidential importance of what had been shared throughout the event, with unique stories building a precious data collection. On reflection it could be easy to share the content in other forums damaging the research process. This heightened the importance of my role in the safeguarding process bringing a new awareness to practising good research practice.

Anonymity of participant identity posed a particular challenge within such a small organisation (Seale, 2007). The mini-summit took place on site; this had advantages due to the logistic ease for participants, and provided a known venue, avoiding concerns about parking and getting lost. However, it did pose problematic when colleagues would observe their presence and

ask what they were doing. I raised this with participants during the welcome, reminding them of the confidential nature of the meeting. Participant identity thus remained anonymous. All participants were given a pseudonym known only by me, and the information was stored in a password-protected computer. Pseudonyms were allocated during the transcription process, and all digital recordings were deleted once this was completed (Sapsford and Jupp, 2006).

3.9 Chapter summary

This chapter began by introducing the paradigm of constructionism as the underpinning philosophy for AI. This paradigm emphasises that research is done with and for people, to recognise the practice strengths which can be further built on (Reed, 2007). The researcher role has been recognised as active within this, observing and facilitating the data generation. This chapter illustrates the strength of the AI method, a genre of AR which potentially excites an embedded phenomenon and brings new life to its inquiry. AI combines the researcher values and desire for a collaborative approach when exploring the NRN transition. This makes the methodology well placed to add to the body of knowledge in seeking further meaning and development to the subject.

The chapter shares the data generation activities used throughout the stages of the AI process (define, discover, dream, and design) and the bespoke approach that the methodology brings to the data analysis. The following chapter will share with the reader the analysis generated from the mini-summit data, which has been drawn from the 4D framework, while mapping out the influence that the findings have on the research inquiry.

Chapter 4: Presentation of the findings

This chapter initially outlines participant demographics and the context of the organisation where the study was conducted. It then moves on to explore the emerging themes and sub-themes arising through data collection and analysis.

Understanding the local context:

The study setting has British Crown Dependency but is not part of the National Health Service. This excludes the healthcare organisation from the DH influence and policy initiatives, providing the opportunity to create a bespoke process which is fit for the needs of the healthcare community. The purpose of this research was both to identify and to situate participants' visions for supporting and aligning the needs of the NRN and the health care organisation. The study aim is to understand the meaning of support, mindful of the context that a general hospital in a small island environment brings to the process. Following NMC registration, the NRN, moves from the UK to join a clinical nursing team within the study setting. On joining the healthcare organisation, the NRN is required to successfully achieve a six month probation period, incorporating a competency programme which is overseen by the designated preceptor and senior nurse manager. The inclusion of a probation period is atypical to the traditional NRN's induction. Therefore it could be argued that this could create additional pressure on the individual to achieve.

4.1 Participants demographics

Nine participants were senior nurse managers, and six were NRNs who had been qualified between ten months to eighteen months. At this time the healthcare organisation employed seven NRNs who met the sample criteria. This resulted in the data collection being governed by this NRN timeframe; six of the seven eligible NRNs were therefore represented. There is one hospital on the island and this has eleven general wards, nine

of which recruit NRNs. All participants were female (the two male senior nurses, in post at the time of the mini-summit, did not join the research study). Professional details of each participant have not been given as this would expose the individual identity in such a small workforce group (Johnson, 2001). Table 4.1 illustrates the pseudonym, and uses N to distinguish the NRN from the code of M for the senior nurse manager.

No	Pseudonym Neophyte Registered Nurse (N)	No	Pseudonym Senior Nurse Manager (M)
1	Ada	1	Gina
2	Betty	2	Hilda
3	Cassie	3	Isobel
4	Dot	4	Janet
5	Elsie	5	Kate
6	Fay	6	Lucy
		7	Marcia
		8	Nadia
		9	Pippa

Table 4.1 Participant pseudonyms and coding

4.2 Method of analysis

Data collected during the single mini-summit event took place in June 2012. Making sense of the data began with each of the AI phases providing links through the verbal discussion, observations and drawings. The data derived from each of these phases were recorded through post-its, drawings, audio material and flip charts which were retained as field notes.

The 4D process is iterative, with participants discussing, debating and summarising each phase, bringing collaboration to the central findings. Therefore a pragmatic approach was taken which both acknowledged the social interaction and the situational meaning. This influenced both the participants and myself in the development of their ideas and the exploration of potential action. Rorty (1999) advised that truth cannot be the goal of inquiry, as the experience will merge with the ideas dependent on the context in which they take place.

To explore the multiple meanings and to ensure against bias I continued to remain impartial and where appropriate made entries in my field notebook as part of reflexivity (Reed, 2007). A key characteristic of AI is its collaborative nature; which includes the process of data analysis, shifting the emphasis from reliance on models to the responsibility of researcher to represent the collective meaning (Reed, 2007).

To structure this process I followed Braun and Clarke's (2006) guidance to identify, refine and review emerging 'patterns of meaning', and to enable the initial, sub-themes and core themes to emerge. Attride-Stirling (2001) advises that the analysis process is not aiming to realise the beginning or end of the inquiry, but is a means of breaking up text and finding significance. Codes and, features of the data, were subsequently grouped into an 'initial' thematic map where they were reviewed and reduced further, until the final phase of analysis and refining led to naming themes (appendix 12). Table 4.2 illustrates the six phases of the thematic analysis (TA) adopted for this study, this is followed by a detailed report of the process.

Phase	Description of Process
Familiarisation of data	The researcher repeatedly listens to audio recordings, then transcribes the material, reads and re-reads transcripts, recording initial ideas.
Generation of initial codes	Interesting features are coded taking a systematic approach throughout the data.
Search for themes	Codes are collated into potential themes with all relevant data incorporated.
Review of themes	Researcher reviews themes, matching codes with data to ensure they work individually and as an entire data set. A thematic map of analysis is generated.
Defining and naming themes	Continuous analysis and refinement of each theme and the story the analysis shares. Clear definitions and names given to themes.
Production of themes	A selection of extracts to define final analysis, relating back to the analysis to the research questions and literature.

Table 4.2 Phases of thematic analysis.

When analysing the data, Ludema (1996) cautions against presenting 'narrative thin' text, and implores researchers to fully report the participant story. The innate process of the 4D phases made this challenging as the participants led and focused the key elements, naturally reducing and refocusing the data collection throughout. However, the data gathered allowed me to combine the participant themes using the post-it entries, drawings and oral stories which kept the data alive. Each piece of data was scrutinised and coded enabling me to consider all data sources, strengthening the overarching analysis (Holloway and Fulbrook, 2001).

Phase 1. The data were transcribed verbatim and analysed using TA (Braun and Clarke, 2006). Braun and Clarke (2006, p79) advise that there is no prescribed way to carry this out, however *'thematic analysis is a method for identifying, analysing and reporting patterns (themes) within the data'.* It was through the act of continuous engagement with the transcripts that familiarisation and pattern recognition began to develop. Diary entries observing ideas and observations were recorded to highlight these patterns. Trustworthiness was in part established through this reflexivity and by my prolonged engagement with the data. Reflexivity engages self-questioning and self-understanding (Patton, 2002), which enabled me to develop my political and cultural consciousness in order to form my perspective. The process opened my thinking, challenging my assumptions and ideological illusions. Additionally, my prolonged engagement with the data enabled participant stories and responses to maintain their currency, and for me to keep focused on the research questions, avoiding the risk of becoming side-tracked by preconceived ideas or initial thoughts. The act of immersing myself in the data invoked validity, trustworthiness and truth in the essence of the participant experience (Holloway and Wheeler, 2013).

Phase 2. Transcriptions and field notes were duplicated into three copies to enable meaningful text to be highlighted with different coloured pens, and researcher notes to be added. Codes were allocated, and interesting features of the data grouped. Table 4.3 illustrates an example of how data were coded:

Data extract	Coded for:
… you will build a relationship with the people on the ward and they will know you, you know them, you know who you can speak to for advice on certain things more than others (N6)	1. building a team relationship 2. gaining trust

Table 4.3 Coding extracts

Phase 3. Initial codes with similar properties were grouped into initial themes. It was at this stage that transcripts were cut into data extract segments, to enable the movement between potential themes and when identified a code was given. These were collated, and stored in a labelled plastic wallet where they were reviewed and mapped to verify their place. One wallet was reserved for 'miscellaneous' for data extracts that did not obviously correspond.

Phase 4. A large wall chart was created, mapping the initial themes to identify if a coherent pattern of extracts had been established. From these preliminary ideas sub-themes emerged which were captured by one of four core themes. Here the trustworthiness of the process and the emerging themes identified was considered. This involved returning to six participants, three from each group, in order to confirm my analysis and to ensure that I had accurately interpreted and represented their perspectives and views (Guest *et al.,* 2012). Their confirmation of textual material contributed towards the rigour and trustworthiness of data analysis, aspects which are discussed below.

Phase 5. To further review the story (Braun and Clarke, 2006) and the process, a chart was collated providing an extract from the transcript, the theme title and a theme definition, which is shown in appendix 12.

Phase 6. The final stage of TA is presented through the remainder of this and the following chapter. Throughout the six phases I followed Braun and Clarke's (2006) checklist (Appendix 13) to ensure that I had stayed true to the TA process.

4.3 Trustworthiness

Trustworthiness or rigour can be defined as *'the means by which we demonstrate integrity and competence, a way of demonstrating the legitimacy of the research process'* (Tobin and Begley, 2004, p390). Although the issue of quality criteria remains unresolved (Rolfe, 2006), it is generally agreed that research needs to be trustworthy thus generating rigour (process) and relevance (outcome) (Ibid). The qualitative research generally links to concepts of c**redibility, dependability, transferability** and **confirmability** to trustworthiness and have been used to address the rigour within this study (Lincoln and Guba, 1985).

Credibility addresses the focus of the study, exploring the decisions made about the context, the inclusion of participants who can contribute to the aims of the project and the data collection and analysis process. This was an important stage in my research journey, particularly due to my change in employment. Although the organisation were interested in the aims of my study, I had concerns over the number of eligible participants and how confidentiality could be maintained in a small community. I wanted to ensure a participant variability (Adler and Adler, 1988), which included diversity of clinical experience, age, and gender conscious of the wealth of rich data that individuals could bring to the study. The sample varied in terms of length of experiences and age but not in gender.

The credibility of the study was also established through the presentation of self and how it was believed by the participants. Acknowledging this, I took time to achieve rapport through my correspondence, explaining that I was both a registered nurse and a lecturer. I made sure that the purpose of the research was understood and how it may positively influence the future transition needs of the NRN, building on the researcher/participant relationship. Inclusive of trustworthiness is dependability. Lincoln and Guba (1985) stress the close connection between credibility and dependability with the former enhancing the latter.

The notion of **dependability** seeks to provide **transparency** in all processes, a form of audit that may facilitate future researchers repeating the study. In order to achieve this I have sought to achieve a transparent report of the study for the reader (Braun and Clarke, 2006; Reed, 2007)

throughout chapters four and five. This was particularly pertinent when identifying study context, participant characteristics, data collection and process of analysis, ensuring that it was systematic and did not inadvertently exclude important data. I acknowledged this through **confirmability,** both through the incorporation of sharing quotations from the transcriptions and seeking confirmation by six participants (Graneheim and Lundman, 2004). In addition, Koch (2006) emphasises the importance of self-awareness, managing personal biases, knowledge and experience, these aspects were managed through my diary and described throughout the thesis.

Trustworthiness also includes the question of transferability, or applicability (Koch, 2006), which refers to *'the extent to which findings can be transferred to other settings or groups'* (Polit and Hungler, 1999, p. 717). This research was small and true to many qualitative studies has not been designed to make generalisations; however, themes that come from the work can inform future practice initiatives.

Developing a thematic map

In keeping with the AI approach the generative material was led by participants and captured their experience of a positive supportive workplace. The Dream phase builds on the discovery phase where participants explored their wishes for the future and the actions needed to make their vision reality (Design phase). The map presented in figure 4.1 shows how the preliminary stages of the initial themes (small outer boxes) evolved to sub-themes (middle boxes) to inform the core themes.
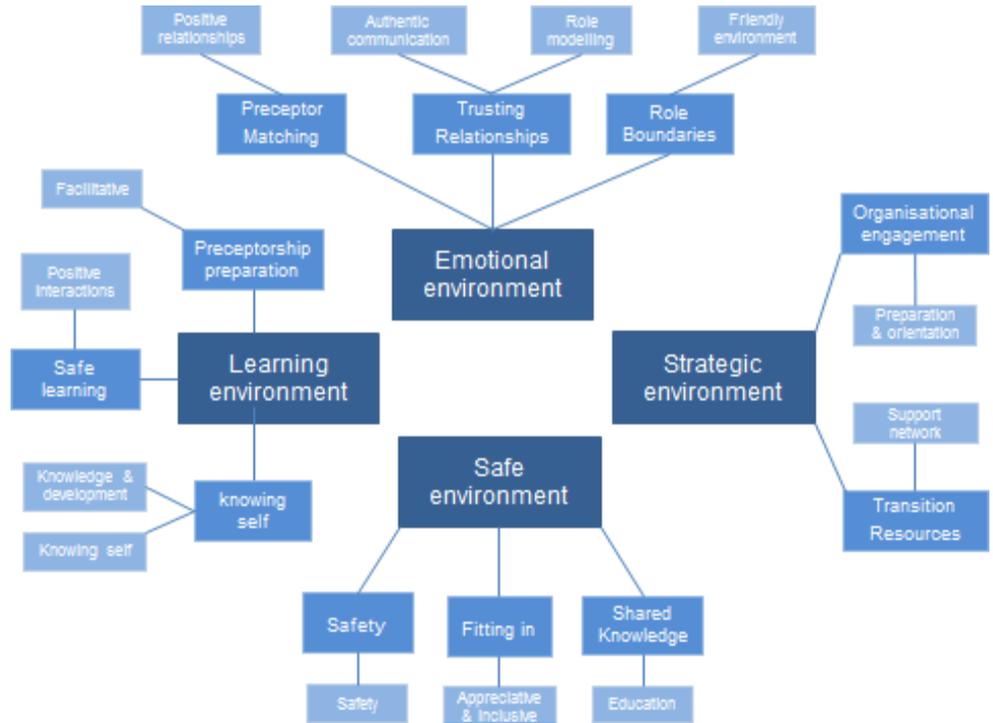
Figure 4.1 Thematic map initial themes, sub-themes and core themes

Analysis of the mini-summit provided a wealth of data that was organized into four core themes. These core themes were: *safe environment; strategic environment; learning environment;* and *emotional environment*. Their definitions are shown below.

Core Theme	Theme definition which comprised of:
Safe environment	Safety for the patient, the NRN and the clinic team.
Strategic environment	The influence and strategic involvement of the whole system.
Learning environment	An environment which was receptive to the individual learning needs and able to facilitate a safe and an inspiring culture.
Emotional environment	Matching preceptor to preceptee, building relationships and creating role boundaries.

Table 4.4 Core themes and their definitions.

The core themes (navy) and their sub-themes (white) are shown in the diagram below. Although the themes are presented individually they are interrelated and interface with each other. For example, preceptor preparation is dependent on resources.

Figure 4.2 Core themes and sub-themes

In reporting and presenting the themes the following sequence will be used to structure the discussion:

- The presentation of the initial sub-themes and core thematic map
- Data arising from the sub-themes
- Summary of the core themes

4.4 Safe environment
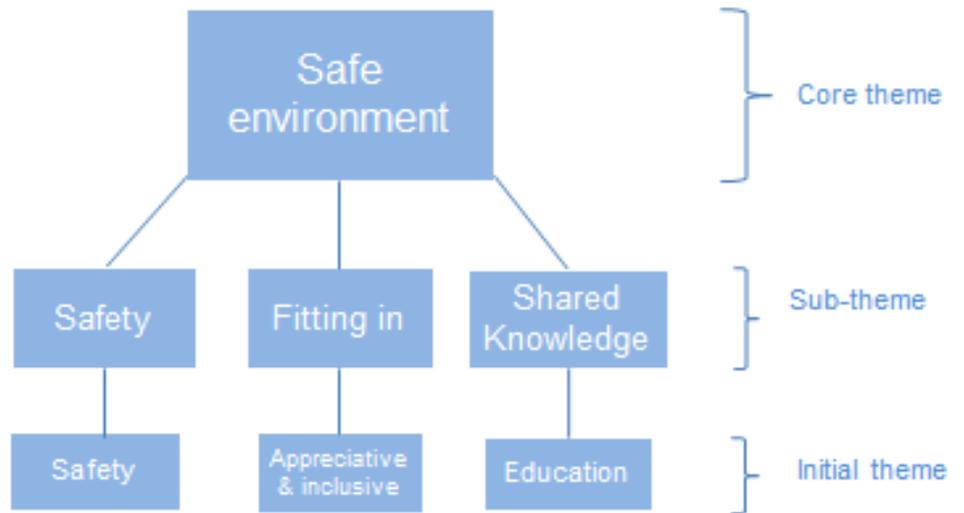
Figure 4.3 Initial themes of Safe environment

The theme of 'Safe environment' emerged from three sub-themes, *safety, fitting in* and *shared knowledge*. For example, the idea of safety embraced support mechanisms for the NRN participants which promoted notions of safe practice in relation to the patient, the nursing team and themselves. Data throughout the four phases highlighted the new member influence, within the context of safety, both in the clinical environment and their impact on that environment. The following extracts share the participant conversation, throughout the four phases, which reflected on the idea of safe environment.

Safety was a recurrent theme throughout the mini-summit. Safety in the context of patient care, clinical practice and also in feeling supported in individual knowledge and decision making. *'Approachable, valued, inclusive and facilitative team'* were words used in the discovery phase which were found helpful in making a scenario safe and thus considered as making an experience positive. These words introduced the relevance of the team environment on the individual performance and also on how this environment could enable safety in asking questions, carrying out practice and working together. When the skill mix had a range of

approachable and experienced nurses available, to offer advice and assist in the decision making process, participants felt more confident and safe in their practice:

'*Somebody is there that you know is much more experienced than you*' (Betty, N2)

When colleagues used a questioning approach and shared ideas, participants described this as critical to building their self-confidence as well as being a contributory factor in achieving safe practice. This was evidenced by the drawings of clinical staff working together, discussing patient care and being receptive to new ideas. Cassie's (N3) picture depicts team members working in the foreground and others in the background, communicating a professional chain of advice and support.
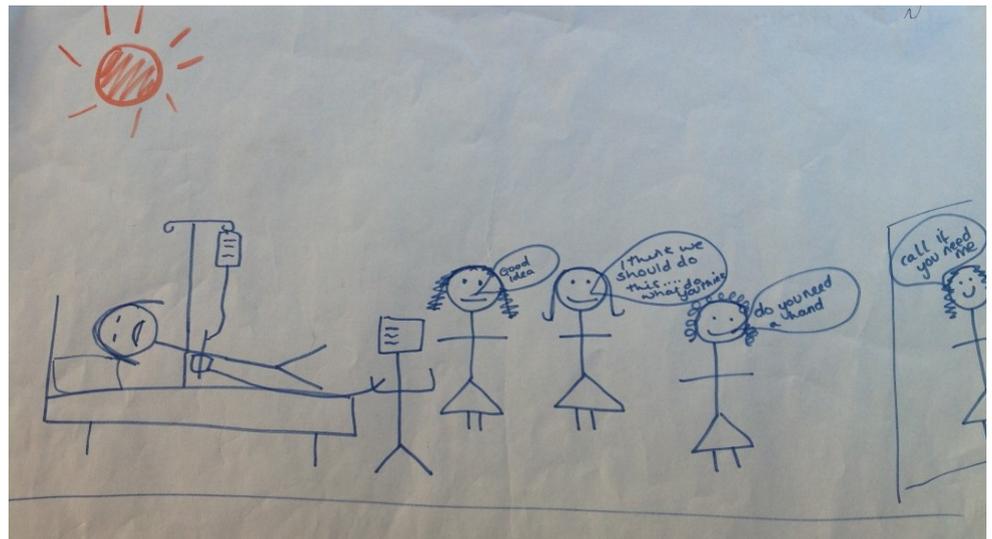
Figure 4.4: Professional chain of advice and support (Cassie, N3)

Additionally for Cassie (N3), it was important to convey the effect that the team involvement had on supporting her clinical practice: both appreciating their skills and having other registered nurses available to support her in her decision making. This not only validated and substantiated her practice but allowed her to '*take control',* which enabled her '*to feel…..valued and needed within the team'.* People were working with Cassie, believing in and reinforcing her practice knowledge and ability, building and developing her professional role within the team. Engebretson and Littleton (2001)

raise the importance of the relationship between integrating professional experience with formal knowledge and the role of that relationship in developing expertise.

Kate's (M5) drawing emphasise this collaborative approach. The picture illustrates her working closely with an NRN, discussing the clinical scenario and supporting them with their practical experience, actively involved in and partnering the experience and practice exchange. Kate identified this as an important element of her leadership role and the expressions suggest a harmonious encounter. Olson's (2009) study found that the NRNs expect and want the ward leader to be in contact with them throughout their transition, working with them in a caring and approachable way.

Figure 4.5: Close working between manager and NRN (Kate, M5)

This approach was seen by Pippa (M9) as '*managing them* (NRN) *in a way that keeps the patients in the ward safe'*. She believed that support for the NRN was '*about nurturing them and developing skills'* which the group acknowledged through their dream phase was the way to '*achieve exemplary care'* (Lucy M6). The drawings used sunshine, smiles and interaction to represent the positive experience; implying that when team and partnership working happened it created happy practice episodes.

This environment was seen as mutually beneficial to both participant groups, generating open dialogue which enabled guidance and constructive advice.

> *'someone is there that you know is much more experienced than you, that you can still call the shots but you know there is someone there to guide you….. they don't completely take over which is quite nice, because you need to learn as well'.*
> (Fay, N6)

Fay wanted to be able to perform but with a safety net of support behind her, this was reinforced by Dot (N4) who wanted to feel able to *'take control'* with guidance. Randall Andrews' (2013) study also revealed this NRN expectation, observing their wish to both be respected in their role and be supported in delivering safe practice. The managers emphasised the importance of safety but from the perspective of the patient: *'my primary managerial concern is to ensure patient safety'* (Pippa M9).

In combination with this collaborative safe network approach (situated learning), Fay (N6) raised the relevance of past learning:

> *'Using your previous knowledge you always go back to your research'* aware of the need to *'learn from your mistakes, but I like to be practical and learn, and then go home and read.'*

This foundation knowledge informed the practice 'Doing', while '*constructive feedback'* supported the NRN to make sense of situations and to inform their on-going practice (Being). Both participant groups identified through the Discovery and Dream phase that talking through the situation developed the understanding of the event, moving into the 'Being stage' (Duchscher 2008). Gadamer (1979) endorses the act of conversation, valuing its ability to encourage insight and questioning to focus the outcome perspectives. This brings integration and clear working boundaries to the team.

Six of the fifteen drawings portray 1:1 discussions taking place away from the clinical area, perhaps signalling that there is a need for reflective time

105

and space to make sense of the experiences gained. This process was seen as an 'in action' or 'immediately after' activity, with both groups desiring protected time to achieve this both inside and outside the clinical environment. This is further explored in the sub-theme *safe learning.* In the next drawing, Lucy (M6) portrays all the factors explored thus far. She shows how a safe environment provides a supportive step by step approach for the NRN to share and discuss their practice with an experienced nurse, taking each stage one at a time to develop their knowledge and understanding, enabling them to feel safe in their practice.
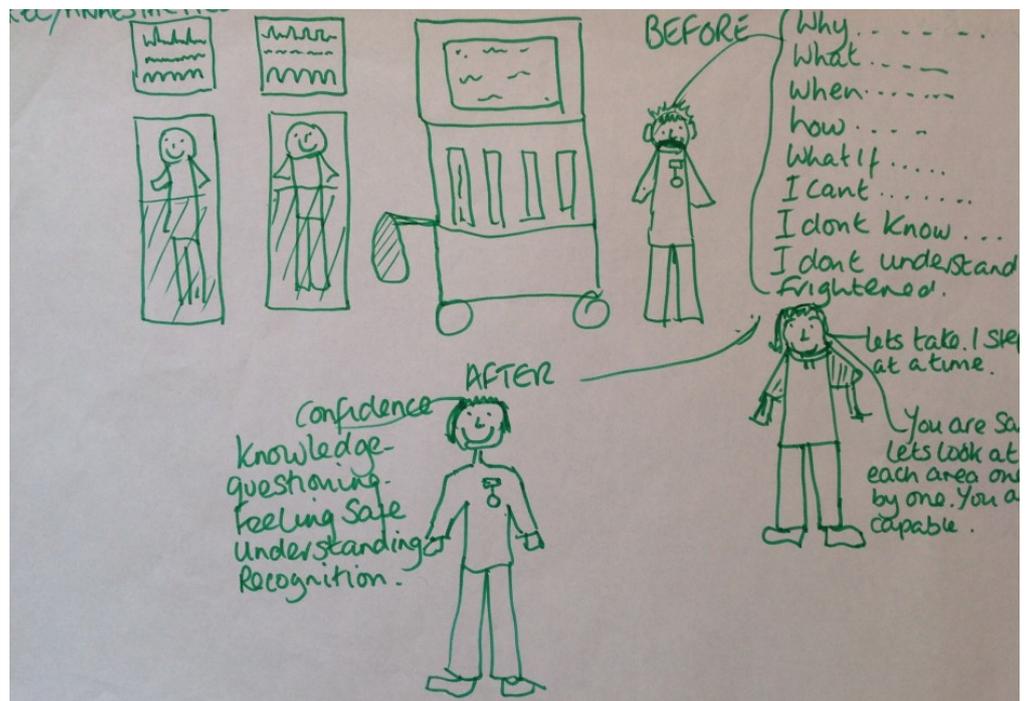
Figure 4.6: Building confidence and knowledge to achieve a safe environment (Lucy, M6)

These findings reflect those of Dellasega (2009), who suggests that some aspects of the support process need a personalised and bespoke approach. This personalised approach played an important part in the Dream and Design phases, which challenged the current generic transition paperwork. The group realised that the paperwork did not address the individual; instead, they collectively viewed it as *'a list of things to be ticked off'.* This led participants to design a transition programme which had an interactive and facilitative approach incorporating the wider organisational context but also addressing individual learning needs.

Fitting in was identified by all participants as crucial. They highlighted the influence that the immediate ward culture had on *'working relationships between nurses who are new and the person working with them'* (Pippa M9). Data from the important story (Discovery) identified *'being an active participant in an understanding environment'* to be a significant aspect in feeling accepted and safe within a team. The NRN wanted *'to feel that they were helping'* and part of an inclusive and approachable team. Developing a relationship which made them *'feel(ing) equal – needed'* (stories to preserve). Whilst the NRNs see themselves as having moved away from the role of student in a mentor relationship to one of being an equal team member, the manager views it as a process of transition which is a *'nurturing and **evolving** process'* (Pippa M9).

Fitting in and joining an established team was not always easy. Both participant groups acknowledged the importance that trust had on forming relationships and practicing safely together. NRNs recognised that trust was an influential factor in their team integration, job satisfaction and feeling safe in their practice delivery:

> *'sometimes people are not very welcoming, they have got their own reasons, and that can be hard, so it takes you a while to fit it, I suppose that you have to prove yourself… prove you know what you are about, that you are not going to make mistakes, that they can trust you'.* (Ada, N1)

This legitimacy to practice (Lave and Wenger, 1991), proving yourself as safe and competent, was instrumental in achieving *'a relationship of trust'* (key learning discovery) within the nursing team. An extract from Fay (N6) summarises the challenges of being accepted into a team by reflecting:

> *'good twelve months to feel like a real nurse…. to gain confidence but also confidence in the people there as well, they have been there ten to twelve years, so you are fitting into their world and sometimes there is not much movement for allowing you to fit in, which is a shame'.*

This 12 month timeframe correlates with Duchscher's (2008) transition stages, identifying this as the 'Knowing' stage, which happens between 8 and 12 months. Fay shares the complex relationship of building mutual trust and confidence within teams. The desire to gain self-confidence, while establishing confidence in the surrounding relationships, was of equal importance. This is a fundamental process for new members, as they observe the behaviours around them to establish who will be supportive and have a value set which resonates with their own. This enables the new member to find their place within the team structure and has an influence on the quality of the NRN transition experience (Thrysoe *et al*., 2012).

NRNs wanted the team to be able to empathise with their transition experience, which was consistent with Olson's (2009) study in which team support was highly valued. Throughout the mini-summit activities, examples of empathy naturally materialised. An example of this was when Lucy (M6) shared her transition as an experienced nurse arriving from a UK teaching hospital to the research area:

> *'I hated it... they did not want my knowledge and there was lots of discrimination… you're not from x, no I never went with it, I kept fighting, but slowly, slowly things got better'.*

This shared story came from an interlude between activities with the NRN and manager finding common ground, developing a relationship of trust which strengthened throughout the event. Similar conversations took place on an equal level, diminishing the hierarchy and introducing the *empathy* that the NRNs were seeking. Fay (N6) saw this as a relationship *'to give and receive, you are obviously compounding the support group between you.'* She spoke of the need to share the responsibility and complex nature of the job, believing that all team members were involved and had something to offer. This understanding of the individual transition experience evolved throughout the Dream and Design phases. As the managers listened to the stories, a new appreciation of the NRN induction experience developed, which informed a new way of thinking about the welcome and the transition preparation:

> '*Making them* (NRNs) *feel part of a team from the offset, how they are received onto the ward, portfolio's there for them… name badges, uniforms etc. with everything co-ordinated*.' (Janet, M4)

There was also a realisation by the managers that the NRN's preparation and welcome could start much earlier, soon after their successful interview and job offer.

Fay (N6) spoke of the importance of having *'like-minded people to ask advice from',* finding that when they were approachable, they gave her confidence and self-belief to use both her knowledge and skills. Johnstone *et al*. (2008) considered the freedom to ask questions as being important when fast tracking confidence.

There were similarities for both participant groups, with each group identifying the need to feel themselves an active and respected player within the team. This is recognised in Casey *et al's* (2004), Ulrich *et al's*. (2010) and Kalisch *et al's.* (2010) work, which saw the important connection between being respected and being acknowledged within a team and the effect this had on building relationships and trust. The NRN was initially seeking these outcomes from their immediate clinical team, however, as the mini-summit progressed so the realisation arose that:

> '*The newly qualified should also work with other people so they get to know them because for 2 weeks you might not have met anybody else…. Work with the HCA, on the doctors round…. Work with the sister for a bit'.* (Fay, N6)

Fay raised the importance of understanding the roles and processes of the clinical environment and, supporting the NRN to build up their networks. This theme evolved throughout the mini-summit, with joint working featuring relationships between manager and NRN, writing learning contracts in collaboration with the manager and the preceptor to focus the transition process (collaborative learning).

The senior nurse managers discussed the advantages of having networks beyond the immediate team. They were able to benefit from the knowledge and relationships around them to share understanding and advice through peer support, bringing guidance and safe decision making to their practice. They had access to and connections with support resources available beyond the immediate ward, which enabled them to seek advice and information with safety.

Shared knowledge and prior learning were viewed as the foundations to being able to practice safely as described by Fay (N6):

'….*educational background it's in there, that's making your instinct work…. While using your research to back up your practice*'.

NRNs found that the '*anonymity of their uniform allowed them to use their knowledge and to feel equal*' (Discovery), finding that the uniform gave them the reassurance which supported their practice, and normalised their position within the team. An example of this is shown in Dot's (N4) picture. This told the story of a clinical emergency which happened during her night shift. The emergency team members were not familiar with Dot and therefore unaware that she was newly registered. She knew the patient and their medical history whilst the emergency team had the clinical expertise; bringing these two things together, she was able to play a prominent part, using her knowledge throughout the care delivery. She found this advantageous as the emergency team treated her as an equal rather than the 'new nurse', which she felt enabled her to positively use her skills. She also felt that her uniform allowed her to merge with other team members, enabling her to use her knowledge, experience and the resources around her to achieve a successful clinical experience. This event played a significant part in building her self-confidence, realising that she could manage her role and patient care.

110

Figure 4.7: Positive clinical experience (Dot, N4)

The Discovery phase brought agreement amongst the NRNs in that they were not trying to hide their acquisition to the profession, but their experience had shown that it had an influence on how they were viewed. They wanted to be treated as a legitimate team member.

Preceptorship was found to be advantageous with regards to sharing knowledge and experience. However, both participant groups acknowledged that professional responsibility required the learning to continue beyond the clinical environment (Design). The collective group Dream was to achieve a position where *'we pride ourselves in that we are forward thinkers creating a culture of on-going learning'*. The participants valued a culture which is open to learning, where they could use the collective knowledge and integrate it into the philosophy of the transition process. This played a prominent part in the Design phase, with the collective group wanting an interactive education programme which accommodated: e-learning, work based learning, project working, clinical supervision, mandatory training, and a network for the NRN. This Design aimed to provide a number of avenues for the NRN to access information, allowing them to build safe learning networks beyond the team.

111

Theme findings

Support can be seen as providing a safe environment for the NRN, one in which they feel valued as an active part of a trusting team. A team that embraces the knowledge and skills of the NRN whilst creating a facilitative and shared environment provides a professional chain of readily available advice and backup. This level of support was seen by the collective group as a strong foundation for progressing knowledge and understanding within the practice arena and in achieving the Dream of '*exemplary care'*. Three important factors emerged throughout this core theme:

1. the NRN wants to feel that the team is not only there for them, but that they **want** to be there for them, making the support process authentic

2. that the NRN role is valued within the team bringing confidence to their ability to safely perform their role

3. that support is a collaborative and collective process which achieves the best outcome for staff and patient a like

These factors are underpinned by the understanding that the transition of a NRN into a team is a potentially disruptive episode for all team members.

4.5 Strategic environment

Figure 4.8 Initial themes to Strategic environment

Strategic environment represented the idea of the organisation's engagement with supporting NRN to embed themselves within the workforce and the availability of resources to make the transition more distinctive and applicable to their needs. These domains generated much debate and discussion during the Dream and Design phases as evidenced below. Participants were beginning to work outside their sphere of influence as they realised how the whole organisational system affected the transition and their role within it:

> *'It's about changing the whole culture of the organisation here. So it's changing everything, it's not just about you, it's the whole thing.'* (Marcia, M7)

This raised interesting debates and challenged values and knowledge within the participant group. At times, this realisation sent the group into decline, particularly the senior nurse managers. The atmosphere of the mini-summit moved from a state of excitement, where development and innovation were flourishing, to an impasse where they became overwhelmed by the complexity of influencing and implementing practice change. Although this shifted the group dynamics temporarily, the

113

atmosphere of trust already established within the group soon enabled them to progress again. This altered the direction of the event and shifted the group dynamics by using energy produced through the mini-summit to influence progression:

> *'But if we don't progress with all these things and we stick with the inertia of always using lack of staff as an excuse for moving forward then the whole of the NHS would be in the same way. There comes a point that you have to say actually regardless of where we are we need to go forward with this because if we don't we're going to end up in an organisation that...'* (additional voices takeover) (Lucy, M6).

It was at this stage the group began to move forward with a renewed energy to achieve:

> *'a wonderful organisation that they can be proud of'.*

Organisational engagement: This sub-theme highlighted a number of significant factors which were dependent on the organisational engagement and commitment in order to realise the group's ideas. Participants from both groups began to understand the influence that the organisational culture had on how ideas were adopted and embedded into its working philosophy.

The mini-summit enabled group members to understand the mutual needs of the transition programme and that the present model was not fulfilling these:

> *'None of us have ever asked what people think of this document* (transition programme). *We've just automatically used it. It's only this afternoon that we realised that we actually don't like it'* (Nadia, M8).

The document in use was a workbook with competencies for the NRN to achieve and had been developed by one department. Senior nurse

114

managers realised that they had just accepted the current transition programme, having not considered or questioned its content. However, they now realised that it did not fulfil the needs of the NRN or those of the established workforce nor did it fulfil practice needs. All the participants were able to see the beneficial factors for all the associated members if the group's ideas were implemented:

'If you were thinking about a short-term, medium term and long-term, I mean the short-term win that you could have is getting new members of staff together and say, you know what would have been really useful for you knowing, coming to a new organisation? What would you think that the website should look like? What would you like to see in your preceptorship pack? And then from the preceptors' point of view, you know from the preceptor, what would help the new person come in and then from the managers' perspective, what would help you. So you know you've got a lot of people who are... who've got a lot of views and then see what you want it to look like. Because I'm sure there's lots of preceptor packs out there that are fabulous, that work really well'.
(Gina, M1)

Gina was endorsing a collaborative approach, which introduced wider organisational participation into the local needs for the transition programme. Pine and Tart (2007) suggest that this opens up the opportunity for the organisation to create a bespoke support model. Participants explored the local needs and practicalities of the transition process:

'It's making sure that when they arrive on the island that they know where they're going, they've somewhere to stay, they've got away from the airport'. (Janet, M4)

This illustrates awareness that moving to the island was a significant event which could add additional stress to the transition process and therefore needs to be factored into the programme of support:

'it was a very bad time for me because we actually moved, moved countries, moved house very quickly and I think actually I was very low in mood, because to move the family as well, was a nightmare, and you know what a house move is like…' (Fay, N6)

Fay's story was representative of the participating NRNs and highlights the personal and professional transition which took place over a short time period. This is representative of the vulnerability identified through Meleis *et al's*. (2000) transition theory. Ada's (N1) picture portrays the highs and lows of her own unique transition. She worked hard in order to achieve her qualification and then she was unable to secure a UK job, which required her to apply elsewhere, resulting in physically having to move countries. The period between becoming a registered nurse and having a job offer left Ada emotionally exhausted even before starting her new role.
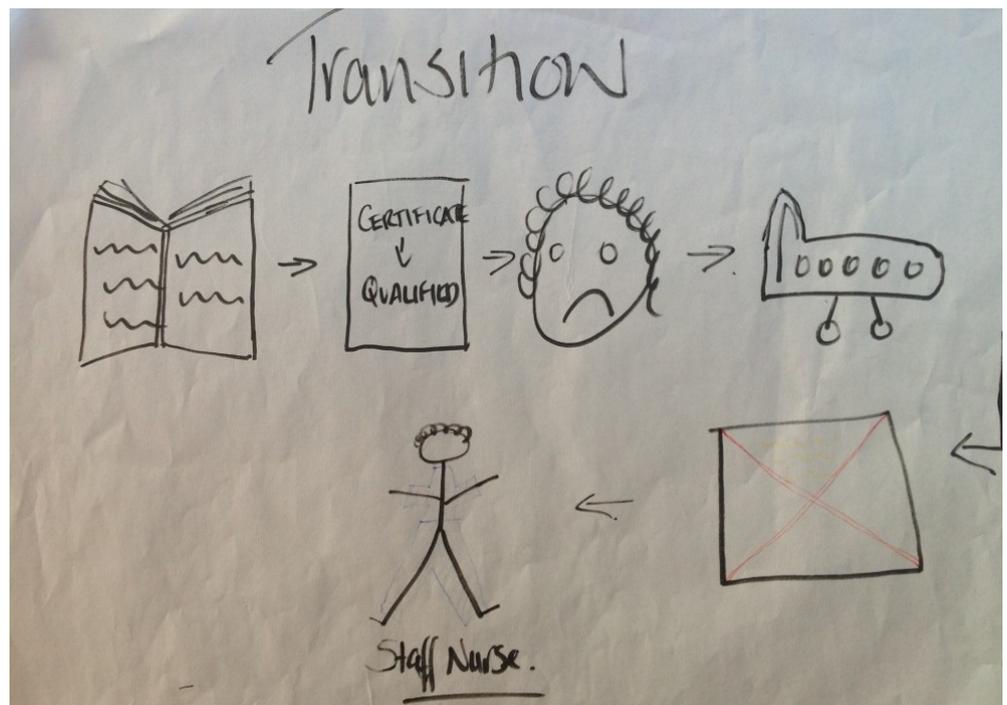
Figure 4.9: From student nurse to commencing staff nurse role (Ada, N1)

The work and stress involved in finding a new job meant that the NRN participants had not always had time to professionally or emotionally prepare themselves for their new role. They acknowledged that they would have benefitted from having time to prepare:

'I just didn't have time to prepare, it was very much of a, right let's go…. hoping that there would be all these plans in place, but it wasn't really on the ward.' (Fay, N6)

The NRNs expected the ward to be prepared for their arrival:

'making people feel part of the team, organised for their arrival, that they were accommodated individually to the ward and that they were socially prepared for arrival to the island.' (Elsie, N5)

Considering these factors, Isobel (M3) suggested that the support process should be a *'high organisational priority'* which had a *'business case behind it'* (Hilda M2). The group saw a need for a strategic plan, as they wanted the transition of NRNs to be firmly embedded in the organisational culture and also, in order to achieve this, to be resourced effectively. Lucy (M6) believed that the strategic plan should be led by:

'a committee made up of patients, the public, doctors, a multi-disciplinary group including patients'.

As the mini-summit developed, so did the appreciation that the introduction of a new professional to the organisation was a significant event. It would need a variety of people and departments (particularly education) to be involved in the planning for the arrival of an NRN. Fay (N6) felt that it was a whole system responsibility; not just that of the ward:

'The place you are working at in the whole hospital has the responsibility beyond the mentor and beyond the ward; they should take a key interest…. The little things, the welcome should be done well as it can be 3-4 months later and you just feel like an afterthought. Things that you are missing that you don't even realise you are missing until you hit certain situations.'

The lack of organisational responsibility clearly had an effect on Fay, not only making her feel that they were not interested, or did not see her

transition as a priority but also that she was not being equipped with information which was relevant to her job. Part of this responsibility was about giving time to the transition process:

> '… to have someone who could be your mentor and actually have time for you, that would be lovely, rather than you are an afterthought all the time and having to do all your paperwork externally, in your own time, in people's houses, to actually see that this educational transition needs to happen and it should be allocated the right time and not your own time, because it sort of feels like, because if you have been told that your mentor on any of your paperwork, oh they haven't got time to do it, you just think, it makes it feel unimportant where it is really important to do.' (Fay, N6)

Nadia (M7) reflects the importance of accommodating time and space for the preceptorship process in her drawing, making it part of the daily shift activity.

Figure 4.10: Time and space for preceptorship process (Nadia, M7)

Transition resources: This sub-theme addressed two distinct areas: achieving the right skill mix of qualified nurses, and ensuring value for money. A recurring pattern from both participant groups during the Discovery phase was the relevance of *'joining an established team'* (Discovery through to Design), and *'an effective working team with an exceptional skill mix of qualified nurses'* (Lucy M6). NRNs connected good examples of ward based support to where there had been a good staff skill mix and a well-established ward team. Scott *et al.'s* (2008), Parker *et al.* (2012) and Kramer *et al's.* (2013a) *studies each* associated a supportive, friendly environment and a well-established team with retention, job satisfaction and facilitative support.

The need for resources and '*significant investment*' into the support processes discussed throughout the mini-summit emerged during the Dream and Design phases. The collective group viewed the transition process as being in the interest of the organisation to make it a priority. Considering the expense of the NRN recruitment and the cost of staff shortages, it appeared highly appropriate to invest in retention methods:

> *'if you're looking at how much you've already spent on the new employee, you're already putting a resource out there so the resource is there, so it's just making sure you get value for money with that.'* (Janet, M4)

To create the best support process for the NRN, the group created a Dream that involved having a blog. It was thought that this would encourage debate and provide a discussion forum which enabled the opportunity for NRNs to share experiences and engage with like-minded peers:

> *'I would like to have better contact with other nurses in the same situation that I can talk to and say how you are feeling? A wall. Like they're doing for any other educational area.'* (Dot, N4)'

This idea initially caused concern among the managers, as they had concerns about professionalism, confidentiality, and organisational

interpretation. However, after group debate it was appreciated that the blog did not have to be used negatively but could facilitate a supportive forum where NRNs could interact and share experiences safely with peers in similar situations:

> '*That's having an open organisation where if you are on a blog and you have a criticism that you're not going to be punished if you're highlighting a criticism. But I think you can be critical without being... if you're not going to be criticising patients you want to be... not even practices, but you're going to be maybe criticising certain aspects or how you can improve, that's not even about criticising it's about let's find out how we're going to change this, this is not working. Personal interaction.*' (Marcia, M7)

The blog was also seen as a vehicle for gaining information and knowledge:

> '*Where would I get this information, have you come across... such and such a better course and then you would maybe say yeah, I spoke to so and so, why don't you try that. That's what I mean about we're all clear. It's a network.*' (Dot, N4)

The blog resource was identified as a support process which would always be accessible:

> '*And it's 24 hours, seven days a week, whereas you have to wait for this education centre to open'.* (Elsie, N5)

It was thought that the blog would also complement the preceptor role and enable the NRN to seek support and guidance independently.

The managers highlighted the additional responsibility that the preceptor had and thought that *'the preceptor should be rewarded'*:

*'It's also a heck of a responsibility for the nurses on the ward mentoring/preceptoring because it is not just like, "I have got a tag along", there is so much you have got to look after…..
If you have got someone who is struggling, it is really hard work on the preceptors as well and we have now brought so many new starters, PQ's and students that it's all the time, perhaps a bit of a shift, they put someone with them so it's really hard work, it's quite exhausting at times I think.'* (Pippa, M9)

Theme findings

The participants view was that support programmes for the NRN should be an organisational priority. This was due, in part, to the influence they had on workforce planning but also the need for representation and active involvement in the preparation and implementation of the programmes. The addition of the NRN to the professional nursing team was viewed as an important process which should have value attached to it. Four points emerged throughout this theme:

1. The preceptorship programme was seen as a potentially supportive process, however; in its present form it did not reflect the needs of the NRN or the ward team. A collaborative approach was needed to design and inform its content.

2. NRNs viewed support as available beyond their immediate environment, welcoming the opportunity to share experiences, advice and questions with peers who were in a similar position.

3. Allocated time is a vital component of support which needs to be factored into the daily activity of the ward.

4. Resource investment was needed for the preceptor and NRN to access peer support beyond the immediate clinical environment. This would provide the opportunity for the individual to take responsibility for accessing specific support for their personal professional needs. The Dream phase identified blogs, online forums, clinical supervision, and

learning opportunities and well managed organisational inductions to achieve this.

4.6 Learning environment
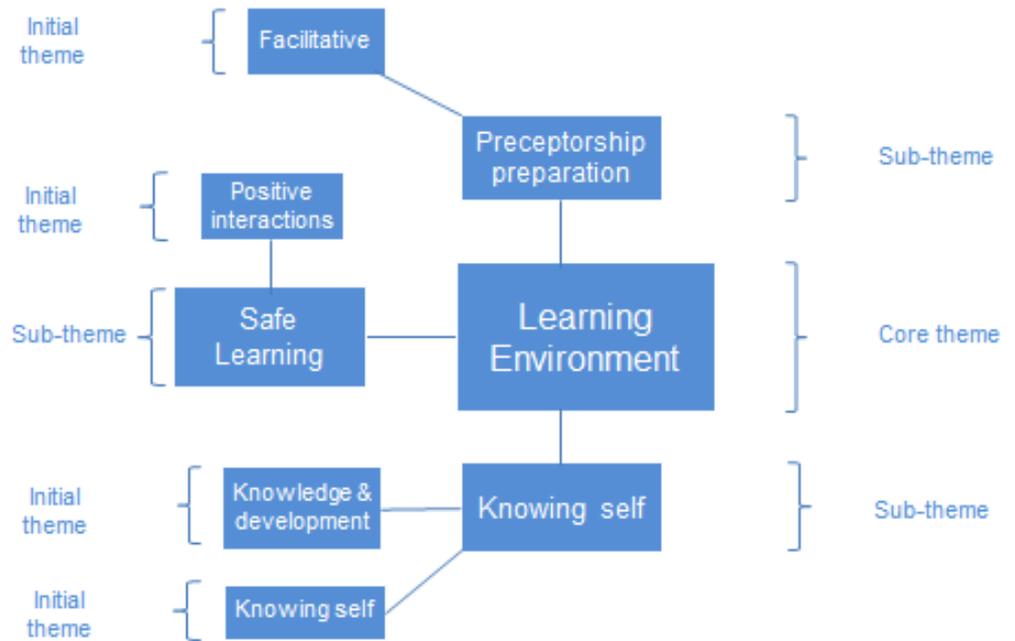
Figure 4.11 Initial themes to Learning environment

This core theme emerged from three sub-themes, *Preceptor preparation, safe learning* and *knowing self*. Each of these themes supported an environment that enabled a culture of learning which enabled individual and team development. Data throughout the 4D phases highlighted how a shared approach to learning facilitated knowledge, safety and responsibility encouraging a tripartite commitment between practice, team members and the NRN. The following extracts share participants' conversations throughout the four phases on the support processes.

Preceptor preparation: The challenge of supporting the NRN through their transition was apparent throughout the mini-summit with many participants reflecting back to their own personal experience as a frame of reference. This stimulated a debate where individual values were shared,

revealing a variety of expectations and professional differences relating to the transition process. This correlated with the work of Ethridge (2007), in which the generational spread of practitioners encapsulated various layers of knowledge, which were then considered by the individual as the norm. This debate and thus the new understanding it generated enabled the group to make sense of their individual views. This both influenced and progressed the Design phase:

> *'As I said, everybody is different, every university is different, although we all get degrees or diploma's there doesn't seem to be a clear outcome, we are all over the place, people's education levels are all over the place, people's basic skills and mathematics are all over the place, English, you need that too, I say start at base level and work up and you will quickly learn whether you need to be faster or slower with that person, if you are a good mentor, you will develop very quickly.'* (Fay, N6)

Here, Fay discusses the diversity in the educational preparation delivered for nursing. She suggests that preceptors need to understand the associated university curriculum and more about the individual NRN in order to manage the preceptor role and in order support the individual. Understanding the individual's strengths and weaknesses would enable a bespoke working plan to be structured for the NRN's particular support needs. Fay suggested that with a good mentor the preceptee would be more likely to flourish:

> '*You watch other people and I suppose it's the, you learn whether you want to be like that nurse or not like that nurse, so I suppose you respect the people that are using the newest evidence, using the guidelines, using the procedures, as tight as they possibly can and not to, shall we say dust them over, procedures and policies, so those people you tend to respect, therefore you would take their advice more, and people whose advice is asked of other colleagues you tend to note.'* (Fay, N6)

Fay was recognising the vital role that the preceptor potentially has in teaching and guidance, which is influential in imparting the clinical standards and the practice expectations. This was also acknowledged through the wider group. This encouraged the managers to consider the preparation and support needed for the preceptor to manage their role:

> *'Preparing the preceptors, so it's about how do we look after those preceptors and really keep them up to date with the curriculum and interested in their role?'* (Nadia, M8)

This was consistent with Chandler's (2012) study which highlighted the crucial need to prepare the preceptor, equipping them with learning and teaching strategies, and securing discussion time with fellow preceptors and educators. These teaching strategies could be used to inform as well as to maximise on the learning opportunities available, in line with the preceptee's needs, identifying the right support for the individual:

> *'The supernumerary role is good, it does help but sometimes, supernumerary can also be quite boring, sometimes you are just following someone around and you never get a feeling of it, it's like someone carrying a weight around, it isn't until you pick the weight up that you know what it feels like.'* (Fay, N6)

Balancing the supervision with the opportunity to practice takes the NRN from detached observer to involved performer (Benner 1984) allowing them to move forward in their new role. The development of a preceptor support group was identified in the Dream and Design phases as an important forum to keep the preceptor enthused and up to date. The forum would enable preceptors to share good practice, maximising on the potential of the preceptee working with them.

Safe learning: Feeling professionally and personally safe during their practice learning was fundamental to achieving support for the NRN. The NRNs felt that they could learn safely from '*an experienced staff member*' that made '*time to make sense of incidents, and acute situations*'

(Discovery). The managers recognised the value of *'open discussions which were honest and thoughtful'*. Both groups discussed the benefits of reflective and constructive feedback, giving time to the activity of understanding and developing their practice. The managers suggested that this process could be strengthened with '*preparation, organisation and anticipation incorporated into the socialisation'*, viewing it as a potentially structured activity rather than purely reactive to the event.

Both participant groups portrayed break out space in their drawings allowing time for discussion and knowledge exchange away from the clinical activity. The managers further amplified the point of *'taking time, protecting time and space'* in their key findings (Discovery). Hilda's (M2) picture is an example of this, clearly dividing her drawing into two parts. She gives equal space/value to 1:1 practice supervision and to the discussion time away from the clinical area.

Figure 4.12: Making sense of practice situations (Hilda, M2)

Conversation was seen as an important element when achieving support:

> *'Some people need to have the conversation for a light bulb*
> *to go off in their head and go, oh yeah, but they knew it all*
> *the time, they just needed the conversation'* (Hilda, M2)

Consistent with Dyess and Sherman's (2009) study, the group found that the benefits of shared discussion could '*enable the registered nurse to move forward in their professional practice*' (key learning). This developed into the Dream of having peer forums and clinical supervision where safe dialogue could happen with others. The supervision was seen as potentially developing the learning and practice understanding. This idea was developed by Dot (N4), who wanted to be able to access this kind of support at any time and so suggested an online forum:

> *'I just want time to go on a website which is interactive, you know what's going on, you go and find the information'*

> *'you can ask questions, talk to each other, forums'* (Cassie, N3)

The group realised that support could be available in a variety of formats and could be accessed beyond the clinical setting. This led to the Dream of creating a blended approach to the availability of support. This would enable the NRN to learn and share in the safety of their peer group but also have access to the learning opportunities both within their practice teams and through education resources.

Knowing self was found to be a relevant skill when identifying the type of support needed to work through the transition process. Having personal and professional insight into their support needs gave the individual a clear understanding of who they were and what support needs they had which needed to be met. Both participant groups identified the importance of having a clear understanding of self and being able to connect this information to the opportunities around them in order to manage and enhance their individual learning.

The NRNs used words such as *'determination, commitment, loyalty, insight and reflection*'; identifying the personal characteristics that they had used to support their progression. The NRNs appreciated their own responsibility within the transition process and felt there was a '…*need for*

self-awareness' (Discovery key learning). Ada (N1) viewed her *'strength of character, development, social skills' a*s attributes that had supported her through her own transition. Kelly and Ahern (2009), Caballero *et al.* (2011) and Thrysoe *et al* (2012) would concur, viewing these skills as social intelligence and characteristics of work readiness. Ada recognised the role that her own character and social skills played in interpreting the interpersonal dynamics around her and aligning her professional knowledge with her environment. The experiences had not always been easy, with the majority of the NRN participants reflecting on the difficulties of being welcomed into the team:

> *'in the beginning my confidence got battered to a negative degree and it is now climbing again and now I am voicing my opinions more, I am finding that I am quite a strong character and I am coming back to being me again, I haven't been me for a long while, because you keep your head down, you keep quiet, you try not to ask the daftest questions, you stay safe and it takes you twice as long, then tough, they won't know, but you stay safe'.* (Fay, N6)

This text reflects the potential vulnerability of the NRN (Meleis *et al.*, 2000) during this stage of their career when there are a number of changes happening around them. The fear of looking foolish was a consistent concern which reduced their self-belief further. However, it was acknowledged that some individuals thrived on the challenge of a new environment:

> *'I love going somewhere new and having to just go, "oh my god, sort it out!" as to other people, that's dangerous, they have found they just can't do that, so it's also that person who is moving to and the way that they need to be supported, you know which can be very different for different people. That people have to take some responsibility for knowing themselves and knowing how best they work, because you know if I look at some of the new staff I have got at the moment and some people need lots of spoon feeding and they will do well and other people can hit the*

floor running and we just need to keep an eye. I have some people within two weeks of supernumerary practice, by the end of week one they were like, "you know this is ridiculous I don't want to be taught, I want to do it" so it's very much about the mentor and them working together and being open and honest and adult about it but then that person also has to take responsibility for how they are coping.' (Pippa, M9)

Here Pippa highlights the variance in the individual needs, which require different support approaches. Identifying these needs was seen, in part, to be a responsibility of the 'new staff' member as they had greater understanding of how they work. If they were able to consider what they required to achieve their role, this would help the ward team understand how they could best support them. Pippa mentions the need for an open and honest relationship to ensure that all are aware of the needs. However, Fay (N6) identified a more discreet approach, demonstrating the complexity in securing the *'honest relationships'* (Discovery) which Pippa (M9) recommends as being required within the team to achieve a collective understanding of the individual needs. Lave and Wenger (1991) would relate this to the NRN's feeling of legitimacy within the community and needing to learn more about it before this trust can be achieved. Although there was participant agreement that *'knowing self and sharing this information'* was fundamental in getting the right support for the individual, it is evident that this is less straight forward in practice.

The evolution of the mini-summit resulted in both groups appreciating their responsibility in getting the support process right for the individual and fellow team members.

'*For me, if I just had an hour a week to go and say... at the end of a working week, I'm going on the preceptee network, or I'm going to reflect on what I've done this week, what am I missing, what have I still to do, who can I contact, that's it and then I can have a chat with the ward sister, I've been on the preceptee programme, I'm aware that I'm missing this particular skill, could you support me or could you let the staff nurses know that. I haven't passed an NG (Naso*

> gastric*) tube before; if there's any coming on the ward could you give me a shout. These are just simple basic things. I don't want a big fancy, all singing, dancing...'* (Dot, N4)

Dot wanted the opportunity to take charge of her learning by reflecting on her progress, and identifying her future needs.

> *'But that's someone that takes ownership of their practice which you do. But that is a good way of providing ownership.'* (Hilda, M2)

This escalated the debate about practitioners taking ownership for personal learning needs and articulating them appropriately within the team and also encouraged the NRN to manage this aspect of their development and support needs.

Theme findings

The participants viewed support as providing a learning environment which was receptive to the individual learning needs and able to facilitate a safe and an inquiring culture. The diversity in the workforce raised important differences in team members which highlighted the influence, positive and negative, that the established and new members had when interacting with one another. This further amplified the importance of the preceptor role and the ward manager function in achieving an inclusive learning environment. Four important factors emerged throughout this theme:

The provision of time and space was found to be a vital and supportive tool.

1. Support was achieved in and beyond the clinical area, with participants wanting an *interactive and blended programme approach* (design), where peer and supervised conversations helped in making sense of transition experiences.

2. Preceptors were an influential support tool for facilitating professional growth and sharing the role parameters/expectations.

3. Preceptors required curriculum knowledge, role-preparation and shared dialogue.

4.7 Emotional environment
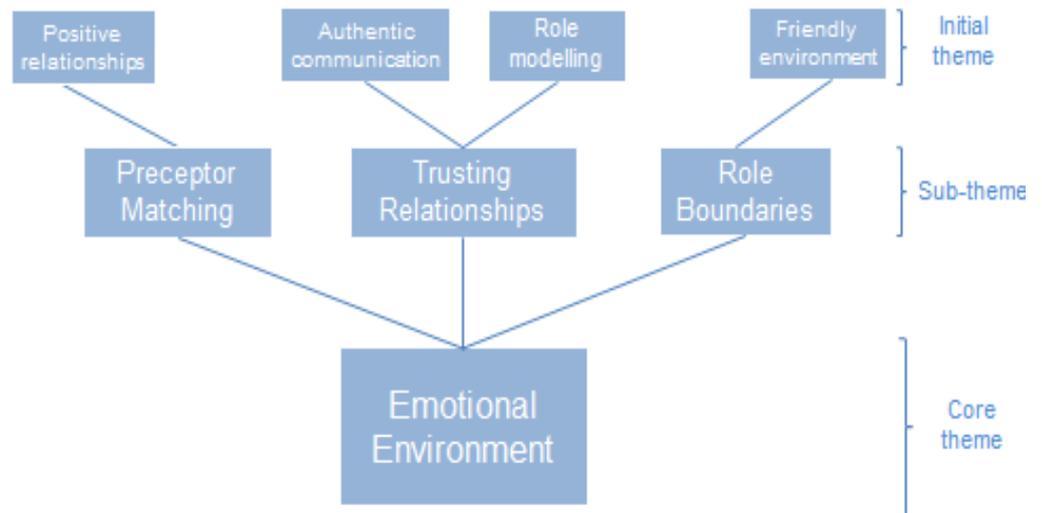
Figure 4.13 Initial themes to Emotional environment

Emotional environment comprises three sub-themes: *preceptor matching, forming relationships* and *role boundaries*. The emotional environment and the team members within it were considered a fundamental aspect of the provision of support for the NRN. This was influenced by both the individual introduction and the clarity given to the parameters of the person's role. The stories that came from the Discovery phase demonstrated the relevance of '*a strong preceptor relationship and a good working team*'. The senior nurse managers expressed the need for *'Manager input, not just from the preceptors'* (Discovery) as being an important element of this process. Pippa (M9) shares a story when she joined a non-nursing team which include these developed theme:

> *'they didn't know anything about clinic practice, medicine, etc. so there was no one in that team to turn to for advice and I didn't know anyone so I wouldn't of known who to have gone to, to say I'm struggling or whatever'.*

As an experienced practitioner, Pippa (M9) was unclear about the support network and the boundaries of her work which limited her ability to perform her role.

Preceptor matching:

The preceptor/mentorship role was identified throughout the Discovery phase as a significant aspect of the support process. This progressed to discussion about how careful consideration needed to be given to how the preceptor was identified and matched to the NRN:

> *'every person is going to need supporting in a different way'*
> (Pippa, M9)

> *'I think you have got to see what type of person you are mentoring, see how they learn, are they visual, do they need to go home and read it, do you need to set them a little piece of homework so they can actually go home and read it and then speak back to you what the procedure is that you are doing tomorrow, and time, it really needs to be put into the new qualified.'* (Fay, N6)

The individual not only has different needs, but different ways of learning and working. Time is identified as fundamental in achieving the support. However, it was apparent that generational differences also influenced the support process, which was consistent with the work by Buerhaus *et al.* (2006) with NRNs identifying the benefits of a preceptor who had a similar personal/professional background as them:

> *'Empathy, somebody who remembers their student days and knows what it's like, somebody maybe similar like myself, who is married with children, maybe a mentor who is married with children who can understand, maybe somebody who is sixty five and near retirement, maybe who doesn't understand an eighteen year old newly qualified, maybe similar in age, similar interests, that might help'* (Fay, N6)

131

Fay (N6) identified well with her mentor and found that their shared experiences enabled confidence to develop in their preceptor/preceptee relationship. This was discussed further in the 'important stories' from both participant groups: *'aligning the mentor to the newly registered nurse and constantly reviewing the processes'* (managers), and making sure that *'the right people are involved and given the time'* (NRNs):

> *'picking the right type of mentors, people who do mentorship courses are not always the right people to do it, a lot of people don't want to do it, because they just see it as added work load for them, I do think you have got to find the correct person for a mentor, and we have all had bad mentors and good mentors and if this person is going to be good mentor then you need to support them, by giving them time off to take the newly qualified.'* (Cassie, N3)

Information from the NRN's interview and follow up conversations were suggested as ways to support the process of matching the right preceptor to the individual.

> *'I think it's individualised for that individual person, make them look at the right preceptor, you know and you've had the time. Get to know these people, so they've come in front. You did interview them.'* (Isobel, M3).

As the Dream phase developed, the senior nurse managers considered the prospect of contacting the NRN post-interview. This would provide the opportunity for the NRN to consider and articulate their support needs, allowing the manager to use the information to match them to an appropriate preceptor. This idea evolved further in the Design phase, where the managers realised that this process was the initial framework for a learning contract which could be developed between the manager, preceptor and NRN, forming a tripartite agreement to support the transition process.

Role boundaries:

The NRN wanted *'control over their role',* believing that this would enable them to put their new skills into practice. To achieve this they spoke of the need to understand the parameters of their role. They wanted to know and to understand the expectations of the work environment and of their role within it. A similar dialogue came from the senior nurse managers who wanted *'to understand the expectations and the ability of the newly registered nurse'* (Discovery). Having this information would enable them to have a good understanding of the NRN's ability and their potential support needs. This mutual understanding is a crucial foundation to forming this team relationship.

Pippa (M9) encapsulates the difficulties when this was not forthcoming during a senior transition:

> *'I didn't know what to do and I felt like a complete failure because I had set up education packages but there was no support, no one to tell me what to do and I just for the first few months was just foundering around with no guidance. I needed guidance to what kind of things that were expected of me and I didn't have a clue, I had no boundaries, I had no, really no expectations of what was expected of me and actually my boss was really, really nice, "lovely, let's go have lunch, let's do this", but he was actually too nice because he didn't set me any goals, or boundaries or anything, it was really, really unhelpful.'*

A *'positive environment'* was not solely about kindness and compassion but about being clear about the role expectations, bringing reassurance and direction to the transition. This was demonstrated as Pippa's story developed into a positive transition experience:

> *'I had lots of other grade 6s, you see I was lucky I knew people and I knew people that I felt would be good for me, good to work with, my manager was brilliant but then, I can work well with him he is very hard, facts, figures, and stuff like that, so that was good for me'.*

133

This time Pippa had understood the environment she was in, the useful networks around her and she related well to her mentor/manager. In addition, she knew how she worked and therefore how she needed to perform her role. These factors enabled her to quickly transition into her new role.

Trusting relationships: The importance of working relationships and their significance to the support process became evident in the Define and Discovery phases. How the team members interrelated with each other and with the NRN *'helped people feel valued, and in understanding who they are'* (Discovery). This collective group statement identified the importance for both participant groups to feel part of a team where *'respect, listening, sharing knowledge and experience'* and *'the importance of trusting/encouraging relationships'* was recognised. The participants agreed that a key element' in achieving support was being in *'a rounded team with a shared philosophy'.* This concept continued to evolve in the Dream phase, wanting *'to engage the newly registered nurse within the workplace and the organisation with all staff members active/involved throughout the process'.*

There was group agreement that forming relationships was a crucial factor in accessing support:

> *'I think that staying in the same place for a while does help…*
> *you will build a relationship with the team'.* (Hilda, M2)

This was supported by the NRN view:

> *'Obviously it's nicer if you know the people as well, and you*
> *have worked with them before because everybody takes on*
> *their own role in that situation and everybody knows their*
> *own role.'* (Fay, N6)

Fay highlighted that each team have their own ways of working and that when familiar with the styles and values, it becomes easier to understand the team members and to then build relationships. This was consistent with

the research undertaken by King *et al*. (2005), Maben *et al.* (2007) and Randall Andrews (2013) in which language, behaviour and values all impacted on the transition process:

> *'people on the ward will know you, you know them, you know who you can speak to for advice on certain things more than others, someone can give you bad advice and others good'.*
> (Cassie, N3)

Cassie was aware of the relationships which could support her needs; Merton *et al's.* (1957) work credits the NRN in having this ability to be selective with regards to the values and attitudes around them. The NRNs understood this and identified the need for time to understand the team ethos, wanting to work with all members to be able to confidently connect with *'shared values'.* The importance of understanding ward rules and organisational values is also reported by Feng and Tsai (2012).

Theme findings

Support could be achieved through the provision of clear role parameters as well as the internal and external networks available to the NRN. Three important factors emerged through this core theme:

1. The senior nurse manager was identified as fundamental in planning the transition to maximise on the skills and resources available in and beyond the team.

2. Support was getting the right preceptor for the NRN. The ward manager was seen to have the knowledge of their team and thus the ability to match the preceptor to the NRN.

3. Support could be achieved through a tripartite relationship between the manager, preceptor and NRN creating a learning contract for the NRN to follow.

4.8 Summary of the findings

This chapter presented the four core themes emerging from the analysis of the mini-summit data. The concept of support was seen as multifaceted and multi-layered by study participants. The NRN was actively shifting from a student-mentor relationship to team member, wanting support in the form of guidance and constructive feedback to practice their knowledge and skills. The NRN identified their acceptance within the professional team as a vital part of the support process, finding that it gave them the sense of contributing to the needs of the clinical area and achieving their own professional goals. The data demonstrated that they wanted to be respected within the team and of value to it. The NRN participants saw the ward manager as fundamental in leading the support process, due to their comprehensive knowledge of the team attributes, which enabled them to match relevant learning opportunities as well as the preceptor to the preceptee.

Although the manager and the NRN shared similar values at the start of the mini-summit, it was only as the event developed that it became apparent that the manager had not considered the transition as such a powerful workforce issue. Initially, the manager saw support as a relatively conventional nurturing role which took place within the immediate clinical area. As the mini-summit progressed, the managers realised the significance of meeting the support needs for the individual NRN and realised the implications for the wider organisation. Their responsibility for ensuring that it happened successfully became more evident. There was a realisation that this was not a functional process which involved the acquisition of skills, but a developmental activity influenced by all team members and affected both the collective productivity and the patient care. Key factors that then emerged from the findings, for the manager, were the preparatory and support needs of the preceptor and NRN and how this needed to start directly after the recruitment process. The role of the preceptor was recognised as vital in the support process; in sharing the strategic plan, team expectations and in modelling good practice. Support was not a purely generic task, but required some bespoke planning and facilitation.

Both groups were in agreement that support was a shared and collaborative process, which needed to be delivered through trusting relationships, both within the clinical team and the greater organisation. Space and ward time were needed to provide an opportunity for discussion which would allow reflection helping make sense of practice experiences. This activity was an important element in achieving support. The four core themes demonstrated the importance of the team in the support process which could: provide safety; knowledge; value; and bring confidence to the NRNs ability to perform. The effective delivery of support was found to be beneficial to: the organisation by improving staff retention rates; the clinical team by stabilising the workforce and enhancing the skill set; the individual by facilitating development and learning; with the overall outcome of providing good and safe patient care. Therefore when effectively managed, it not only adds value to the NRN, but brings wider rewards. These findings and their implications for policy practice and research will be discussed in the following chapter.

Chapter 5: Discussion of the findings

In this chapter I will present a synthesis of the key findings which have emerged from the study. I begin by discussing the originality of the findings which will be appraised in relation to the literature and theory discussed in chapter two. This will be used to further highlight the distinctive contribution of my work in respect to debates surrounding the support for NRNs during the transition process.

The purpose of this research study was to understand:

- What constitutes *support* in meeting the needs of neophyte registered nurses and the healthcare organisation during the transition period?

- What factors are perceived by the neophyte registered nurse and the senior nurse manager of most value in achieving an effective transition into the professional workforce?

- What can we learn from professionals' experience of support to guide education policy and practice for neophyte registered nurses and senior nurse managers in relation to transition and in aligning new staff into healthcare organisations?

This chapter explores how the research objectives have been met and discusses the key findings from the study. The originality of this work comes in three dimensions:

- Application of Appreciative Inquiry to the field of workforce development during the transition process for NRNs, and healthcare organisations.

- The data themes generated have created a new understanding to the way in which the organisation, senior nurse manager and NRN can work together during the transition process.

- The development of a conceptual model to enhance understanding of influential processes associated with the transition of NRNs.

Each of these will now be explored:

5.1 Application of AI

The findings of this study both support (Kramer *et al*., 2013a; Randall Andrews, 2013) and challenge (Horsburgh and Ross, 2013) and illustrates the ultimate goal participants have of achieving the key findings. This research contributes to the body of knowledge through the unique approach that AI brings to this study phenomenon. Previous work in this area has not examined this subject through an AI lens; indeed, existing studies have centred on addressing the challenges that the transition can create (Kramer 1974; Benner, 1984; Casey *et al*., 2004; Morrow, 2009; Duchscher, 2012; Thrysoe *et al.,* 2012 Kramer *et al.,* 2013a;). Although related research up until now has adopted a range of study designs, they have been confined to the difficulties which surround the transition and support processes.

This thesis explored the inquiry from the perspective that organisations are socially constructed (Cooperrider *et al.,* 2003; Haslebo and Haslebo, 2012). Moreover, AI aims to embed a collective model of engagement to identify and progress the best of what is happening within an organisation. This encourages people to construct their desires of what should be, based on their organisational experience of what can be (Cooperrider and Srivastva, 1987; Zandee and Cooperrider, 2008). It is this element which differentiates AI from other more traditional qualitative designs (Bushe, 2011). However, this requires:

> *'…the researcher to wholeheartedly engage with the complex, messy and emergent nature of organizational and societal life. It asks…for an intuitive approach to inquiry rather than a mechanical use of available techniques'* (Zandee and Cooperrider, 2008; p. 191).

139

A crucial aspect of the AI process is its aim to get as much of the organisational system involved and working together as possible (Whitney and Trosten-Bloom, 2003). This collaborative and progressive approach to the inquiry was in part the appeal that the AI methodology had and aligns with my personal philosophy (chapter one). AI engenders a sense of progress, bringing empowerment and renewed energy to the research participants. In my research, the group wanted ownership and they were enthused by the mini-summit process which allowed them to explore a new way of thinking. The affirmative approach instilled through the methodology was appropriate as the inquiry was taking place in a small community of practitioners. This served to overcome contentious and negative story telling which could incite ill feeling between the participant groups and the wider community.

Creating an environment which fostered trust and cooperation was fundamental to achieve the open discussion required (Ulrich *et al*., 2010; Blomqvist, 2014). This is essential for both the AI process and for the researcher. Creating good relationships within the participant group enables difficulties to be resolved through dialogue and mutual understanding (Etherington 2007). An example of this was apparent during the Dream and Design phase, when Dot (N4) and Nadia (M8) entered into frank debate about professionalism and confidentiality in practice. Both freely articulated their view, respectful of the other and apparently uninhibited by the hierarchy imbalance within their relationship. The AI research tool puts particular demands on a facilitator who must work throughout the process to maintain an affirmative approach.

The ideology underpinning the data collection process within AI enables an approach which considers the NRN and the healthcare organisation collectively. There has been a tendency to consider the transition process from the NRN perspective without the voice and the experience of other important stake-holders (Ferguson and Day, 2007; Price, 2009; Kostovich and Thurn, 2013; Phillips *et al.,* 2013). The inclusion of participants in this study enabled them the opportunity to scrutinise their understanding and experience of support, moving the subject to a new level of understanding. The setting of the forum facilitated time for two distinct perspectives to be

heard, and working together in co-constructing meaning around successful transition stories was pivotal to inform future action.

The mini-summit provided an opportunity for both groups to enter new areas and explore a range of wider issues linked to the opportunities available to the transition process. The openness of the dialogue enabled shared appreciation of the responsibilities associated for both organisation and individuals. This depth of understanding evolved gradually through the 4D process revealing the principles of AI, as Table 5.1 exemplifies:

The principles of AI	Demonstrated through the data collection and findings
Constructionist	The participants appreciated the concept of support and its influence on the individual, the team, the organisation and the patient whilst being grounded in their knowledge and understanding of how they could effect this.
Change	The participants embraced the opportunity of contributing recommendations for new ways of managing the support process for the NRN, in turn enhancing the clinical team experience.
Poetic	Through shared stories connecting and replicating the working patterns that participants were seeking, with all creating the action plan.
Anticipatory	Collaborative involvement in creating the potential future for the support process.
Positive	Positive questions achieve a shared understanding of a positive transition process inspiring the discussion to live on.

Table 5.1 The 5 principles of AI identified within the research study.

This unique collaborative process used an adaptation of Cooperrider *et al's*. (2008), 4D framework: Define, Discover, Dream and Design. As the participants moved through the phases, their group behaviour reflected the dreams that they were discussing, with examples of empathetic trusting relationships being played out. The participants were feeling respected for

their knowledge and contribution and this sense of empowerment gave them the confidence to perform.

The collaborative working style introduced the bigger organisational picture which allowed many of the elements to come together in one place where participants could make sense of the whole picture (Ludema *et al*., 2000). An example of this was when the senior nurse managers realised that the support process was greatly influenced by them and had an effect on the clinical team and the organisation. The AI process and the results that came from it supported the notion that innovation is a social process which is enriched when bringing different groups of people together (Lundvall, 1992; Orchard *et al.,* 2005). This further demonstrated the important learning resources available within the workforce itself and how it could be used to inform new ways of working.

- The findings from the mini-summit initially uncovered the similarities between the participant groups, particularly in the data of the opening exercise (Define), where the elements of inclusivity and professional relevance within the team emerged. However, this initial alignment shifted as participants moved their Discoveries and Dreams into the application of the 4D process. This challenged participants to hear and voice the information in various ways, analysing it against their own values and experiences to shape a potential future. The divide between the NRN and the senior nurse manager then became apparent. These similarities and differences revealed themselves in the following forms. The NRN was optimistic and had high expectations of what could be achieved to fulfil their support needs. Although they embraced the next stage of their professional journey, they were also anxious to perform well and to integrate into the team (Hunt, 2004; Bjerknes and Bjørk, 2012; Chandler, 2012). Therefore the transition was not an isolated process, but was dependent on a number of activities, primarily, the wealth of experience and expertise available in the registered team members. The NRN could see how they could learn and develop through working closely with these colleagues. They could also see how the ward manager was central in leading this process (Cho *et*

al., 2006; Johnson and Rea, 2009; Regan *et al.* 2009; Ulrich et al., 2010; Omansky, 2010; Parker *et al.,* 2012; Cleary *et al.,* 2013; Walker *et al.*, 2013) to maximise the learning opportunities available to them. Although the NRN participant was aware that they had a responsibility to identify and build on their skills, they also needed the team to guide them through this.

- The Define and Discovery phases confirmed that senior nurse managers and NRNs held similar values and desires regarding the importance and meaning attached to 'support'. However, as the intervention progressed into the Dream and Design, the reality of practice did not match. As discussions gained momentum, a realisation emerged that support involved more processes than were either currently being utilised or were available.

- The senior nurse manager became acutely aware of the relevance that support had to the nursing workforce and the wider organisation. Through this they were able to appreciate the complexities and multifaceted nature of support and how this affected the NRN and the clinical team.

- The NRN had not previously appreciated the complexity of the organisational culture and how this influenced the introduction of new ideas (Clearly *et al.,* 2013).

These elements are important findings which will be explored in greater depth when discussing the themes.

As the mini-summit progressed into the Design phase, the new understanding allowed participants to shape and progress their ideas (Bushe, 2011). This has been represented through figure 5.1, which illustrates how the 4D process created the structure for the data phases, using the activities to frame the dialogue. The participants initially required direction; however, as the mini-summit progressed they started to lead the process, using the group interpretations to focus the key outcomes. This correlates with the inductive nature of the qualitative data analysis, where the themes inter-connect to the data (Patton, 1990). The phases highlight

the forms of data gathered at each stage and how they were integrated throughout the analysis of the findings. The communication and the interest in the topic have continued beyond the intervention, with all participants voicing how inspired they were by both the method and the resulting action plan. This enabled a collective realisation that they shared experiences, which in turn encouraged open discussion and triggered a desire for action (Harter *et al.,* 2005).
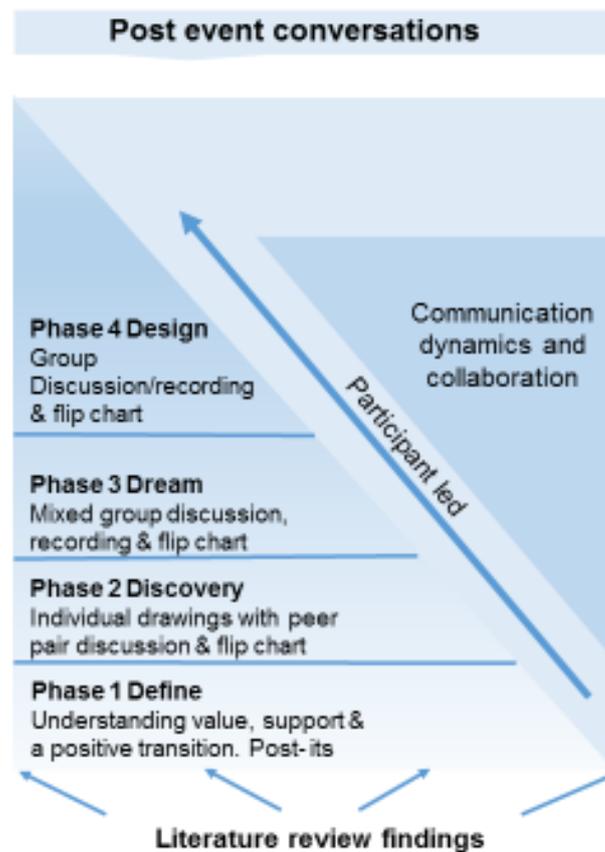
Figure 5.1 Researcher interpretation of the data collection process

AI enabled a wide variety of evaluation and was particularly successful in this story as demonstrated by the interest shown by the participants in the organisation in using participatory approaches to evaluation.

- Participants were evaluated through their commitment to group learning.
- Evaluation was demonstrated through the desire to build capacity.
- Participants by agreeing to engage in this work demonstrated a wish to be evaluated as a means for development of knowledge.

The findings from the study highlight the complex interactions that are necessary to develop knowledge and to meet the objectives of the research. The AI conversations enabled the participants to evaluate the knowledge shared, consistently validating it both during and post data collection, while action planning it and supporting it. It is through this process that Reed *et al.* (2002) suggest that evaluation is interwoven into the AI methodology in its co-construction and reflexive relationship. This was achieved as each phase progressed to action points, developing the next stage, energised by the generative process of the methodology.

Findings - four themes

The four final themes which emerged through the data analysis extend understanding of the subject of support in the context of NRNs. They introduce new insight into the influence and responsibility the process of transition has for the individual and the workplace. Traditionally, there has been a tendency for other researchers to focus their attention on the NRN alone (Walker *et al.*, 2013). This study has examined how the senior nurse manager and the NRN inter-connect with one another. The themes focus on the interest, commitment and interactions of the organisation and its membership. The present day healthcare culture aims to achieve a patient-centred approach to care, one which empowers and prioritises the individual and their needs. This study, although small, supports McCormack and McCance's, (2010) aspiration for a person-centred culture, advocating that we reflect this approach in the transition process for the NRN.

The four overarching themes, generated from the data included: *safe environment; strategic environment; learning environment* and *emotional environment* which all interrelate, revealing the diverse influences and crucial elements of an effective transition process.

5.2 Safe environment

The theme *safe environment* related to the recognition of an enabling and nurturing cultural setting which encompassed the notion of safety: to practice and grow, both as a professional and an individual, and to be able

to contribute to and play a valuable role in the team. The overarching message from participants was that the confidence to practice safely was achieved through direct experience, a finding recognised in previous studies (Ulrich *et al.*, 2010; Pfaff *et al.,* 2013). An environment which facilitated the safety to ask questions and to practice professionally with and among experienced team members was highly valued by all participants and seen to be a crucial aspect of the transition. This theme encompassed three sub themes; safety, fitting in and knowledge. Together these represented participants' desire to connect to and be accepted within the practice environment to both understand and perform safely within it.

The importance of the working environment as a significant element in the success of the transition process has been illustrated in other studies (Levett Jones and FitzGerald, 2005; Scott *et al.,* 2008; Duchscher, 2009; Feng and Tsai, 2012; Kramer *et al.,* 2013a). These studies focus on the benefits of collegial relationships and orientation processes which illustrate the importance of the NRN feeling part of and valued within the team. Less consideration, however, has been given to the effect of a new member joining the team, and in particular, that individual's need to both integrate and perform effectively. This study illustrated that this need was crucial to both participant groups. For the NRN, the change in the environment introduced different rules and increased responsibility, focusing their awareness on practicing their knowledge safely. The change in the team membership heightened the senior nurse manager's responsibility for the safety of patients, NRN and team. In bringing the two participant groups together, this study highlighted the effect of the new practitioner joining the established team and the importance of relationships and shared working.

The findings also illustrated that the working environment did not expect or anticipate the NRN being ready to practice safely. This was representative of the 'push and pull' concept described by Wenger (1998), with the NRNs clearly indicating that they wanted to be an active participant within the clinical team, accepted and of value to it. However, the team was not always receptive to this, wanting to 'test out' the NRN against their standards:

> *'I suppose that you have to prove yourself… prove you know what you are about, that you are not going to make mistakes, that they can trust you'.* (Ada N1)

Trust, safety and empathy were words which frequently occurred throughout the findings for both participant groups, making these concepts significant for the collective team in achieving an effective transition (Johnstone *et al.,* 2008). In order for this to occur, the provision of clarity and context was essential, particularly for the NRN who Benner (2004) suggests needs rules to guide their practice as they do not have the experience to inform their situation. The practice culture therefore needs to feel safe, have clear working boundaries and instil a sense of individual value and security (Kramer *et al.,* 2013a), which enables the NRN and the team to re-form successfully. Therefore a fundamental aspect of containment, when integrating a new member, is to balance the newcomer needs with the needs of the established team.

In order for the NRN to have the confidence to ask questions, which could enable them to grow into competent practitioners, the data showed that they needed to feel that their role was valued:

> *'someone is there, that you know is much more experienced than you, that you can still call the shots but you know there is someone there to guide you….. they don't completely take over which is quite nice, because you need to learn as well'.* (Fay, N6)

The learning and confidence of the NRNs was enhanced when they were able to practice autonomously within the containing framework of a supportive team. When this occurred they felt that there was respect for them and their ability. A sense of value and learning was further enhanced when there was a professional 'safety net' of experience and expertise. This coupled with regular and frequent feedback reinforced and advanced their developing practice knowledge and offered opportunities for the safe sharing of work experiences, correlating with the findings of Johnstone *et al's* (2008), Lavoie-Tremblay *et al's.* (2008) and Duchscher's (2009) studies.

Wenger (1998) suggests that active participation enables the NRN to gain knowledge and understanding through their performance and engagement (Bandura 1977), not just cognitive attainment of knowledge (Lave and Wenger 1991), but also that gained through social learning (Wenger 2000). Fay (N6) recognised the importance of this *'…pick(ing) up the weight'* of the work to situate her learning, and think more deeply about the activity. This study found that this was also important to the managers, who used their social and professional networks within and beyond the team to achieve reassurance and safety. They highlighted the situated nature of knowledge (Lave and Wenger, 1991) and how this enhanced their professional knowledge and skill and thus safe practice. In situating the learning and feeling confident in their performance, both participant groups were able to legitimise their place within the professional team (Lave and Wenger, 1991) and develop trust and acceptance within their relationships. This illustrates the NRN as a social being (Wenger, 1998) and is supported by the findings in this study. The participant stories in this study focused on individual and team behaviours that made them feel welcomed, valued and supported. Therefore, further research is necessary to consider how acceptance can be gained throughout the team.

The findings from the study highlight the importance and value attached to the NRN feeling equal and accepted. These findings are consistent with other researchers (Randall Andrews, 2013). However, this was not limited to the NRN; the managers also shared this in the Define phase, revealing the importance of a cohesive team which acknowledged the part played by each individual. This mutual need became a central feature in achieving a strong foundation to the new member engagement. This demonstrated the collective team was going through a process of situational learning, as they started to re-form as a cohesive team. In contextualising this process, they needed clear boundaries to shape their roles. The findings from this study indicate that to feel supported and thus to make the support process authentic, the NRN needs to feel that the team is not only there for them (Chandler, 2012), but that they wanted to be there for the team. This becomes an important aspect of the transition process as it illustrates the shift from supervised student to autonomous professional.

These findings are consistent with those of Olson's (2009) and Bjerknes and Bjørk's (2012) study, where NRNs highly valued collegiality. However, in bringing the two groups together, it became apparent that this was of prime importance to all participants as they collectively desired mutually supportive and inclusive relationships within the team. The transition process is happening throughout the team and thus some support needs will apply to all members both new and established. This illustrates that support needs to be a collaborative and collective process in order to achieve the best outcome for staff and patients. This would suggest that it is of equal importance to the organisation as it needs to embed the support process into the organisational philosophy in order to validate its relevance to the wider community.

5.3 Strategic environment

The theme *strategic environment* was defined as the influence and deliberate involvement of the whole organisation and resource system throughout the transition period. A planned environment which captured the notion of strategic commitment brought credibility, ownership, collaboration and identity to the transition, making the process more effective. Data from these themes illustrated that the participants were challenged to consider the concept of organisational systems in relation to transition. Both participant groups appreciated the enormity of the transition, understanding that its activity and value were determined by the engagement of the organisation, and by the resources invested into it. The commitment from the organisation was found to be critical to the transition process as it acknowledged its value to and for the workforce. These discussions amongst the participants brought new thinking and awareness to the subject, forming a fundamental aspect of AI, which Bushe (1998) identifies as a 'generative metaphor'.

The importance of the strategic environment is a finding which has not been observed in published literature to date, although much has been written on contributing factors such as the workplace (Halfer and Graf, 2006; Mooney, 2007a; Horsburgh and Ross, 2013; Cleary *et al.,* 2013; Wing *et al*., 2013), leadership (Evans e*t al*, 2008; Ormansky, 2010; Walker *et al.,* 2013) and organisational commitment (Cho *et al*., 2006; Kelly and

Ahern, 2009; Caballero *et al.,* 2011; Chandler, 2012). Whilst these significant factors are present in the findings from this study, the data goes further by highlighting the pivotal part that the strategic environment has in recognising, valuing and investing in the transition process. Organisational commitment to the process of transition was deemed to bring credibility to it, empowering nurse leaders and workforce members to prioritise and maximise on the opportunities available to new recruits. It was apparent from the findings that the principles of the transition process were agreed as exemplified in the field notes (Appendix 3), however, the reality of what this meant in practice and what this involved were not (Nadia, M8 p.113).

Organisational support at this research site was predominantly delivered through a probation package which incorporated competencies and orientation. This required the NRN to embark on a new course of prescribed learning. This approach did not acknowledge the individual in the process nor indeed give them professional responsibility to plan and develop their role and career. It could be argued that the professional start to their career was being stifled, having come from an environment of adult learning to a more paternalistic one which was directing the transition. If the preceptor is unfamiliar with the organisational programme and the standards that have to be met, they may be unclear about what they are aiming to achieve, resulting in the package being done to rather than done with the NRN. This could, in part, be due to not appreciating the value of the probation package but it is also apparent that time, and thus commitment, was not allocated to the activity, an issue also recognised by Feng and Tsai (2012). One manager recalled that the package had been written by the organisational education centre without practice consultation:

> *'It came from education. It is what happens. I mean it's a good idea, we needed something, but we weren't involved, it was quickly drafted'.* (Kate, M5)

In the absence of consultation, practice commitment and engagement were minimal, making practitioners detached from the transition process, and not valued within it.

The NRN needed to take ownership of their own learning needs and the preceptor needed to be able to use their own expertise to facilitate this. This does not negate the role of prepared programmes but encourages a more person-orientated approach which inspires the individual to consider their own needs; with them taking responsibility and, in part, leading their transition. McMillan *et al.* (2003) are supportive of this approach, recognising the importance of working with the individual's qualities and characteristics, as this promotes ownership and self-evaluation in the workforce. This encourages a transition which is designed with and for the nursing workforce, making it a shared appreciation of its purpose, content and delivery. This generates a workforce which is actively engaged with the transition process, understanding it and embedding it into the practice philosophy.

The concept of the strategic environment embraced the participant's generative thinking and the realisation that the transition process should be an organisational and workforce priority. The healthcare organisation in which this study took place was affected by the global pattern of declining registered nurses (WHO, 2006; DH, 2010a), resulting in heavy investment in recruitment of nurses to the island. This brought an appreciation that the organisation and the members within it had a responsibility to nurture and orientate new recruits, thus promoting integration. From the data it is evident that the participants were seeing the transition process through a new lens, using the opportunity to consider how they could transform the current practice which they and their organisation were engaged in. Instead of feeling they were part of a problem, they felt they were part of the overarching forward motion of service development. Through the AI process the participants had a new sense of commitment to and within the organisation. They recognised that any member joining an organisation was a significant event for both parties, both had invested in the move and both expected returns (Janet, M4 p.118).

Investment into the new recruit has the potential for long term value for individual and organisation (Kramer *et al*., 2012). Further discussion led participants to the notion that the needs of the NRN were not significantly different from any new staff member to the organisation. All new staff needed to be valued and guided through its organisational expectations

and guidelines to enable them to perform. Therefore the recruitment commitment does not cease at the point of entry, but needs to be shaped in line with the service and individual needs (Haslebo and Haslebo, 2012). The philosophy is the same in terms of how people are treated and valued within the process of transition and in joining the organisation. This indicates that the introduction of new members to the organisation is not an isolated activity, but a shared responsibility throughout the practice and organisational community. To achieve this, they need to be involved and active in its purpose and delivery. This not only instils inclusivity, but also introduces potential new ways of operating (Giddens, 1987), as they will be able to creatively add to its design. This enables understanding and thus ownership of the move to the new practice community, allowing the workforce to believe in and value it rather than seeing it as an additional role (Robinson and Griffiths, 2009).

These principles bring a new understanding to the transition process, moving forward from the acquisition of skills (Gerrish, 2000; Duchscher, 2009; Phillips *et al.,* 2013) and building on Vygotsky's (1978) work, which advocates a process of role acquisition. This introduces a more complex and holistic approach which endeavours to help the individual not only understand the role, but provides them with all the necessary attributes to take the role on successfully. A central finding of this study is the importance of a strategic environment which is conducive to acquiring these attributes to take on the role successfully. A notion which is congruent with the recommendations is made through the DH publication 'A High Quality Workforce' (DH, 2008b). Therefore, the need for a strong foundation of a strategic environment is worth exploring, as it could be critical to a successful transition process and the establishment of an effective workforce.

For participants in this study the transition, in the context of strategic environment, was seen as a process which went beyond the immediate ward environment. This was because it was dependent on the commitment of the wider organisational community to shape and strategically lead it. Commitment in this context meant the provision of resources, the guidance of policies as well as the input of the relevant hierarchal layers. It also highlighted the complex organisational strands which informed its effective

delivery. During data collection, the generative process revealed the managers interest in the impact of the transition process on the organisation, the team and the NRN. However, it also revealed that they had not fully considered how the whole organisational system influenced the transition, NRN and thus potentially their team. Both participant groups realised the importance of the whole organisation in making people feel legitimate and worthy and part of the organisation, as illustrated below;

> *'The place you are working at in the whole hospital has the responsibility beyond the mentor and beyond the ward; they should take a key interest…'* Fay (N6).

Both participant groups expressed the need to feel valued by the organisation, which helped them to feel legitimate within it (Wenger, 1998; Feng and Tsai, 2012). This was achieved in part when time was made available for them within the scope of the transition process (NMC, 2006; Whitehead *et al.,* 2013). This brought value to their learning and recognition to their place within the workforce. This acknowledgement was found to be crucial in validating the individual contribution made by the NRN, aiding their ability to practice effectively. When there was this sense of respect and acceptance from the team and ward manager, the NRN participants felt valued. The ward manager role has been recognised in this way through previous studies (Kalisch *et al.*, 2010; Randall Andrews, 2013), however, the importance of the team is less considered, as they focus on the tensions rather than the enabling behaviours being sought by the NRNs.

The importance of the ward manager role is not new to the subject of NRN transition into the healthcare workforce (Chitty, 2005; Shirey, 2006; Kramer and Schmalenberg, 2008; Parker *et al.,* 2012; Walker *et al.,* 2013). However, study data indicated that they had no creative involvement in the planning and delivery of the organisational transition strategy. Consequently the transition activity and organisational values were neither understood nor embedded into the ward culture. This made it difficult for the ward manager to effectively lead the process and to make it an authentic activity. This finding concurred with that of Robinson and Griffiths (2009) and Clearly *et al's*. (2013) studies which found that where the

transition process was not valued by those involved, it could become a paper exercise. Arguably this lack of clear policy and strategy hampers the quality of the transition process, as it cannot be fully engaged with when the workforce is unclear of its rationale and value. This results in the potential opportunities and benefits of the transition not being fully achieved, which could delay an effective integration into the workplace. This not only minimalizes opportunity for the organisational workforce but also does not achieve the NMC, (2006) and DH (2010a) policy recommendations.

Additionally, this finding suggests that;

1. The senior nurse managers need organisational and educational support to enable them to effectively lead their team and the NRN through the transition process. Support in this context would involve increasing the senior nurse manager's knowledge and understanding of the pre-registration preparation, gaining an appreciation of the curriculum and the foundations of the registrant role. This would enable the senior nurse manager to have a current understanding of the NMC requirements and the expected level of knowledge and skills amongst the NRNs.

2. That the transition is a shared process and therefore the collective position of the organisation is fundamental to the development and delivery of the transition strategy.

3. The senior nurse manager had not appreciated the enormity of their responsibility to the transition process or that of the culture, with Marcia (M7) realising that:

   'It's about changing the whole culture of the organisation here. So it's changing everything.'

Here the magnitude of the transition is understood, appreciating that it is not a simplistic process which could effectively be accomplished in one department alone but that it required change and thus nurse leadership to shape, develop and coordinate its delivery in collaboration with the

154

organisation. This puts additional pressure on to an already complex role which has many competing priorities.

This illustrates the notion that the strategic intentions to provide support need to engage with the NRN, preceptor and clinical team. A collaborative approach enables the effective use of the transition process, a process which represents the organisation, the practice and the individual. This engagement brings purpose and value to the activity and to the individual which in turn enhances the quality of the patient care. Therefore, the transition needs to be an active part of the leadership role and the strategic transition framework needs to be resourced through the provision of time and preceptor preparation.

5.4 Learning environment

The theme *learning environment* was defined by participants as a cultural setting which promoted scholarship and was fundamental to the concept of support. This made Wenger's (1998) work on communities of practice a particularly appropriate framework for this finding, as he recognised the importance of knowledge generation through shared interactions which work towards shared goals. For the participants to feel supported in their role, there needs to be an environment which promotes learning (Manley *et al*., 2009). This should be multi-faceted and non-linear in its activity, with knowledge being contextualised and socially embedded while new layers of learning are evolving through daily activity. Maximising on this, having practice scenarios and being supervised through the process of learning were important methods of achieving support. The nature of learning might be of a formal or informal kind. This could be achieved through structured learning opportunities or through the wealth of experienced knowledge and skills available within the practice community. In this way, the process of learning became one of social competency and complex personal development (Illeris, 2003), which acknowledged individual and team needs. Additional data which fell within the theme of *learning environment* was further organised into the sub-themes of *safe learning, knowing self* and finally *preceptorship preparation,* in which the participants recognised that a shared approach to learning facilitated knowledge, safety and responsibility.

The significance of the quality of the learning culture in relation to transition is established, particularly in contextualising clinical experience, social interactions (Dyess and Sherman, 2009; Chandler, 2012) and encouraging practice learning (Franco and Tavares, 2013). The data supports the view that NRNs' learning is not an isolated event but an ongoing process, needing to be owned, facilitated and resourced. Meleis *et al's*. (2000) notion that learning is change indicates this to be the start of a potential learning organisation where the NRN is exposed to the realities of the complex healthcare arena (DH, 2010a; Clearly *et al*., 2013; Little *et al*., 2013). It is interesting to note briefly that the creation of a learning organisation is not without difficulties. Government set healthcare targets, together with financial constraints, can threaten the existence of a quality learning environment so creating a barrier to the development of a learning organisation. However, in order that a healthcare organisation can deliver exemplary care it needs to provide a culture and an environment in which staff can develop. Word constraints prohibit in-depth discussion on this point but arguably the development of a learning organisation is synonymous with an effective organisation and the provision of quality health care. The findings from this theme suggest that learning and practice become one and the same when the clinical team and larger organisation engage in the interplay of the two. Participants in this study recognised some key factors to this being effectively achieved would require the team culture to: be receptive to NRNs as individuals; inclusive in their approach; and facilitative in their style.

In this study the NRN felt able to perform their role but their confidence to demonstrate this appeared to be influenced by the team behaviours and the working environment (Casey *et al*., 2004; Mooney, 2007a; Thrysoe *et al*., 2012). This finding reflects the 'imagination stage' of Wenger's (2000) model, which encourages orientation and reflection leading to the construction of self-image. In this manner it could be argued that the NRN is finding their identity by contextualising their knowledge and being challenged which in turn questions their practice, all of which is crucial to professional development. However, a vital element within this process was the culture in which they were performing and its ability to shape professional development (Fay, N6 p.126)

156

Both participant groups acknowledged these challenges and identified the crucial resource of having space and time to reflect on and gain understanding of practice experiences. This concept was celebrated in the Discovery phase, where value and support was attributed to having time with a preceptor to contextualise experience (Clark and Holmes, 2007; *Dyess and Sherman, 2009*) and to have a safe learning space. This finding supports Duchscher's (2001) study where she identifies the NRNs desire to practice competently but found that they could lack the confidence to do so. This study responds to and builds on the findings of Bjerknes and Bjork's (2012) work where they found that the nature of working and conversing together was a form of learning for the NRN. Both participant groups in this study highlighted the crucial nature of reflective time and learning time. This was illustrated through discussion and drawings, demonstrating the significance for both groups of its place in providing support and in understanding the transition needs. Equal value was attached to supervised learning at the bedside and relational experiences being discussed away from the patient, as exemplified through Hilda's (M2) drawing on page 124. They were seeking an environment which enabled learning in action and on action and encouraged work based learning as part of their daily work activity. This incites a workplace culture which engages in knowledge exchange and safe inquiring learning. This finding correlates with those of Grealish and Kaye (2004) who acknowledge the importance of the team community sharing learning. This uses the diversity of their knowledge to promote a culture which engages with the organisational goals but which is also committed to the development of one another within the learning environment.

Authors such as Henderson et al. (2012) support the concept of a learning environment, linking it to the provision of a non-hierarchal and receptive background. The findings from this study concur but go further by suggesting that by providing time and space in which individuals discuss and reflect on issues together, the structure and development of the learning can be enhanced. This mode of informal learning has been seen to not only encourage knowledge exchange but to aid the integration of teams (Ryan *et al*., 2010; Bjork *et al*., 2013; Franco and Tavares, 2013).

157

This inclusive and active engagement in learning enhanced cognitive development (Haas *et al,* 2002) and was found to be a significant aspect in achieving an effective transition:

> '... *they knew it all the time, they just needed the conversation'*

Here Hilda (M2) recognised the vital role that shared communication had in developing knowledge and practice trust. This culture in which the learning takes place promotes a feeling of security which introduces trust in the knowledge and skills which are being acquired. The NRN felt safe in their practice ability and the senior nurse manager was facilitating safety for patient and team alike, therefore meeting the needs of the practice environment and the larger organisation. This informal learning was an important element of the team integrating and the NRN having a sense of identity and belonging within it.

The NRN participant while acknowledging their role shift from student to registrant recognised that their support needs had changed. They no longer needed a mentor or teacher but instead the collegial support of an experienced practitioner who could enhance their confidence to practice as an autonomous professional (RCN, 2010).

Data also revealed that the NRN considered that they had a responsibility to themselves and to their new team to have a firm understanding about their ability and professional needs:

> '*people have to take some responsibility for knowing themselves and knowing how best they work'* (Pippa M9).

There was a sense that ownership for the transition process rested in part with the newly appointed individuals and that they had to learn to assume their professional responsibilities as registered nurses. This is consistent with existing literature which considers the self-awareness of the NRN in respect to practice experience (Meleis *et al.,* 2000) the focus has been one of personal and professional intelligence (Kelly and Ahern, 2009; Caballero *et al.* 2011). Within this study the participants recognised the complex

needs of the NRNs but also the professional responsibility of the individual within the process.

This infers that the transition process needs to be, in part, led and informed by the NRN to enable the ward manager to resource their individual needs. This aspect of the transition to date has not been directly considered but could inform a strong foundation for registered practice. Preparation by the NRN would also facilitate a more constructive relationship between themselves and the preceptor from the outset; the NRN would be in a position to inform a preceptor of their needs.

The findings revealed support in relation to the learning environment was a combination of activities which encompassed human interaction and learning. Pivotal to the transition process was the nurse preceptor, a finding which is consistent with other studies (Clark and Holmes, 2007, Duchscher, 2008; Glen, 2009, DH, 2010a; Park *et al*., 2011, Chandler, 2012). Preceptors were found to be influential in helping the NRNs to understand the parameters of their responsibilities and in displaying positive role modelling in terms of practice and organisational standards (Rush *et al.,* 2009; Allen 2009; Park *et al*., 2011). Their role is fundamental to the organisation as they can inform the NRN of the quality and governance expectations, they can model good practice and they can embody organisational standards. The preceptor role therefore has great influence, developing the social learning within the bounds of the organisation (Hodges *et al*., 2008).

Some authors suggest that the preceptor has a role of teacher, developing practice skills (Chandler, 2012; Clearly *et al*., 2013). However, this study found it to be more helpful if the focus of the role was one of sharing practice learning. It seems acceptable based on these findings that the preceptor becomes the conduit between HE and HC, supporting the move from student to professional. However, this is a specialised role which needs preparation and support (Whitehead *et al*., 2013) to be effective for both the NRN and the organisation. Preparation in this context would involve curriculum understanding, practice experience, and local policy knowledge in order to help the transition of the NRN between HE and Healthcare. The preceptor therefore has a specialist role which is a vital

resource to the organisation and an important retention tool (Kelly and Ahern 2009; Duchscher, 2009; Parker *et al.,* 2012; Giallonardo *et al.*, 2010; DH, 2010a). Correlating with Robinson and Griffiths (2009) this study suggests the need for significant organisational investment into the preceptor role to ensure that they can fulfil the remit.

The study findings illustrated a sense of responsibility and ownership from the NRN participants; keen that the transition was not a process which was done to them, but one in which they were actively involved. They sought a learning environment which would empower them to develop self and share experiences and opportunities with peers.

> *'I just want time to go on a website which is interactive, you know what's going on, you go and find the information'* (Dot, N4)

The use of the forum networks would provide autonomy and the safety to ask questions about practice scenarios and learning opportunities. This negates the risk of appearing unknowing to experienced colleagues, a finding which is recognised within this staff group (Johnstone *et al.*, 2008). Blogs, online networks, and clinical supervision, were identified as resources which could achieve this aspect of their learning. It was agreed that some of the support needs could be met through peer support which could be achieved through an online forum which would enable the NRN to converse with fellow NRNs. They could then contextualise their experience against that of a peer and build future learning opportunities.

> *'you can ask questions, talk to each other, forums'* (Cassie, N3)

The significance of support from peers is also reported by Ranse and Grealish (2007) recognising their willingness to share their knowledge and experience to extend their learning. Additionally this would potentially remove some of the isolation experienced by some following a transition. This level of support was also considered to be beneficial to the preceptor, strengthening their knowledge and support strategies. Supervision and formalised support processes have been discussed through the literature

(Dyess and Sherman, 2009), however, this has not been explored through the internet or wider access such as CHAIN. This would bring instant knowledge and the opportunity to share and thus warrants further research into the feasibility of its use.

5.5 Emotional environment

The theme of *emotional environment* captured the desire of the NRN participants to have control over their role and to be allowed to perform it. This is a particularly interesting finding from this study as it contradicts current literature which indicates a lack of confidence in undertaking the role (Casey *et al*., 2004; Kelly and Ahern, 2009; Chandler, 2012; Wing *et al*., 2013). NRN participants, however, did indicate that the transition from student to NRN was an emotional time, echoing the notion of 'overwhelming stress' on joining the new community of practice as described by Duchscher (2009, p.1106) and Feng and Tsai (2012). The transition process in this study was more complex as the NRN participants were not only moving from the security and status of university affiliation (Evetts, 2006; Duchscher, 2009) but also making a geographical move. This meant a new home and a new work location, bringing with it new relationships both inside and outside the work environment. Thus, this was a very demanding period of time in their personal and professional development which challenged their perceived position in relation to those around them and required a great deal of emotional investment (Fay, N6, p.115).

This journey was characterised by a pattern of multiple transitions for these particular NRNs. Change of this magnitude can bring vulnerability (Meleis *et al*., 2000) and represented a potential challenge for the individual as they endeavoured to contextualise their new work environment and for the senior nurse manager as they embraced the new recruit.

Aligning the challenges faced by the NRN with the challenges of the senior nurse manager role is complex and non-linear due to the personal and professional expectations relating to the transition. This could potentially disable the transition from happening effectively. The participants collectively identified the relevance of a collegial and friendly working

environment (Lavoie-Tremblay *et al.*, 2008; Ulrich *et al.*, 2010) which was empathetic to the process. The AI solution-focused approach enabled the participants to explore new ways of working to achieve this. The generative discussion stimulated 'free-thinking', removing the participants from the constraints of their habitual workings to exploring new opportunities informed by their positive experiences. This united the lived experience with the not yet articulated possibilities enabling new transition practice strategies to develop through the collective participants.

Data relating to this was organised into sub-themes, entitled *preceptor matching, role boundaries* and *trusting relationships.*

Considering these multiple transitions, the participants used the AI solution-focused approach to transform the current transition process within the organisation. They identified the valuable opportunity available in the time span from successful interview to commencing registered practice. This space could provide time to consider early socialisation (Page, 2005; Price, 2009; Chandler, 2012) needs, encouraging the NRN to reflect on their strengths and weaknesses and their proposed contribution to the professional team. It could also give managers informed time to prepare the team and plan for the NRN (Isobel, M3, p.131).

The importance of engaging in early conversation with senior nurse managers was also recognised by Dyess and Sherman (2009) as a beneficial way of valuing and integrating the NRN. This could also dispel potential feelings of isolation for this NRN participant group. Dialogue is an essential element of situating learning, gaining understanding with and through participation which is recognised as an enabler to individual growth (Jonsdottir *et al.*, 2004). Gergen (2009) would argue that it was an essential element to the transition process for both participant groups, due to its ability to challenge the tacit understanding of each. In view of the NRN's desire 'to carry out their role' this approach also enables personal professional responsibility to identify individual learning needs. In sharing the expectations of the forthcoming transition process, all team members could be informed and thus prepared for the new recruit. This activity provides the collective knowledge for a transition plan, which creates the foundations for a person-centred approach to an individual's support

needs. Creating a bespoke approach to the transition (Dellasega, 2009) was discussed and prioritised by the participants throughout the mini-summit. In having a greater understanding of the NRN's experience to date and their emotional and ongoing needs has the potential to nurture their autonomous role. The development of a transition plan brings clarity to the NRN role and to its boundaries. It also has the potential support integration, with the surrounding community having knowledge of the individual and their needs. This both supports and builds on Johnstone *et al's* (2008) study, which identified the need for the workplace to be prepared for the NRN.

This illustrated the value of the AI process in bringing different levels of the workforce together to learn from one another and to innovate together. It also further amplified the influential role that the senior nurse manager has in planning the transition, in preparing the individual, the team and the workplace environment. The ability to plan and the provision of time therefore become important skills and resource requirements for the manager and need to be factored into their role to ensure that the transition foundations can be formed. This aligned with their understanding of the pre-registration curriculum gives the manager a comprehensive understanding of the needs of the new staff members. This finding reinforces Duchscher's (2009) recommendation for research on preparatory understanding of the transition and Page (2005), who advocates starting the socialisation early due the impact this has on practitioner growth.

The transition plan and shared knowledge addresses the anticipatory aspect of Scott *et al's* (2008) socialisation model, which advises that consideration is given to expectations, values and knowledge prior to commencing professional practice. The transition plan could alleviate the potential tensions of introducing new knowledge and standards to the NRN and the established team (Lave and Wenger, 1991), ensuring that there is clarity and understanding for both in the process. The transition plan also allows the manager to consider the following finding within this theme which recommends matching the right preceptor for the NRN:

> *'every person is going to need supporting in a different way'*
> (Pippa, M9)

Participants in this study considered that ward managers had the requisite expert knowledge of their team and the specialist skills to identify the right preceptor for the NRN.

An individualised approach to the transition has been seen as advantageous to the transition process (Johnston *et al*., 2008) and echoes the recommendations of McCormack and McCance (2010). The team become aware of the transition, making it an inclusive process, while the introduction of a formal learning contract acknowledges the individual and creates a progressive learning environment. The Design phase of the data collection formalises the process into a tripartite agreement building on the learning needs with the preceptor, manager and NRN. This active management engagement concurs with findings from studies by Cho *et al.,* (2006), Omansky (2010) and McCarthy and Murphy (2010). This preparatory activity accommodates the potential emotions within the transition and starts the process of aligning the needs of the individual and employing healthcare organisation.

Arguably the most important factor for the participants was their collective need to be appreciated within the team. They sought an environment which was receptive (Chandler, 2012), welcoming and respectful of their role, they were keen to be valued and to feel valuable to the clinical team. While this finding resonates with Randall Andrews' (2013), where this was an expectation of the NRN, this study finds that it is a crucial aspect to the working environments of both participant groups:

> *'the importance of trusting/encouraging relationships'.*
> (Collective Discovery)

Relationships embodying trust and empathy were deemed fundamental to the support process, as they enabled individuals to seek expertise and knowledge, creating a professional environment which enabled openness and trust. Goleman (1998) would argue that relationships are crucial in helping the individual to make sense of their understanding, making

emotions a cognitive tool, and thus can impede or motivate learning. This makes acceptance, trust and respect important aspects within the findings as the development of relationships will be dependent on these attributes. Trust was an important word which was frequently used collectively and a phenomena which came from Levett-Jones' (2007) and Kelly and Aherns' (2009) work, linking the crucial role that manager and team have in accepting and respecting the NRN in their new role.

The findings within this theme illustrate the prominent part that the Senior Nurse Managers play in the transition process (Shirey, 2006; Kramer and Schmalenberg, 2008; Regan *et al.,* 2009; Kramer *et al.,* 2010; Karmer *et al.,* 2013a; Walker *et al.,* 2013), acting as advocates and strategic planners in providing a healthy work environment for the newly formed team to unite and thrive. When visible in the transition process they are influential in, and an important role model for, achieving the organisational standards. When actively involved in the transition, the manager is able to both understand the effect it has on the workforce, and are better informed to carry-out their advocacy role in championing its relevance throughout the organisational strands. The study findings extend the current understanding of the senior nurse manager's role in the transition, and their need to be active within it to make it effective.

Creating a person-centred transition emphasises the need for a whole system approach, making it a community-orientated process inclusive of HE curricula. The challenge of balancing the priorities of daily activity with this individual workforce need is an organisational challenge which requires strategic guidance. However, this approach could provide an empowering work environment when introducing the NRN to the profession.

To further illustrate the study findings, Figure 5.2 shows how a person-centred approach to the transition process can be developed following the NRN's successful interview. By incorporating the modes of support identified through the findings, the NRN can have a bespoke transition plan which fulfils individual and local needs generating the role parameters which all members can work to. This incorporates the pre-work experience

and actual work experience identified in Scott *et al's.* (2008) socialisation model.
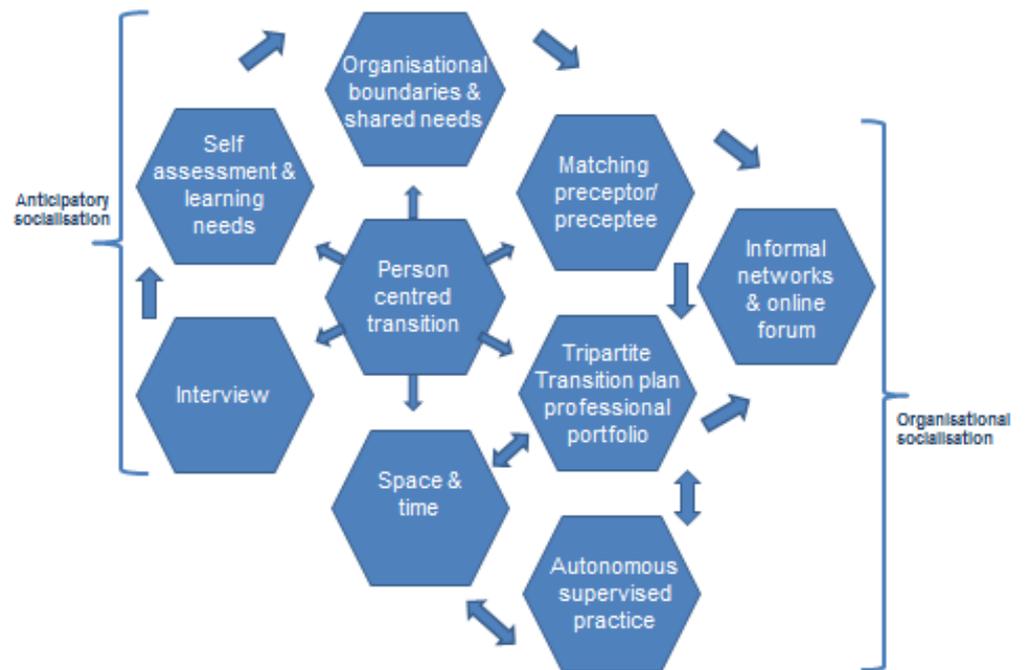
Figure 5.2 A person-centred transition

5.6 The development of a collaborative conceptual model for transition

This study is underpinned by a combination of three theoretical models, Scott *et al.* (2008), Duchscher (2008) and Wenger (2000). The findings resonate with the words of Wenger (1998) '*learning entails realignment'.* A healthcare community mirrors the conceptual notion of a 'Learning Society', in which there is constant change and re-alignment. A new member joining the team, as in this study, creates another facet of this process. The importance of shared practice learning and feedback to further progress understanding echoes Wenger's (2000) concept of the 'push and pull' effect within the team. The study revealed, however, that this act of dialogue was seen to be crucial to the process of shaping the team and aligning social competence. Furthermore an organisational culture in which this occurred was seen by participants to engender

166

professional growth, and therefore a fundamental aspect of the support process. The study findings illustrate that the organisational influences on the new recruit as reported by Scott *et al*. (2008) need to go further to incorporate the concept of a person-centred transition plan; designed not only to meet the organisational needs, but those of the individual. Such a plan would provide role and practice boundaries for the individual and for the community that they joined. It was also seen as a means of enabling professional growth by shaping the transition and keeping the neophyte safe and not overwhelming them.

Education was seen as essential in shaping and developing the professional nursing team, encouraging reflective practice and personal inquiry. A key finding of the study was that with active engagement and understanding of the pre-registration nursing curriculum and articulation of the organisational boundaries, the neophyte, team and nurse leader were better able to achieve an effective transition. This suggests the need for a tripartite collaborative approach with education, the profession and healthcare organisation providing policy guidance to formalise the support process.

The findings from this study revealed that the process of joining a new profession and team is not solely about knowledge and skills acquisition. It involves social competency and requires the entire team to learn and re-form within the context of their new relationships, resources and working agenda. Therefore the team members affect the transition stages and the socialisation process affects the collective team. This process creates the boundaries, shapes the working environment and nurtures the professional growth (Lauder *et al.,* 2008) of both the NRN and the organisation.

The theoretical models of Scott *et al.* (2008) Duchscher (2008) and Wenger (2000) present a somewhat linear approach to the process of transition. The findings from this study, however, have demonstrated the multifaceted and multi-layered aspects of the transition, enabling the development of a new conceptual model for that transition. The model (figure 5.3) illustrates the influential role that the healthcare organisation has in providing and delivering support. It suggests that support is not the sole responsibility of any one member, but a partnership between health

education and practice, organisation and team, nurse leader and team, team and new member.
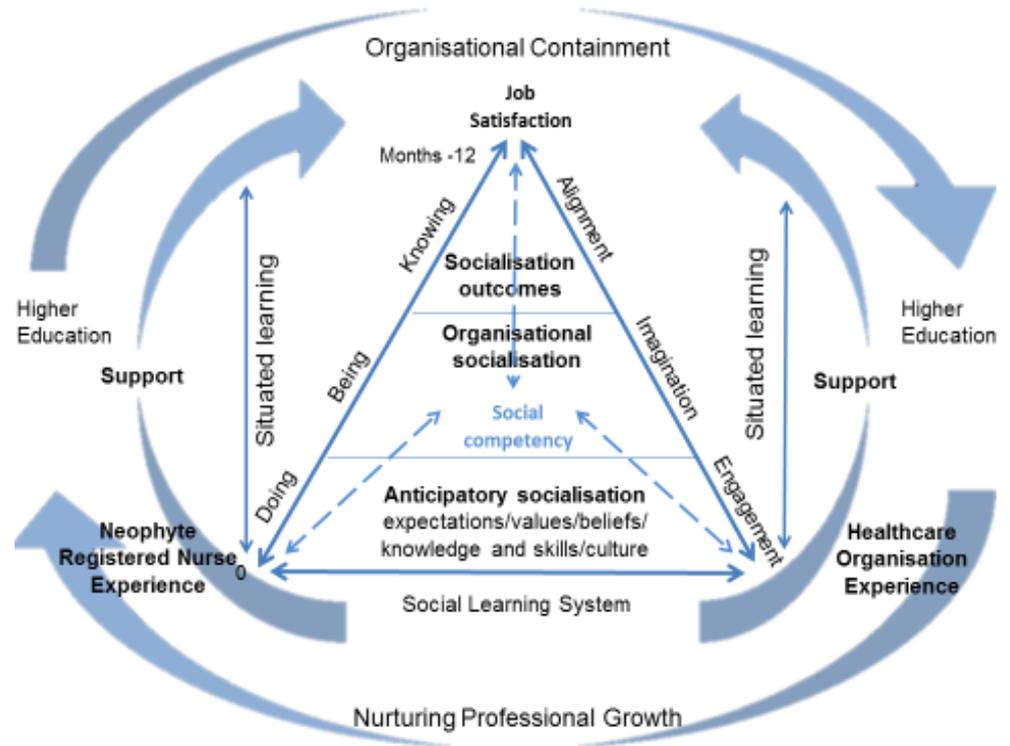
Figure 5.3 Conceptual Model: reforming teams through the transition process

The concluding chapter will explore the implications for future practice and workforce development.

Chapter 6: Conclusions and recommendations

This chapter summarises the outcomes and achievements arising from the study. It identifies future directions for research on the subject and considers the implications arising from the study for nurse education, healthcare employers and nurse practitioners.

6.1 Outcomes and achievements

This study set out to explore the concept of support for the NRN and for the senior nurse manager during the transition period. I was particularly interested in establishing the interpretations attached to the meaning of support and the accompanying expectations, enabling me to consider how this might then be achieved in practice. Previous research has tended to consider the transition process from the perspective of the NRNs only (Casey, 2004; Dyress and Sherman, 2009; Bjerknes and Bjork, 2012). I had a particular interest in this topic from the perspective of the senior nurse manager as well as the NRN. In addition, previous studies have focused on the barriers and the culture shock (chapter two, Duchscher, 2008; Lavoi-Tremblay *et al.,* 2008; Kramer *et al.,* 2013a) which has accompanied the NRN in relation to transition. Such an approach can negate the opportunity to build on the effective aspects of the transition process, an opportunity which this methodology and study offer.

The findings demonstrate that there are shared understandings, at varying levels, between the NRN and senior nurse manager around what 'support' might encompass when entering the workplace. There was also an evident desire to embed these understandings in daily practice. However, the challenge to achieve this came through the need for organisational recognition and resource commitment. With active engagement and understanding of the pre-registration nursing curriculum, and articulation of the organisational boundaries, the NRNs, the team and the senior nurse manager were better able to achieve an effective transition. This reinforced a need for a collaborative approach between HE, healthcare and the clinical team by providing policy guidance to formalise the support process. This could shape the transition, creating clear boundaries and clarifying some of the local and personal interpretation. This heightens the urgency

to achieve job satisfaction and thus retention through an effective transition when addressing the global concern of the increasing nursing shortage (WHO, 2006; Buchan and Seccombe, 2011). This prioritises the need to value and support the individual and create a professional practice learning environment to achieve a sustainable workforce. Although this has been explored from the NRN's experience, there has been less debate on the organisational perspective when leading the transition process and on the affirmative stories which recognise a successful experience for the NRN and senior nurse manager. These are two areas that this study has focused on.

6.2 Strengths and limitations of AI and of this study

AI is a new methodology to this subject area with no previous studies found exploring the phenomenon in this way. It shares insights into the organisational engagement, and examples of good practice, creating a healthy understanding of the workplace. This not only gives organisations something to celebrate but also enables the workforce to own and inform the themes explored.

The rationale for selecting AI as the methodological approach for this study was provided in chapter three. One reason was AI's positive focus, which introduced a new approach to a long standing workforce issue. It also enabled participants to explore the 'best of what is' in order to consider 'what might be' in the future. This approach was particularly beneficial for a small community such as the one studied. It moved away from blame or critical comment to acknowledging the good and developing it into practical action. Initially it was challenging to maintain the positive focus, with some, particularly the senior nurse managers, needing to discuss the problematic history attached to the current practice. Although it was essential to uphold the principles of AI, it was also important to maintain my relationship with the participants (Mason, 2006).

This challenged my facilitation, as I wanted to stay true to the tenets of the methodology while conscious that some needed to explore the negative in order to make sense of the positive. I was challenged to balance the importance of building a listening rapport with the participants and managing the precious time available. However, the act of exploring some

of the negative scenarios through an appreciative eye enabled me to facilitate creative solutions. An example of this came when some participants became demoralised by their perception of the organisational engagement in a past scenario. When exploring this further, they were able to see why it had not worked, becoming excited by what could have been done to enhance it. As found by Martinetz (2002), study participants were initially seduced by the negative, but the positive became equally contagious. The energy and the motivation of the discussion changed following Bushe (2011) and Reed's (2007) belief that behind every negative story lays a positive.

The second and overwhelming reason for using AI was the generative quality that it brought to the study phenomenon. Generativity occurs when participants collectively discover and or create new ideas to inform their future (Bushe, 2007). The methodological choice enabled the subject of transition to incite new ideas and models, freeing participants from the constraints of their current practice to reshaping it. This approach was achieved in part through the style of the questions that I prepared for the mini-summit. They evoked reflection and thought which resonated with the participants past and present (often emotional) experience (Bushe, 2007). The act of sharing and listening to the participant stories built relationships, which enabled participants to view their reality with a new eye. This aspect of the AI process was dependent on my preparation and understanding of the methodology and my ability to craft the appreciative question to build rapport and energy (Ludema *et al.,* 2000).

This research process was therefore influenced by my facilitation, enthused by my commitment to the methodology, style of engagement and relationship with the participants. I used an informal approach between self and participant (Carter *et al.,* 2007), observant to the group process and accurate recording, using my past skill and experience to capture the activity. This was further shaped and informed from AI training and discussion with AI experts and enthusiasts. Each element brought insight to the methodology and to my facilitative approach.

Thus the AI process and my facilitative approach empowered the participants to think differently about the concept of support for the NRN and motivated new insight and responsibilities to be mapped and

considered. It demonstrated how the provision of time and space stimulated dialogue which enabled empathetic and productive relationships to develop, strengthening understanding and future networks. Although this was in part a facilitated activity, the appreciative dialogues enabled the participants themselves to become more facilitative within the process (Dewar and Sharp, 2006). This encouraged a shared and dynamic approach (Boyle *et al*., 2010) where the participants were engaging through active participation. This constructionist practice mirrors the process of collaborative learning and deep personal introspection (Brooks and Brooks, 1996).

Much time and thought was given to the choice of methodology and to the possible alternatives. Due to the nature of the phenomenon being studied and the sensitivity regarding the needs of the research site, I would argue that AI was the appropriate choice. However, this does not mean that it is not without its limitations. A key limitation being the balance of power (Reed, 2007). AI is recognised as having a positive influence on relationships and communication across the power hierarchies. The new ideas have the potential to be powerful resources which staff can use to contribute to change and development within their organisations (Cooperrider and Srivastva, 1987). Although this theory aligns with my philosophy, I would argue that power is a contentious feature of AI and of this study, due to the challenge in achieving its equal distribution. Although the participant stories and my interpretations identified new ways of working and staff were energised to make change. This could not be activated as it was not acknowledged by those with the power to make change happen.

Although I have a great deal of professional facilitation experience, I recognise that I am a novice researcher. The connection of these two activities challenged my inherent desire to take the facilitation role forward, which if not self-censored, could have dominated the research process. I was confident in my knowledge and ability to probe deeper and to achieve a more in-depth understanding of some issues during the mini-summit. However, analysing the data presented as a greater challenge for me, I was overwhelmed by the volume of material generated and the crucial importance of representing the participant voice. I am conscious that a more experienced researcher might have achieved further depth

throughout the data analysis phase. The impact of this experience/inexperience on the study is difficult to determine, as each will have brought a unique aspect to the study. I endeavoured to manage this tension through peer support with a critical friend, recording my thinking through my research journal and by being true to the TA process (appendix 12).

The shared nature of the methodology enabled the participant to be the expert, active in dialogue and discovery together; reflecting on experience and imagining its appearance within a new context. Participants appreciated the opportunity to share their experience and ideas, speaking candidly about transition scenarios both positive and negative. One NRN was recorded on tape in conversation with a manager: *'I am really enjoying myself today; I had not expected it to be so interesting and so much fun.'* This not only illustrates the inclusive and progressive nature of the methodology (Watkins and Mohr, 2001), but it also acknowledged their individual identity within the organisation (Boje, 2011).

A strength of the methodology was that it allowed the participants to share my passion for the research phenomenon, and that of other authors (Duchscher, 2012; Johnstone *et al*., 2008; Wangensteen *et al.,* 2008), in wanting to get the support right for this workforce group. AI was in part responsible for this, providing a framework which facilitated the search for effective and positive stories. This encouraged participants to unpick values and relevance, making sense of and building on from these strong foundations. This introduced new energy to an established workforce challenge, revealing that the NRN needs were not completely different from any other new member joining a team. The integration and the need to feel valued were crucial factors for all the participants studied.

A further strength of the research design was bringing the NRN and the manager together to share and co-create (Faure, 2006) within a positive paradigm and is a unique feature of the inquiry. This is an approach which has not been traditionally used in this subject, as the focus tends to concentrate predominantly on the experience of the NRN. Although important, this only represents one perspective, which offers a narrow lens on a complex and potentially costly workforce phenomenon. This generated a more in-depth understanding and perspective of the concept

of support, creating a depth to the fundamental importance of getting the support process right for the new employee and for the organisation. This may not have emerged if the research had not been undertaken combining the two groups, or also if this constructive approach had not been used. The opportunity centric research approach enabled participants to build on good experiences, recognising the organisational and local strengths, removing any blame anxiety. This process moved the transition needs into an exciting organisational opportunity rather than an additional task which needed to be achieved, which adds a different and positive element to the research.

The mini-summit framework was a strength of the thesis inquiry where the collaborative nature of the process facilitated debate and actively empowered the participants to consider the whole organisational system within the activity. However, this advantage came at the cost of time. With the organisational pressures of taking fifteen registered nurses out of practice the mini-summit was bound to a limit of four hours. Although this focused the event at times it curtailed debate; reducing the opportunity for ideas to reach their natural conclusion. This also potentially weakened the progression opportunities which needed dedicated time in order to develop action and project plans.

AI usually involves large numbers of participants from a range of different roles throughout the organisation, allowing for a range of good practice experiences to be analysed, progressed and integrated into the organisation (Cockell and McArthur-Blair, 2012). The sample size for this AI intervention was small and so only took a snapshot view of the research inquiry, however, it was a comprehensive representation of the island community.

The design chosen for the study was ambitious with the incorporation of Discovery, Dream and Design throughout the mini-summit creating a lot of data for study. The methodology created some challenging learning for me, due to the multiple layering of the data generated. To date there is little guidance on effective approaches and tools to analysing AI data, with Reed (2007) found to be the sole researcher attempting the challenge. She concurs that '*it is a challenge to analyse data in ways that are inclusive of all these dimensions of similarity and difference*' (p, 149). This stage of the

doctoral journey caused me much reflection and consideration on how to achieve my desire to stay true to the methodological process while also providing an academic and scientific approach to my analysis. The resulting decision to work with thematic analysis was taken in part due to the flexible approach that it provided and also through discussion with fellow AI researchers. This was framed by Reed's (2007) advice to keep a clear AI analysis audit trial.

The use of AI is considered to be a complex methodology for doctoral studies, in part due to its roots in organisational change. On meeting with and discussing my research with Bushe (a renowned expert in AI), at an AI conference in 2012, he was quick to share that *'AI does not fit well with the doctoral journey'*. He was alluding to the transformational change quality which comes from the AI process, which makes it difficult to fit into a structured doctoral study. The methodology uses four phases to generate ideas and meaning to inform change, this study only incorporated three of these phase.

6.3 Recommendations and implications

The preceding chapter expounds my conceptual model which illustrates the transition as a shared experience between NRN and clinical team. The model evolved through the findings which identified the challenges that a new member brings to the team and the time that it takes for the team to re-form. The thesis intention was not to initiate organisational change, but to establish the meaning of support and the values attached to the transition. Thus three models, Duchscher (2008), Scott *et al*. (2008) and Wenger (1998), were used to consider the individual and collective needs of the transition process.

Four key components: learning, collaboration, professional growth and organisational containment were found to be of significant importance, therefore these will be explored through the recommendations.

6.4 Healthcare employers and nurse practitioners

Support was found to be a multi-layered and, in part, a bespoke process which was reliant on an environment which was able to engage with a new

member and meet their learning needs. Learning was a key component of support, and the quality of this was dependent on both the engagement of the team and of the larger organisation. As a new community of practice the team is learning together, negotiating and generating understanding (Wenger, 1998). This means that the team is essential to the transition process, and an active component of its success.

Scott *et al's*. (2008) model considers the time period prior to starting the NRNs' role, focusing on what they expect of it and bring to it. This provides prime time for the NRN to consider their needs based on their learning styles and experiences. Bringing this information to the new working environment enables the NRN and senior nurse manager to start the next stage of their learning, co-creating a transition plan. This starts the process of professional development, with the NRN taking responsibility for their needs and building a relationship with the manager. This preparatory activity enables NRN and manager to develop a transition plan between them, which identifies the boundaries of the role and the supported needed to achieve this. Wenger (1998) identifies three parts to the community of practice:

Engagement - This centres on relationships, and was highlighted by the participants as a fundamental element in achieving the transition. Each wanted to be there for the other and to be respected within the team, identifying the team as a safe environment for the NRN to practice in. This was also found to enhance the team experience when all members felt part of a strong team and valued for their role within it. In preparing the team for the NRN and sharing the NRN's learning needs, it became a collective responsibility and a joint experience. Time became an essential component in bringing value to the process, it also allowed the NRN the opportunity to contextualise and deepen their learning. This makes the availability of space away from the practice area of primary importance, enabling team members to explore practice scenarios to strengthen the practice of all. The successful engagement of the team was found to be vital in facilitating the transition process.

Imagination - In creating a culture that is working together, sharing and understanding the transition process, rather than making it the responsibility of one member, it becomes a group activity. This makes the

transition a collective process which actively takes ownership for the new member, the group is involved in the NRN's orientation, learning needs and professional development. It allows all members to explore learning opportunities and to reflect on who they are within the team. This shifts the traditional emphasis from the acquisition of skills to one of professional development and social learning.

To further enhance the shared participatory approach to the transition, the resource of an internet peer forum enables independence in seeking trusting relationships and extending networks. This facility empowers the NRN to share ideas, anxieties and mutual learning needs in the relative safety of their peer group. This introduces autonomous space, encouraging independence and a shared responsibility to the transition process, while extending the learning environment.

Alignment - There has been a tendency for the transition process to be 'timetabled', determined by the clinical environment or through a prescribed organisational programme. Wenger (1998) suggests that this top-down approach not only loses the collaboration, but also loses the individual. Empowering the NRN to identify their needs is part of the professional development which informs their ongoing practice. This also allows them to flourish in areas of confidence, enabling them to contribute to and be recognised within the team and larger organisation. This involvement brings autonomy and stability, which enables safety and containment for professional growth to evolve. A failure to involve the individual becomes apparent when the workforce has not been engaged in the transition process, leaving the individual to interpret information themselves, rather than to understand its value and its purpose within the context of the organisation and patient care.

This requires a new cultural approach to the transition process, viewing the arrival of a new member as a shared enterprise, which needs organisational investment.

6.5 Education

It is recognised that each new registrant enters the profession with a unique educational and practice experience, with each HE and HC

providing a variation on the NMC pre-registration programme. This not only compartmentalises education and practice, but views them as two distinct activities.

The pre-registration curriculum is a shared responsibility between HE and healthcare, and thus their partnership needs to facilitate the NRN with the skills to contextualise practice experience throughout their career. Learning is continuous. The principle of Wenger's (1998) work applies here too, to the preparation for registration. However, the interpretation of educational learning and practical learning could be better understood. HE and healthcare working together to ensure that the two approaches interrelate, with each informing and progressing the other would normalise the expectations and opportunities available to the practice arena, strengthening ongoing professional development and also the organisational learning culture.

The uniqueness of the NRN is to be celebrated, as they bring something new to the practice arena. However, with this comes individual needs. Scott *et al's*. (2008) model identifies the period between registration and starting professional practice; where expectations, values, knowledge and skills have been acquired in preparation for the registered role. The findings from this study recommend that HE and healthcare should work collaboratively to create a transition plan with the NRN, to help them gain insight into their strengths and needs but also to set a framework for the established team to work from. This becomes the foundation for the NRN's professional portfolio and sets the standard and expectation for their professional practice.

Although there was a recommendation for the HC education department to play a stronger role in influencing the strategic direction and practice learning needs, I would suggest that this role should not become the responsibility of one defined discipline alone. Instead this needs to be a partnership between education, practice and the healthcare organisation. HE plays a fundamental role in providing support and development for all members of the practice community. Therefore it would be beneficial to strengthen and integrate the academic within the practice arena, making it active within strategic planning, organisational development and the healthcare field.

6.6 Future research

There has been minimal research exploring the positive experiences of the transition process. It is evident that the concept of support in the context of the NRN has attracted limited research attention, which has been a challenge when comparing the study findings or considering future practice initiatives. More research in these areas would build understanding in what works for the NRN and in what works for the healthcare organisation. Comprehensive guidance is needed to inspire and map out the importance support has in the provision of practitioner and patient safety. This would create a positive outcome for healthcare.

This study researched two key stakeholders involved in the transition process. It would be beneficial to expand this to include health education in order to identify how academia perceives the support needs of the NRN. The findings could then be integrated into the curriculum and/or transition plan. The AI process was initially designed as an organisational change method, making it a strong research methodology to pursue this workforce phenomena.

AI is relatively new as a methodology and as suggested by Reed (2007), I would encourage more researchers to use it. It is only through achieving more AI studies and having experienced AI researchers that we will generate new understanding about the methodology and further validate its place within qualitative research. This would also improve the guidance which is presently needed to direct the researcher, particularly around the analysis process of the research. This would bring a stronger understanding to AI as a research tool.

6.7 Conclusion

Whitney (2004) suggests that the AI process can elevate organisational consciousness which is true of the research discussed in this thesis. It was evident that those participating in the study and engaging with the AI process brought the subject of NRN support needs, and their relevance in the healthcare environment, to the fore. They highlighted the need for the transition process to have greater priority within the strategic planning. The learning environment needs to be led by the organisation and to actively engage with the clinical leadership. A strategic culture which understands

and welcomes the challenge of supporting NRNs is needed to create an inclusive workplace environment, which would then impact positively on achieving exemplary patient care. NRNs are a crucial aspect of the future nursing workforce; making it important that they are given the tools to effectively integrate into the healthcare organisation in order to understand and manage their professional position. This study provides insight into how the healthcare organisation and educational providers, in particular those in leadership positions, should influence and champion the organisational commitment to delivering authentic support.

The findings illustrate the crucial role that healthcare organisations and higher education have when integrating the NRN into their professional role. In spite of the different strategic goals held by the two organisations, they both have the shared responsibility of educating the student to the NMC standards for pre-registration. In addition, the collegial partnership in which the NRN has been prepared is the start of the support process, responsible for imparting a good working knowledge of the NMC and University curriculum. It is evident from this study that learning does not happen in health education alone, but is an activity which continues to gain momentum and meaning in the practice arena. However, this relies on the strength of the learning environment, which needs to be organisationally championed and led. This requires the practice community to be receptive to the needs of the individual and aware of the resources available to support them within the organisation.

It is evident through these study findings that the practice environment and the relationships within it are crucial factors when supporting the NRN into their new role. Therefore, the achievement of this is of primary importance for the senior nurse manager. The research has uncovered that the achievement of a supportive transition is a person-centred activity rather than purely one of skills acquisition: for example, - professional growth from the collaborative relationships, shared experiences and the value attached to learning together. The practice culture is fundamental in providing an environment that understands the needs of the patient, the colleague and the organisation, in order to establish clear priorities which provide the containment required to facilitate good practice. Not only is education essential in shaping and developing the professional nursing team, but also in its role in encouraging reflective practice and personal

inquiry. Senior nurse managers need to inspire professional practice, leading both the nursing care and the team formation; the integration and value attached to the NRN being of great importance to all, as this will enhance patient care and aid retention of an effective workforce for the future.

References

Abbott, A. (2005) Linked ecologies: States and universities as environments for professions. *Sociological Theory,* 23 (3), pp.245–274

Adam, A. (2013) Managing insider issues through reflexive techniques: An insider researcher's journey. *Te Kura Kete Aronui,* 5, pp.1-14.

Adler, A. Adler, P. (1988) *Observational techniques.* In Denzin, N.K. Lincoln, Y.S. (Eds.) Collecting and Interpreting Qualitative Materials, London: Sage Publications

Allen, J.M. (2009) Valuing practice over theory: How beginning teachers re-orient their practice in the transition from university to the workplace, *Teaching and Teaching Education,* 25 (5), pp.647-654

Anderson, L.P. Edberg, K. (2010) The transition from rookie to genuine nurse: Narratives from Swedish nurse graduates 1 year after graduation, *Journal of Continuing Education in Nursing*, 41 (4), pp.186-192

Anderson, E.E. Kiger, A. (2007) I feel like a real nurse – student nurses on their own. *Nurse Education Today,* 28 (4), pp.443-449

Andrews, M. Roberts, D. (2003) Supporting student nurses learning in and through clinical practice: the role of the clinical guide. *Nurse Education Today,* 23 (7), pp.474-48

Annells, M. (1997) Grounded theory method, part 1: Within the five moments of qualitative research. *Nursing Inquiry*, 4 (2), pp.120-129

Anning, A. (1997) Drawing out ideas: Graphicacy and young children. *International Journal of Technology and Design Education,* 7 (3), pp.219-239

Anning, A. Ring, K. (2004) *Making sense of children's drawings.* Maidenhead, UK: Open University Press.

Antaki, C. Young, N, and Finlay, M. (2002) Shaping clients' answers: departures from neutrality in care-staff interviews with people with a learning disability. *Disability and Society,* 17 (4), pp.435-455

Ashurst, A. (2008) Career development: the preceptorship process. *Nursing & Residential Care,* 10 (6), pp.307-309

Attride-Stirling, J. (2001) Thematic networks: an analytic tool for qualitative research. *Qualitative Research,* 1 (3), pp.385-405

Baillie, C. Smith, J. Hewison, J. Mason, G. (2000) Ultrasound screening for chromosomal abnormality: Women's reactions to false positive results. *British Journal of Health Psychology*, 5 (4), pp.377–394

Baker, W. Cross, R. Wooten, M. (2003) *Positive organizational network analysis and energizing relationships.* In K. S. Cameron, J.E. Dutton, & R. E. Quinn (Eds.), Positive organizational scholarship: Foundations of a new discipline (pp. 328-342). San Francisco: Berrett-Koehler.

Bandura, A. (1977) *Social Learning Theory*. New York: General Learning Press.

Bandura, A. (2001) Social cognitive theory. An agentic perspective. *Annual Review of Psychology*, 52 (1), pp.1-26

Bardhan, A. Hicks, D.L. Jaffee, D. (2013) How responsive is higher education? The linkages between higher education and the labour market. *Applied Economics,* 45 (10), pp.1239-1256

Barrett, F.J. Fry, R. (2002) *Appreciative Inquiry in action: The unfolding of a provocative invitation*. In Fry, R, Barrett, F., Seiling, J., & Whitney, D. (Eds.), Appreciative Inquiry and organizational transformation: Reports from the fields (pp. 1-23). Westport CT: Quorum Books.

Barrett, F.J. Fry, R.E. (2005) *Appreciative Inquiry. A Positive Approach to Building Cooperative Capacity*. Chagrin Falls, OH. Taos Institute.

Barton, D. Gowdy, M. Hawthorne, B. (2005) Mentorship programs for novice nurses. *Nurse Leader,* 3 (4), pp.41–44

Bauer, T.N. Morrison, E.W. Callister R.R. (1998) ''Organizational socialization: A review and directions for future research.'' In G. R. Ferris (ed.), *Research in Personnel and Human Resource Management*. 16, pp.149–214. Greenwich, CT: JAI Press.

Bauer, T.N. Bodner, T. Erdogan B, Truxill, D. Tucker, J. (2007) Newcomer adjustment during organizational socialization: a meta-analytic review of antecedents, outcomes and methods. *Journal of Applied Psychology,* 92 (3), pp.707-721

Bendall, E. *(*1975) *So You Passed Nurse.* Royal College of Nursing, London.

Benner, P. (1984) *From novice to expert: excellence and power in clinical nursing practice.* Addison-Wesley Publishing Co., Menlo Park

Benner, P. (2004). Using the Dreyfus model of skill acquisition to describe and interpret skill acquisition and clinical judgment in nursing practice and education. *Bulletin of Science, Technology & Society,* 24 (3)**,** pp.188-199

Berger, J. (1972) *Ways of seeing*. London: BBC & Penguin Books

Berger, P.L. Luckmann, T. (1966) *The Social Construction of Reality.* Garden City, NY: Anchor.

Berntsson, E. (2008) *Employability perceptions: nature, determinants, and implications for health and well-being*. Doctoral thesis. Stockholm: Psykologiska institution, Stockholm University.

Bjerknes, M. Bjørk, I. (2012) Entry into Nursing: An Ethnographic Study of Newly Qualified Nurses Taking on the Nursing Role in a Hospital Setting. *Nursing Research and Practice.* Article ID 690348, 7 pages.

Bjørk, I.T. Tøien, M. Sørensen, A.L (2013) "Exploring informal learning among hospital nurses", *Journal of Workplace Learning*. 25 (7), pp.1-24

Blaikie, P. (2000) Development, post-, anti-, and populist: a critical review. *Environment and Planning A*, *32* (6), pp.1033-1050

Blake, H. Malik, S. Mo, P. Pisano, C. (2011) Do as I say but not as I do: are next generation nurses role models for health. *Perspective Public Health,* 131 (5), pp.231-239

Blomqvist, K. (2014) "Building sustainable organizational trust in radical change–the interplay of organizational trust and mindfulness." *Mindful Change in Times of Permanent Reorganization*. Springer Berlin Heidelberg, pp.131-145

Bohm, D. (1998) *On Creativity.* Lee Nichol (Ed) London: Rouledge

Boje, D. M. (2011) *Storytelling and the future of organizations: An antenarrative handbook.* London, England: Routledge.

Bouterie Harmon, R. Fontaine, D. Plews-Ogan, M. Williams, A. (2012) Achieving Transformational Change: Using Appreciative Inquiry for Strategic Planning in a School of Nursing. *Journal of Professional Nursing.* 28 (2), pp.119-124

Boychuk Duchscher, J. Cowin, L. (2004) The experience of marginalization in new nursing graduates. *Nursing Outlook,* 52 (6), pp.289-296

Boyd, N.M. Bright, D.S (2007) Appreciative Inquiry as a Mode of Action Research for Community Psychology. *Journal of Community Psychology,* 35 (8), pp.1019–1036

Boyle, D. Coote, A. Sherwood, C. Slay, J. (2010*) Right Here, Right Now - Taking Co-production into the Mainstream.* London: NESTA.

Bradby, B. (1990) Status passage into Nursing. Another view of the process of socialisation into Nursing. *Journal of Advanced Nursing,* 15 (10), pp.1220-1225

Braun, V. Clarke, V. (2006) Using Thematic Analysis in Psychology. *Qualitative Research in Psychology,* 3, pp.77-101

Briggs, J. (2006) *'Cochrane Qualitative Research Methods Group'*. The Cochrane Collaboration, URL: http://www.joannabriggs.eduau/cqrmg/role.html

Brim, O. G. (1966) Socialization through the life cycle. In O. G. Brim and S. Wheeler (Eds.), *Socialization after childhood: Two essays* (pp. 3-49). New York: John Wiley.

Brim, O. G. Wheeler, S. (1966) *Socialization after childhood.* New York, NY: John Wiley.

Brookfield, S. (1995) *Becoming a critical reflective teacher*. Jossey Bass: San Francisco

Brooks, M.G., Brooks, J.G. (1996) *Creating the Constructivist Classroom*. Course materials from an ASCD workshop by the same title, New Orleans, LA, March 14-15.

Bryman, A. (2001) *Social Research Methods* (2nd. Ed) Oxford: Oxford University Press.

Buckler, S.A. Zien, K.A. (1996) The spirituality of innovation: Learning from stories. *Journal of Product Innovation Management,* 13 (5), pp.391–405

Buchan, J. Seccombe, I. (2011) *A Decisive Decade-Mapping the Future NHS Workforce,* Royal College of Nursing, London

Buerhaus, P.I. Donelan, B. Ulrich, T. Norman, L. Dittus, R. (2006) State of the Registered Nurse Workforce in the United States. *Nurse Economist*, 24 (1), pp.6-12.

Burns, T. (2006) "Hegel, identity politics and the problem of slavery", *Culture, Theory and Critique*, 47 (1), pp.87-104.

Bushe, G.R. (1995) "Appreciative Inquiry as an Organization Development Intervention". *Organization Development Journal*, 13 (3), pp.14-22

Bushe, G. R. (1998) Appreciative inquiry with teams. *The Organization Development Journal.* 16 (3), pp.41-50.

Bushe, G.R. Pitman, T. (1991) "Appreciative process: A method for transformational change". *Organisational Development Practitioner*, 39 (4), pp.1-4.

Bushe, G. (2007) Appreciative inquiry is not about the positive. *Organization Development Practitioner*, *39* (4), 33-38.

Bushe, G.R. (2011) Appreciative inquiry. Theory and Critique. In Boje, D. Burns, B. Hassard. J. (eds) *The Routledge Companion To Organizational Change.* pp.87-103 Oxford: Routledge

Bushe, G. (2013) in E.H. Kessler, (ed) *Encyclopedia of Management Theory*, London: Sage

Caballero, C.L. Walker, A. Fuller-Tyszkiewicz, M. (2011) The work readiness scale (WRS): developing a measure to assess work readiness in college graduates. *Journal of Teaching and Learning for Graduate Employability*, 22 (2), pp.41–54

Caliskan, A. (2010) *Examining job satisfaction burnout and reality shock amongst graduated nurses.* Unpublished Master's Degree. Istanbul

Carlisle, C. Luker, K.A. Davies, C. Stilwell, J. Wilson, R. (1999) Skills competency in nurse education: nurse managers' perceptions of diploma level preparation. *Journal of Advanced Nursing*, 29 (5), pp.1256–1264

Care Quality Commission, (2011) *The operation of the Deprivation of Liberty Safeguards in England 2009/10*, March

Carnell. E. Lodge, C. (2002) *Supporting Effective Learning.* London. Paul Chapman

Carter, B. (2006) 'One expertise among many' – working appreciatively to make miracles instead of finding problems: using appreciative inquiry to reframe research. *Journal of Research in Nursing,* 11 (1), pp.48-63

Carter, B. Cummings, J. Cooper, L. (2007) An exploration of best practice in multi-agency working and the experience s of families of children with complex health needs. What works well and what needs to be done to improve practice for the future? *Journal of Clinical Nursing,* 16 (3), pp.527-539

Carver, L. Candela, L. (2008) Attaining organizational commitment across different generations of nurses. *Journal of Nursing Management,* 16 (8), pp.984-91

Casey, K. Fink, R. Krugman, M. Propst, J. (2004) The graduate nurse experience. *Journal of Nursing Administration*, 34 (6), pp.303-311

Chandler, G.E. (2012) Succeeding in the first year of practice. *Journal for Nurses in Staff Development,* 28 (3), pp.103–107.

Chang, E., Daly, J., Hancock, K., Bidewell, J., Johnson, A., Lambert, V. (2006) The relationship among workplace stressors, coping methods, demographic characteristics, and health in Australian nurses. *Journal of Professional Nursing,* 22 (1), pp.30–38.

Chang, E.M. Hancock, K.M. (2003) Role stress and role ambiguity in new nursing graduates in Australia. *Nursing and Health Sciences,* 5 (2), pp.155-163

Charmaz, K. (1995) Grounded Theory, in Smith, J. Harre, R. and Van Langenhove. (eds) *Rethinking Methods in Psychology*. London: Sage

Charmaz, K. (2006) *Constructing grounded theory: A practical guide through qualitative analysis*. London, England: SAGE.

Chernomas, W.M. Care, W.D. Lapointe McKenzie, J. Guse, L. Currie, J. (2010) 'Hit the ground running': Perspectives of new nurses and nurse managers on role transition and integration of new graduates. *Canadian Journal of Nursing Leadership*, 22 (4), pp.70-86

Chitty, K. K. (2005) *Professional nursing: Concepts and challenges* (4th ed.). St. Louis, MO: Elsevier Saunders.

Cho, J. Laschinger, H. Wong, C. (2006) Workplace empowerment, work engagement and organizational commitment of new graduate nurses. *Nursing Leadership,* 19 (3), pp.43

Christiansen, B. (2008) Good work – how is it recognised by the nurse? *Journal of Clinical Nursing,* 17 (12), pp.1645–1651.

Clark, T. Holmes, S. (2007) Fit for Practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies*, 44 (7), pp.2010-2220

Cleary, M. Horsfall, J. Happell, B. (2009) Transition to psychiatric/mental health nursing programs: Expectations and practical considerations. *International Journal of Mental Health Nursing*, 18 (4), pp.265–273

Cleary, M., Horsfall, J., Jackson, D.E., Muthulakshmi, P. Hunt, G.E. (2013) 'Recent graduate nurse views of nursing, work and leadership', *Journal of Clinical Nursing,* 22, (19-20), pp. 2904-2911.

Cockell, J. McArthur-Blair (2012) *Appreciative Inquiry in Higher Education: A Transformative Force*. San Francisco: John Wiley & Sons

Coghlan, D. Casey, M. (2011) Action research from the inside: issues and challenges in doing action research in your own hospital. *Journal of Advanced Nursing,* 35 (5), pp.674-682

Coghlan, A. T. Preskill, H.Tzavaras Catsambas, T. (2003) An overview of appreciative inquiry in evaluation. *New directions for evaluation*, (100), pp.5-22.

Cohen L. Manion L. Morrison K. (2007) *Research Methods in Education* (6th ed) Routledge, London.

Conklin, J. (2005) *Dialogue mapping: Building shared understanding of wicked problems.* Chichester, UK: Wiley.

Cooperrider, D. L. (1986) *Appreciative Inquiry: Toward a Methodology for Understanding and Enhancing Organizational Innovation.* Unpublished

doctoral dissertation. Department of Organiational Behavior, Case Western Reserve University, Cleveland, Ohio.

Cooperrider, D.L. (1990) Positive image, positive action: The affirmative basis of organizing. In S.Srivastva and D.L. Cooperrider (Eds.), *Appreciative Management and Leadership* (pp.91-125). San Francisco: Jossey-Bass.

Copperrider, D. L. Sekerka, L. E. (2006) *'Toward a Theory of Positive Organizational Change.'* In Gallos, J.V. (ed.) Organization Development: A Jossey-Bass Reader (223-238). San Francisco: Jossey-Bass

Cooperrider, D.L. Srivastva, S. (1987) Appreciative inquiry in organizational life, *Research in organizational change and development*, 1 (1), pp.129-169.

Cooperrider, D.L. Whitney, D. (1998) When Stories Have Wings: How "Relational Responsibility" Opens New Options for Action. In S. McNamee and K. Gergen (Eds.), *Relational Responsibility*. Thousand Oaks, CA: Sage Publications.

Cooperrider, D.L. Whitney, W. (2001) "A positive revolution in change: Appreciative inquiry." *Public Administration and Public Policy,* 87, pp.611-630.

Cooperrider, D.L. Whitney, D. Stavros, J. M. (2003) *Appreciative Inquiry Handbook.* Bedford Heights: Lakeshore Publishers.

Cooperrider, D.L. Whitney, D.D. Stavros, J. (2008) *The Appreciative Inquiry Handbook: For Leaders of Change.* Ohio: Crown Custom Publishing.

Cousin, G. (2010) Positioning postionality: the reflexive turn. Savin-Baden, M. Howell, C. In *New Approaches to Qualitative Research, Wisdom and Uncertainty*. London: Routledge Education.

Cowin, L.S. Hengstberger-Sims, C. (2006) New graduate nurse self-concept and retention: a longitudinal survey. *International Journal of Nursing Studies,* 43 (1), pp.59-70

Cowin, L.S. Jacobsson, D.K. (2003) Addressing Australia's nursing shortage: is the gap widening between workforce recommendations and the workplace? *Collegian*, 10 (4), pp.20-24

Crotty, M. (1998) *The foundation of social research: Meaning and perspectives in the research process.* London: Sage.

Cubit, K. Ryan, B. (2011) Tailoring a Graduate Nurse Program to meet the needs of our next generation of nurses. *Nurse Education Today,* 31 (1), pp.65-71

Delaney, C. (2003) Walking a fine line: Graduate nurses' transition experience during orientation. *Journal of Nursing Education,* 42 (10), pp.437-443.

Dellasega, C. (2009) Bullying amongst nurses. *The American Journal of Nursing,* 109 (1), pp.52–58

Dellasega, C. Gabbey, R. Durdock, K. Martinez-King, N. (2009) An Exploratory Study of Orentation Needs of Experienced Nurses. *The Journal of Continuing Education in Nursing,* 40 (7), pp.311-316

DeLser, D. (2001) "Do you really live here?" Thoughts on insider research. *Geographical Review,* 91 (1/2), pp.441-453

Denscomb, M. (2010) *The Good Research Guide: For Small-Scale Social Research Projects,* (4th ed) Maidenhead, Berkshire: Open University Press.

Denzin, N. K. Lincoln, Y. S. (2005) The Sage Handbook of Qualitative Research (3rd Ed) Thousand Oaks. Sage

Department for Business, Innovation and Skills (2012) *Following Up The Wilson Review of Business-University Collaboration. Next steps for*

universities, business and Government. London: Department for Business, Innovation and Skills.

Department of Health (1999) *Making a Difference: Strengthening the nursing, midwifery and health visiting contribution to health and healthcare*, London: Department of Health

Department of Health (2001) *Working together-learning together: a framework for lifelong learning for the NHS.* London: Department of Health.

Department of Health (2006) *Modernising Nursing Careers: setting the direction.* London: The Stationary Office.

Department of Health (2008a) *High Quality Care for All: NHS Next Stage Review Final Report.* Chair, Lord Darzi. CM 7432. London: The Stationery Office.

Department of Health, (2008b) *A High Quality Workforce: NHS next stage review*, London: Department of Health.

Department of Health (2009) *Preceptorship Framework for Nursing*. London, Department of Health.

Department of Health (2010a) Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health professionals. London: Department of Health.

Department of Health (2010b) *Essence of Care*. London: Department of Health.

Department of Health (2012) *The Francis Report*. London: Department of Health.

Department of Health (2013) Patients First and Foremost The Initial Government Response to the Report of The Mid Staffordshire NHS Foundation Trust Public Inquiry. London: Department of Health.

Dewar, B. Sharp, C. (2006) Using evidence: how action learning can support individual and organizational learning through action research. *Education Action Research*, 14 (2), pp.153-159

Disch, J. (2002) Creating healthy work environments. *Creative Nursing,* 8 (2), pp.3-4.

Draper, J. Sparrow, S. Gallagher, D. (2010) "Crossing the threshold: students' experiences of the transition to staff nurse." Final project report PBPL paper 45.

Drury, V. Francis, K. and Chapman, Y. (2008) Letting go and moving on: A grounded theory analysis of disengaging from university and becoming a registered nurse. *Nurse Education Today,* 28 (7), pp.783-789.

Duchscher, J.B. (2001) Out in the real world: Newly graduated nurses in acute-care speak out. *Journal of Nursing Administration,* 31 (9), pp.426-439.

Duchscher, J.B. (2008) A process of becoming: The stages of new nurse graduate professional role transition, *Journal of Continuing Education in Nursing,* 39 (10), pp.441-450.

Duchscher, J.B. (2009) Transition shock: The initial stage of role adaptation for newly graduated Registered Nurses, *Journal of Advanced Nursing*, 65 (5), pp.1103-1113.

Duchscher, J.E.B. (2012) assessed on 24/06/13 newgraduates@nursingthefuture.ca

Duffield, C.M. Roche, M.A. Blay, N. Stasa, H. (2011) Nursing unit managers, staff retention and the work environment. *Journal of Clinical Nursing*, 20 (1-2), pp.23–33

Dyess, S. Parker, C. G. (2012). Transition support for the newly licensed nurse: a programme that made a difference. *Journal of nursing management*, *20* (5), pp.615-623.

Dyess, S. Sherman, R. (2009) The first year of practice: new graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing,* 40 (9), pp.403–410,

Egan, T.M. Lancaster, C.M. (2005) Comparing appreciative inquiry to action research: OD practitioner perspectives. *Organization Development Journal,* 23 (2), pp.29-49.

Egg, P. Scgratz-Hadwich, B. Trubswasse, G. Walker, R. (2004) *Seeing beyond violence: children as researchers. Children in Columbia, India, Nicaragua, and Thailand. Innsbruck,* Australia: Hermann Gmeiner Akademie

Engebretson, J. Littleton, L. (2001) Cultural Negotiation: A Constructivist-Based Model for Nursing Practice. *Nursing Outlook,* 49 (5), pp.223-230.

Etheridge, S.A. (2007). Learning to think like a nurse: Stories from new nurse graduates. *The Journal of Continuing Education in Nursing,* 38 (1), pp.24-30.

Etherington, K. (2007) Ethical research in reflexive relationships. *Qualitative Inquiry,* 13, (5), pp.599-615

Evans, J. Boxer, E. Sanber, S. (2008) The strengths and weaknesses of transitional support programs for newly registered nurses. *Australian Journal of Advanced Nursing,* 25 (4), pp.16–22

Evetts, J. (2006) Trust and Professionalism: Challenges and Occupational changes. *Current Sociology,* 54 (4), pp.515-531

Faure, M. (2006) Problem solving was never this easy: Transformational change through Appreciative Inquiry. *Performance Improvement,* 45 (9), pp.22-32.

Fay, B (1987) *Critical Social Science.* Polity Press, Cambridge.

Feng, R. Tsai, Y. (2012) Socialisation of new graduate nurses to practising nurses. *Journal of Clinical Nursing,* 21 (13-14), pp.2064-2071

194

Ferguson, L. Day, R. (2007) Challenges for new nurses in evidence-based practice. *Journal of Nursing Management*, 15 (1), pp.107-113

Ferguson, L. (2011) From the perspective of new nurses what do effective mentors look like in practice? *Nurse Education in Practice,* 11 (2), pp.119-123

Finlay, L. Gough, B. (2003) *Reflexivity: a practical guide for researchers in health and social sciences.* Oxford: Blackwell Publishing.

Fitzgerald, L. Ferlie, E. Hawkins, C. (2003) Innovation in healthcare: how does credible evidence influence professionals? *Health and Social Care in the Community*, 11 (3), pp.219-228

Fitzgerald, S.P. Oliver, C. Hoxsey, J.C. (2010) Appreciative inquiry as shad ow process. *Journal of Management Inquiry*, 19 (3), pp.220-233.

FitzGerald, M. Pincombe, J. McCutcheon, H. Evans, D. Wiechula, R. Jordan, Z. (2001) An integrative systematic review of nursing curricula, undergraduate clinical education and transition support for new graduates. Commissioned by Queensland Nursing Council, Adelaide University, Adelaide: Joanna Briggs Institute for Evidence Based Nursing and Midwifery

Forbes, V.J. Jessop, A.L. (2004) From expert to novice: The unnerving transition from experienced RN to neophyte APN. *Journal of Holistic Nursing*, 22 (2), pp.180-185

Francis, R. (2013) The Mid Staffordshire NHS Foundation Trust Public Inquiry. URL http://www.midstaffspublicinquiry.com/ report (Accessed 1/6/2013)

Franco, M. Tavares, P. (2013) "The influence of professional identity on the process of nurses' training: an empirical study", *Leadership in Health Services,* 26 (2), pp.118 – 134

Fredrickson, B.L. (2006) *The broaden and bild theory of positive emotions.* Csikszentmihalyi, M. Csikszentmihalyi, I.S. (eds) A Life Worth Living

Contributions To Positive Psychology build theory of Positive Emotions (85103). New York: Oxford University Press.

Friedson, E. (1986) *Professional Powers: A study of the Institutionalisation of Formal Knowledge.* University of Chicago Press, London

Friere, P. (1970) *Pedagogy of the oppressed*. New York: Continuum.

Frost, N. (2011) *Qualitative research methods in psychology. Combining core approaches.* Berkshire: Open University Press.

Gadamer, H.G. (1979) *Truth and Method (*2nd ed), London: Sheed and Ward.

Gerdes, P. (1998) On culture and mathematics teacher education. *Journal of Mathematics Teacher Education,* 1 (1), pp.33-53.

Gergen, K.J. (1978) "Toward generative theory", *Journal of Personality and Social Psychology,* 36 (11), pp.1344–1360

Gergen, K.J. (1990) Affect and organization in postmodern society. In S. Srivastva and D.L. Cooperrider (Eds.) *Appreciative management and leadership: The power of positive thought and action in organizations* (Rev. ed.). pp.153-174. Euclid, OH: Lakeshore Communications

Gergen, K.J. (1999) An Invitation to Social Construction. Thousand Oaks, CA: Sage Publications

Gergen, K. J. (2009) *An invitation to Social Construction*. Sage: London

Gerrish, K. (2000) Still fumbling along? A comparative study of the newly qualified nurse's perception of the transition from student to qualified nurse. *Journal of Advanced Nursing*, 32 (2), pp.473–480.

Ghaye, T. Lee, S. Shaw, D.J. Chesterfield, G. (2009) When winning is not enough: learning through reflection on the 'best-self'. *Reflective Practice*, 10 (3), pp.385-401.

Giallonardo, L. M. Wong, C. A. Iwasiw, C.L. (2010) Authentic leadership of preceptors: predictor of new graduate nurses' work engagement and job satisfaction, *Journal of Nursing Management*, 18 (8), pp.993-1003

Giddens, A. (1987) *Social Theory and Modern Society*. Oxford: Polity Press

Glaser, B. (1998) *Doing grounded theory: Issues and discussions.* Mill Valley, CA: Sociology Press

Glaser, B, Strauss, A. (1967). *The discovery of grounded theory*. New Brunswick, NJ: Aldine Transaction.

Glen, G. (2009) Nursing education – is it time to go back to the future? *British Journal of Nursing*, 18 (8), pp.498–502

Goleman, D. (1998) *Working With Emotional Intelligence*. London: Bloomsbury Press**.**

Goodman, C. Evans, C. (2006) Using Focus groups chapter in Gerrish K and Lacey A . *The Research Process in Nursing*. Oxford: Blackwell Publishing.

Graneheim, U. H. Lundman, B. (2004). Qualitative content analysis in nursing research: concepts, procedures and measures to achieve trustworthiness. *Nurse Education Today*, 24 (2), 105-112.

Grant, S. Humphries, M. (2006) Critical evaluation of appreciative inquiry. Bridging an apparent paradox. *Action Research,* 4 (4), pp.401-418

Gray, D. E. (2013) *Doing research in the real world*. London: Sage.

Grealish L. Kaye L. (2004) Change and challenge: the implementation of a new model of clinical learning for undergraduate nursing students in a cancer setting. *The Australian Journal of Cancer Nursing,* 5 (2), pp.3–11

Green, J. Draper, A. Dowler, E. (2003) Short cuts to safety: risk and 'rules of thumb' in accounts of food choice. *Health, Risk and Society*, 5, pp33-52

Griffiths, R. (1983) *NHS Management Inquiry.* London: DHSS.

Grundy, S. (1982) Three modes of action research. *Curriculum Perspectives*, 2, pp.23-34

Grundy, S. (1987) *Curriculum: product or praxis?* London: Falmer Press

Guest, G. MacQueen, K. M. Namey, E. E. (2012) *Applied thematic analysis*. Thousand Oaks, CA: Sage.

Haas, B.K., Deardorff, K.U., Klotz, L., Baker, B., Cole- man, J. and Dewitt, A. (2002) Creating a collaborative partnership between academia and service. *Journal of Nursing Education,* 41 (12), pp.518-523.

Haggerty, C. Holloway, K. Wilson, D. (2013) How to grow our own: An evaluation of preceptorship in New Zealand graduate nurse programmes. *Contemporary nurse*, *43* (2), pp.162-171.

Halfer, D. Graf, E. (2006) Graduate Nurse Perceptions of The Work Experience. *Nursing Economics*, 24 (3), pp.150-155.

Hall, J.M. Stevens, P.E. Meleis, A.I. (1994) Marginalizationa guiding concept for valuing diversity in nursing knowledge development. *Advanced Nursing Science,* 16 (4), pp.23–41

Hardy, S. Titchen, A. McCormack, B. Manley, K. (2009) *Revealing Nursing Expertise Through Practitioner Inquiry*, Wiley-Blackwell, Oxford

Hargreaves, A. (1994) *Changing teachers, changing times: Teachers' work and culture in the postmodern age*. New York, NY: Teachers College Press

Harrison-White, K. Simons, J. (2013) Preceptorship: ensuring the best possible start for new nurses. *Nursing children and young people*, *25* (1), pp.24-27

Hart, E. (1996) Action research as a professionalising strategy: issues and dilemmas. *Journal of Advanced Nursing*, 23 (3), pp.454–461

Harter, L. Japp, P. Beck, C. (2005) (eds) *Narratives health and healing: Communication theory, research, and practice.* Mahway NJ: Lawrence Erlbaum

Haslebo, G. Haslebo, M.L. (2012) Practicing Relational Ethics in Organizations. Ohio: A Taos Institute Publication

Hay, K. cited in Mclennen, H. (1996) *Situated Learning Perspectives.* Educational Technology Publications*. New Jersey

Hayajneh, F. (2011) Role model clinical instructor as perceived by Jordanian nursing student. *Journal of Research Nursing,* 16 (1), pp.23-32

Hayman-White, K. Happell, B, Charleston R, Ryan, R. (2007) Transition to mental health nursing through specialist graduate nurse programs in mental health: a review of the literature. *Issues in Mental Health Nursing,* 28 (92), pp.185-200

Henderson, A. Twentyman, M., Heel, A. Lloyd, B. (2006) Students' perception of the psycho-social clinical learning environment: an evaluation of placement models. *Nurse Education Today*, *26* (7), pp.564-571.

Henderson, A. Cooke, M. Creedy D. Walker, R. (2012) Nursing students' perceptions of learning in practice environments: a review. *Nurse Education Today,* 32 (3), pp.299–302.

Hickey, M. (2009) Preceptor perceptions of new graduate nurse readiness for practice. *Journal for Nurses in Staff Development,* 25 (1), pp.35–41

Higgins, G. Spencer, R.L. Kane, R. (2010) A systematic review of the experiences and perceptions of the newly qualified nurse in the United Kingdom. *Nurse Education Today*, 30 (6), pp.499-508

Hillman, L. Foster, R. (2011) The impact of a nursing transitions programme on retention and cost savings. *The Journal of Nursing Management,* 19 (1), pp.50-56

Hodges, H.F. Keeley, A.C. Troyan, P.J. (2008) Professional resilience in baccalaureate-prepared acute care nurses: First steps. *Nursing Education Perspectives*, 29 (2), pp.80-89

Holland, K. (1999) A journey to becoming: the student nurse in transition. *Journal of Advanced Nursing,* 29 (1), pp.229-236.

Holloway, I. (2005) *Qualitative Research in Health Care,* Berkshire: OUP.

Holloway, I. Fulbrook, P. (2001) Revisiting qualitative inquiry: interviewing in nursing and midwifery research. *Nursing Times Research,* 6 (1), pp.539–550.

Holloway, I. Wheeler, S. (2013). *Qualitative research in nursing and healthcare*. John Wiley & Sons.

Holstein, J. A. Gubrium, J. F. (1997) *Active interviewing.* In D. Silverman (Ed.), Qualitative research: Theory, method and practice (pp. 113-129) Sage: London

Hopf, C. (2004) Qualitative Interviews: An Overview IN Flick U., von Kardorff E., Steinke I. (Ed) *A Companion to Qualitative Research.* Sage Publications, London.

Horsburgh, D. Ross, J. (2013) Care and compassion: the experiences of newly-qualified staff nurses. *Journal of Clinical Nursing,* 22 (7/8), pp.1124-1132

Hunt, G. (2004) "The ethics of silence," *Nursing Ethics,* 11 (2), pp.108–109

Hyde, P. Boaden, R. Cortvriend, P. Harris, C., Marchington, M. Pass, S. Sparrow, P. Sibbald, B. (2006) *Improving Health through Human Resource Management: Mapping the Territory*, London: Chartered Institute of Personnel and Development and the Department of Health

Illeris, K. (2003), "Workplace learning and learning theory". *Journal of Workplace Learning.* 15 (4), pp.167-178.

Innovations Center Staff (2008) *Bridging the Preparation Practice Gap.* The Advisory Board Company, Washington, DC

Institute for Public Policy Research and PricewaterhouseCoopers (2010) *Capable Communities. Public Service Reform: The Next Chapter.* London: PriceWaterhouseCoopers.

Isen, A.M. (2000) Positive affect and decision-making. In Lewis, M, Haviland-Jones, J.M. (Eds.) Handbook of Emotions (417-435). NY: Guildford.

James, J. (1992) Care = organisation + physical labour + emotional labour. *Sociology of Health and Illness,* 14 (4), pp.487-509

Jamieson, L. Harris, L. Hall, A. (2012) Providing support for newly qualified practitioners in Scotland. *Nursing Standard,* 27 (2), pp.33-36

Jayne, C. Egan, T. Parker, S. (2005) Learning to be a doctor: Medical educators talk about the hidden curriculum in medical education. *Focus on Health Professional Education,* 7 (2), pp.1-17

Johnson S, Rea RE. (2009) Workplace bullying. *Journal of Nursing Administration,* 39 (2), pp.84-90.

Johnson, C.M. (2001) A survey of current research on online communities of practice. *Internet and Higher Education,* 4 (1), pp.45–60

Johnson, D. Preston, B. (2001) *An overview of issues in nursing education.* Australia Department of Education, Training and Youth Affairs. www.detya. gov.au/highered/eippubs/eip0112fullreport.htm

Johnstone M, Kanitsaki, O. Currie, T. (2008) The Nature and Implications of Support in Graduate Nurse Transition Programs: An Australian Study. *Journal of Professional Nursing,* 24 (1), pp.46-53

Jonsdottir, H. Litchfield, M. Pharris, M.D. (2004) The relational core of nursing practice as partnership, *Journal of Advanced Nursing,* 47 (3), pp.241-250.

Kaihlanen, A. Lakanmaa, R. Salminen, L. (2013) The transition from nursing student to registered nurse: The mentor's possibilities to act as a supporter. *Nurse Education in Practice,* 13 (5), pp.418-422

Kalisch B, Lee H, Rochman M. (2010) Nursing staff teamwork and job satisfaction. *Journal of Nursing Management,* 18 (3), pp.938-947

Kavanagh, T. Stevens, B. Seers, K. Sidani, S. Watt-Watson, J. (2010) Process evaluation of appreciative inquiry to translate pain management evidence into paediatric nursing practice. *Implementation Science,* 5 (90), pp.90-103.

Kearney, K. S. Hyle, A. E. (2004). Drawing out emotions: The use of participant- produced drawings in qualitative inquiry. *Qualitative Research,* 4 (3), pp.361-382.

Kelly, B. (1998) Preserving moral integrity: A follow up study with new graduate nurses. *Journal of Advanced Nursing*, 28 (5), pp.1134-1145

Kelly, J. Ahern, K. (2008) Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing,* 18 (6), pp.910-918

Kelly, J. Ahern, K. (2009) Preparing nurses for practice: a phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing,* 18 (6), pp.910-918.

Kilpatrick, K. Frunchak, V. (2006) The nursing extern program—Innovative strategies for students in transition. *Health Care Manager,* 25 (3), pp.236–242.

Kimberly, H.K. (2007) Clinical competence among senior nursing students after their preceptorship experiences. *Journal of Professional Nursing,* 23 (6), pp.369–375.

King, R. Xia, W. Campbell, J. Sethi, V. (2005) Socialization and organizational outcomes of information technology professionals. *Career Development International,* 10 (1), pp.26-51

Kitzinger, J. (1994) The methodology of focus groups: the importance of interactions between research participants. *Sociology of Health and Illness,* 16 (1), pp.103–21.

Kleiber, P. B. (2004) "Focus Groups: More Than a Method of Qualitative Inquiry." *Foundations for Research: Methods of Inquiry in Education and the Social Sciences*. Kathleen deMarrais & Stephen D. Lapan, eds. Mahwah, NJ: Lawrence Erlbaum. pp.87-102.

Koch, T. (2006) Establishing rigour in qualitative research: the decision trail. *Journal of Advanced Nursing, 53* (1), pp.91-100.

Kostovich, C.T. Thurn, K.E. (2013) Group mentoring: A story of transition for undergraduate baccalaureate nursing students. *Nurse Education Today*, 33 (4), pp.413-418

Kralik, D. Visentin, K. Van Loon, A. (2006). Transition: a literature review. *Journal of Advanced Nursing, 55* (3), pp.320-329.

Kramer M. (1974) *Reality Shock: why nurses leave nursing*. St. Louis: CV Mosby.

Kramer M. Brewer B. Maguire P. (2013a). Impact of healthy unit work environments on new graduate nurses' environmental reality shock. *Western Journal of Nursing Research.,*35 (3), pp.348-383

Kramer, M. Maguire, P. Halfer, D. Brewer, B. Schmalenberg, C. (2013b) Impact of Residency Programs on Professional Socialization of Newly Licensed Registered Nurses *West Journal of Nursing Research,* 35 (4), pp.459-496

Kramer, M. Maguire, P. Halfer, D. Budin, W. Hall, D. Goodloe, L. Klaristenfeld, J. Teasley, S. Forsey, L. Lemke, J. (2012) The Organizational Transformative Power of Nurse Residency Programs. *Nursing Administration Quarterly,* 36 (2), pp.155-168

Kramer, M. Schmalenberg, C. (2008) Confirmation of a Healthy Work Environment. *Critical Care Nurse,* 28 (2), pp.56-63

Kramer, M. Schmalenberg, C. Maguire, P. (2010) Nine structures and best leadership practices essential for a magnetic (healthy) work environment. *Nursing Administration Quarterly*, 33 (1), pp.4-17

Krueger, R. A. (2000) *Analysing and reporting focus group results.* Thousand Oaks: Sage

Lacey, C. (1977) *The Socialisation of Teachers*. London: Methuen

Lancaster, L.C. Stillman, D. (2002) *When Generations Collide: Who They Are. Why They Clash. How to Solve the Generational Puzzle at Work.* New York: Harper Business

Lathlean, J. (1987) Are you prepared to be a staff nurse? *Nursing Times,* 83 (36), pp.25-27

Lauder, W. Watson, W. Topping, K. Holland, M. Johnson, M. Porter, M. Roxburgh, M. Behr, A. (2008) An evaluation of fitness for practice curricula: self-efficacy, support and self-reported competence in preregistration student nurses and midwives. *Journal of Clinical Nursing,* 17 (4), pp.1858-1867

Lave, J. Wenger, E., (1991) *Situated Learning: Legitimate Peripheral Participation.* Cambridge, Cambridge University Press

Lavoie-Tremblay, M. Wright, D. Desforges, N. Gelinas, C. Marchionni, C. Drevniok, U. (2008) Creating a health work- place for new-generation nurses. *Journal of Nursing Scholarship*, 40 (3), pp.290-297.

Lee, Y. W. Dai, Y. T. Park, C. G. McCreary, L. L. (2013). Predicting quality of work life on nurses' intention to leave. *Journal of Nursing Scholarship*, *45* (2), pp.160-168.

Leonard, P. Lawrence, J. Leonard, X (2001) Multiple Perspectives on values. *International Journal of Leadership in Education: Theory and Practice*, 4 (4), pp.383-399

Levett-Jones, T. (2007) Facilitating reflective practice and self-assessment of competence through the use of narrative. *Nurse Education in Practice*, 7 (2), pp.112-119

Levett-Jones T. FitzGerald M. (2005) A Review of Graduate Nurse Transition Programs in Australia, *Australian Journal of Advanced Nursing*, 23 (2), pp.40-45

Levine, J. M. Moreland, R. L. (1998) A history of small group research. In A. Kruglanski & W. Stroebe (Eds.), *Handbook of the history of social psychology*. New York, NY: Psychology Press

Lincoln, Y. S. Guba, E. G. (1985) *Establishing trustworthiness. Naturalistic inquiry*, Beverley Hills CA: Sage

Lindsay, R. Breen, R. Jenkins, A. (2002) Academic research and teaching quality: The views of undergraduate and postgraduate students. *Studies in Higher Education*, 27 (3), pp.41-47

Lipscomb, V. (2010). Intergenerational issues in nursing: learning from each generation. *Clinical Journal of Oncology Nursing, 14* (3), pp.267-269.

Little, J.P. Ditmer, D. Bashaw, M.A. (2013) New graduate nurse residency: a network approach. *Journal of Nursing Administration,* 43 (6), pp.361-6

Lockwood, N. R. (2007) *Leveraging employee engagement for competitive advantage: HR's strategic role* (SHRM Research Quarterly Report). Alexandria, VA: Society for Human Resource Management

Longley, M. Shaw, C. Dolan, G. (2007) *Nursing Towards 2015. Alternative Scenarios for Healthcare, Nursing and Nurse Education in the UK in 2015.* London: NMC

Louis, M. R. (1980) "Surprise and sense-making: What newcomers experience when entering unfamiliar organizational settings." *Administrative Science Quarterly, 23 (2)*, pp.225-251.

Louis, M.R. (1983) "Organizations as culture bearing milieux." In Pondy, et al. (Eds.), *Organizational symbolism.* Greenwich, CT: JAI Press.

Ludema, J. (1996) *Narrative Inquiry*. Unpublished Doctoral Dissertation, Case Western Reserve University, Cleveland, Ohio

Ludema, J.D. Cooperrider, D.L. Barrett, F.J. (2000) *Appreciative Inquiry. The power of the unconditional positive question*. In Reason, P. Bradbury, H. (eds) Handbook of Action Research (189-199) Thousand Oaks, CA. Sage.

Ludema, J. Mohr, B. (2003). *The appreciative inquiry summit: A practitioner's guide for leading large-group change*. San Francisco Berrett-Koehler Publishers.

Ludema, J.D. Whitney, D. Mohr, B.J. Griffin, T.J. (2003). The Appreciative Inquiry Summit. A practitioners guide for leading large group change. San Francisco, CA: Berrett-Koehler

Lundvall, B.A. (ed.) (1992), *National Systems of Innovation: Towards a Theory of Innovation and Interactive Learning,* London: Pinter Publishers

Luthans, F. (2002). The need for and meaning of positive organizational behaviour. *Journal of Organizational Behaviour,* 23 (6), pp.695-706

Maben, J. Macleod Clark, J. (1998) Project 2000 diplomates' perceptions of their experiences of transition from student to staff nurse. *Journal of Clinical Nursing*, 7 (2), pp.145-153.

Maben, J. Latter, S. Macleod Clark, J. (2006) The theory-practice gap: impact of professional-bureaucratic work conflict on newly-qualified nurses. *Journal of Advanced Nursing,* 55 (4), pp.465-477

Maben, J. Latter, S. Macleod, Clark J. (2007) The sustainability of ideals, values and the nursing mandate: evidence from a longitudinal qualitative study. *Nursing Inquiry,* 14 (20), pp.99-113

Macbeth, D. (2001) On reflexivity in qualitative research: two readings, and a third. *Qualitative Inquiry,* 7 (1), ppp.35-68

Mackintosh, C. (2006) Caring: the socialisation of pre-registration student nurses: a longitudinal qualitative descriptive study. *International Journal of Nursing Studies,* 43 (8), pp.953-962.

Manley, K. (2004) "Workplace culture: is your workplace effective? How would you know?" *Nursing in Critical Care*, 9 (1), pp.1-3.

Manley, K. McCormack, B. (2003). Practice development: purpose, methodology, facilitation and evaluation. *Nursing in Critical Care*, 8 (1), 22-29.

Manley, K. Titchen, A. and Hardy, S. (2009) Work-based learning in the context of contemporary health care education and practice: A concept analysis, *Practice Development in Health Care,* 8 (2), pp.87-127.

Mannix, E. Sauer, S. (2006) *Status and Power in Organizational Group Research: Acknowledging the Pervasiveness of Hierarchy*, in Shane R. Thye, Edward J. Lawler (ed.) *Advances in Group Processes. 23*, pp.149-182

Marom, M. Koslowsky, M. (2013) Relationships Between Changes In Role Stressors And The Intention To Quit Among Novice Nurses. *European Journal of Business and Social Sciences,* 2 (1), pp.1-14

Martin, K. Wilson, C. (2011) "Newly registered nurses' experience in the first year of practice: a phenomenological study," *International Journal For Human Caring*, 15 (2), pp.21–27

Martinetz, C. (2002) Appreciative Inquiry as an organisational development tool. *Performance Improvement*, 41 (8), pp.34-39

Mason, J. (2006) *Qualitative Researching* (2nd ed) London: Sage

McCabe, T.J. Garavan, T.N. (2008) "A study of the drives of commitment amongst nurses – the salience of training, development and career issues". *Journal of European Industrial Training,* 31 (7), pp.528-68

McCance, T. and Mcilfatrick, S. (2008) Phenomenology. In: Watson, R. McKenna, H. Cowman, S. and Keady, J. (2008) *Nursing Research: designs and methods.* London: Churchill Livingstone.

McCarthy, D. (1996) *Knowledge as Culture: The New Sociology of Knowledge.* London: Routledge

McCarthy, B. Murphy, S. (2010) Preceptors' experiences of clinically educating and assessing undergraduate nursing students: an Irish context *Journal of Nursing Management,* 18 (2), pp.234–24

McCormack, B. McCance, T. (2010) *Person centred nursing*. Theory and Practice. London: Wiley Blackwell.

McMillan, M. Endacott, R. Gray, M. Jasper, M. Carolyn, M.L. Scholes, S. Webb, C. (2003) Portfolios and assessment of competencies: a review of the literature. *Journal of Advanced Nursing,* 41 (3), pp.283-294

McNamee, S., (2003) Appreciative evaluation within a conflicted educational context, *New Directions for Evaluation,* 100, pp.23-40

Meleis, A.I. (1985) *Theoretical nursing development and progress*. FM. Philadelphia: Lippincott.

Meleis, A.I. Trangestein, P. A. (1994) Facilitating transitions: redefinition of the nursing mission. *Nursing Outlook,* 42 (6), pp.255-259.

Meleis, A.I. Sawyer, L.M. Im, E. Messias, D.K. Schumacher, K. (2000) Experiencing transitions: An emerging middle-range theory. *Advances in Nursing Science*, 23 (1), pp.12-28

Melia, K. (1984) Student nurses' construction of occupational socialisation. *Sociology of Health and Illness,* 6 (2), pp.132-151

Mensik, J. (2007) A view on generational differences from a Generation X leader. *Journal of Nursing Administration,* 37 (11), pp.483–484.

Merriam, S.B. (2002) *Qualitative Research in Practice: Examples for Discussion and Analysis.* San Francisco, Calif: Jossey-Bass.

Merton, R.K, Reader, G.G. Kendall, P.L. (1957) *The student-physician. Introductory studies in the sociology of medical education*, Cambridge: Harvard University Press.

Messersmith, A. (2008) Becoming a nurse: The role of communication in professional socialization (Unpublished PhD thesis). University of Kansas, Kansas.

Meyer, J. (2001) *Lay participation in care in an acute hospital setting.* Portsmouth: Nursing Praxis International.

Meyer, J. (2006) Action Research. In Gerrish, K. and Lacey, A. (eds) *The research process in nursing*. (5th ed). London: Blackwell Publishing. pp.273-288

Mills, J., Bonner, A., Francis, K., (2006) Adopting a constructivist approach to grounded theory: implications for research design, International *Journal of Nursing Practice,* 12 (1), pp.8-13.

Mitroff, I., Kilmann, R. H. (1975) "Stories Managers Tell: A New Tool for Organizational Problem Solving." *Management Review*, 64 (7), pp.18-28

Mooney, M. (2007a) Professional socialization: The key to survival as a newly qualified nurse. *International Journal of Nursing Practice,* 13 (2), pp.75-80.

Mooney. M. (2007b) Newly qualified Irish nurses' interpretation of their preparation and experiences of registration. *Journal of Clinical Nursing,* 16 (9), pp.1610–1617

Moreton-Cooper, A. Palmer, A. (2000) *Mentoring, Preceptorship and Clinical Supervision* (2nd ed). Oxon, Blackwell Science

Morley, M. (2009) Contextual factor that have an impact on the transitional experience of newly qualified occupational therapists. *British Journal of Occupational therapy*, 72 (11), pp.507-514

Morrow, S. (2009) New graduate transitions: leaving the nest, joining the flight. *Journal of Nursing Management*, 17 (3), pp.278-287

Meyrick, J. (2006) What is Good Qualitative Research? A First Step towards a Comprehensive Approach to Judging Rigour/Quality. *Journal of Health Psychology*, 11 (5), 799–808

Myers, M. D. (2009) *Qualitative research in business and management*. London: Sage

Myrick F. Caplan W. Smitten J. Rusk K. (2011) Preceptor/mentor education: A world of possibilities through e-learning technology, *Nurse Education Today,* 31 (3), pp.263-267

National Nursing Research Unit (2009) *Scoping review: Preceptorship for newly qualified nurses: impact, facilitators and constraints.* London. NNRU

Neville, M. (2008) Positive deviance on the ethical continuum: Green mountain coffee as a case study in conscientious capitalism. *Business and Society Review,* 113 (4), pp.555-576

NHS Employers Organisation (2009) *The Role of the Nurse*, Discussion paper 3, http://www.nhsemployers.org/Aboutus/Publications/Documents/The_role_of_the_nurse_di scussion_paper.pdf accessed 1/06/11

Nursing and Midwifery Council (2004), *Fitness to Practice, Rules 2004 SI 2004/1761,* Norwich: The Stationery Office.

Nursing and Midwifery Council (2006) *Preceptorship Guidelines, NMC Circular 21/2006*, London: Nursing and Midwifery Council.

Nursing and Midwifery Council (2007) *The future of pre-registration nursing education – NMC Consultation,* London: Nursing and Midwifery Council.

Nursing and Midwifery Council (2008) *Standards to support learning and assessment in practice.* London: Nursing and Midwifery Council

Nursing and Midwifery Council (2010) *Standards for pre-registration nursing education.* London: Nursing and Midwifery Council.

Olson, M. E. (2009) The "Millennials": First year in practice. *Nursing Outlook*, 57 (1), pp.10-17

Omansky, G.L. (2010) Staff nurses' experiences as preceptors and mentors: an integrative review, *Journal of Nursing Management,* 18 (6), pp.697-703

Orchard, C.A. Curran, V. Kabene, S. (2005) Creating a culture for interdisciplinary collaborative professional practice. *Medical Education Online,* 10 (11), pp.1-13

Page, G. (2005) 'Professional Socialisation of Valuers: What the Literature and Professional Bodies Offer', *International Education Journal,* 5 (5), pp.105-116.

Parahoo, K. (1997) *Nursing Research: Principles, Process, and Issues.* Basingstoke, Macmillan.

Park, J.R. Wharrad, H. Barker, J. Chapple, M. (2011) The knowledge and skills of pre-registartion masters' and diploma qualified nurses: preceptor perspective. *Nurse Education in Practice*, 11 (1), pp.41-46

Parker, V. Giles, M. Lantry, G. McMillan, M. (2012) New graduate nurses' experiences in their first year of practice. *Nurse Education Today*, doi: 10.1016/j.nedt.2012.07.003

Pasupathi, M. Weeks, T. Rice, C. (2006) Reflecting on life: Remembering as a major process in adult development. *Journal of Language and Social Psychology,* 25 (3), pp.244-263

Patton, M.Q. (1990) *Qualitative evaluation and research methods.* 2nd Ed. London: Sage Publications

Patton, M.Q. (2002) *Qualitative Research and Evaluation Methods*. Thousand Oaks, CA: Sage.

Perry, B. (2009) Role modelling excellence in clinical nursing practice. *Nurse Education in Practice,* 9 (1), pp.36-44

Pfaff, K. Baxter, P. Jack, S. Ploe, J. (2013) An integrative review of the factors influencing new graduate nurse engagement in interprofessional collaboration. *Journal of Advanced Nursing,* 70 (1), pp.1-17

Phillips, C. Kenny, A. Esterman, A. Smith, C. (2013) Does the choice of pre-registration paid employment impact on graduate nurse transition: An Australian study. *Nurse education today*. Accessed on line 28/07/13

Pine, R. Tart, K. (2007) Return on Investment: Benefits and Challenges of a Baccalaureate Nurse Residency Program. *Nursing Economics*, 25 (1), pp.13-39

Polit, D.F. Hungler, B.P. (1999) *Nursing Research: Principles and Methods, Appraisal, and Utilisation* (5th ed) Philadelphia: Lippincott

Polit, D.F. Beck, C.T. (2008) *Nursing Research: Generating and Assessing Evidence for Nursing Practice,* (8th ed). New York: Lippincott, Williams, & Wilkins.

Powley, E.H. Fry, R.E. Barrett, F.J. Bright, D.S. (2004) Dialogic democracy meets command and control: Transformation through the Appreciative Inquiry Summit. *Academy of Management Executive,* 18 (3), pp.67–80.

Preskill, H Tzavaras Catsambas, T. (2006) Reframing Evaluation Through Appreciative Inquiry. Sage publications: California

Price, S.L. (2009) Becoming a nurse: A meta-study of early professional socialization and career choice in nursing. *Journal of Advanced Nursing,* 65 (1), pp.11–19.

Procter, N. Beutel, J. Deuter, K. Curren, D. de Crespigny, C. Simon, M. (2011) The developing role of Transition to Practice programs for newly

graduated mental health nurses. *International journal of nursing practice*, 17 (3), pp.254-261.

Pullin, C. (2001) Appreciative Enquiry in Financial Planning and Life'. *Journal of Financial Planning,* 14 (10), pp.52-54

Quinn, C. Clare, L. (2008) Interpretative phenomenological analysis. In R. W. H. McKenna, S. Cowman, & J. Keady (Eds.), *Nursing Research: Designs and Methods.* Edinburgh: Elsevier; pp.375–384.

Race, T.K. Skees, J. (2010) Changing Tides: Improving Outcomes Through Mentorship on All Levels of Nursing. *Critical Care Nursing Quarterly*, 33 (2), pp.163-17

Ramsden, P. (1988) *Improving Learning; new perspectives*, London: Kogan Page

Rance, K. and Grealish, L. (2007) Nursing students' perspectives of learning in the Nursing students' perspectives of learning in the clinical setting of the Dedicated Education Unit. *Journal of Advanced Nursing,* 58 (2), pp.171-179

Randall Andrews, D. (2013) Expectations of Millennial Nurse Graduates Transitioning Into Practice. *Nurse Administration Quarterly,* 37 (2), pp.152-159

Reason, P. Bradbury, H. (2007) *Inquiry and Participation in Search of a World Worthy of Human Aspiration, Handbook of Action Research,* Paul Reason and Hilary Bradbury (eds), Sage Publications, London

Reason, P. and Bradbury, H. (2008) Introduction. In Reason, P. Bradbury, H. (Eds.). *The SAGE Handbook of Action Research: Participative Inquiry and Practice* (Second Edition) (pp. 1-13). London: Sage Publications.

Reed, J. (2007) *Appreciative inquiry: Research for change*. London: Sage: Thousand Oaks.

Reed, J. Pearson, P. Douglas, B. Swinburne, S. Wilding, H. (2002) Going home from hospital: an appreciative inquiry study. *Health and Social Care in the Community,* 10 (1), pp.36–45

Reed, J. Proctor, S. (1994) (eds) *Practitioner research in health care.* London: Chapman Hall.

Regan, S. Thorne, S. Mildon, B. (2009) Uncovering blind spots in education and practice leadership: towards a collaborative response to the nurse shortage. *Nursing Leadership,* 22 (2), pp.30-40

Ritchie, J. Spencer, L. O'Connor, W. (2003) *Carrying Out Qualitative Analysis in Qualitative Research Practice: A Guide for Social Science Students and Researchers,* London: Sage.

Robinson S. Griffiths P. (2009) Scoping Review: Preceptorship for Newly Qualified Nurses: Impacts, facilitators and constraints, London, KCL

Robson, C. (2002), *Real World Research.* 2nd ed. Oxford: Blackwell

Rogers, P. J. Fraser, D. (2003) Appreciating appreciative inquiry. In H. Preskill & A. T. Coghlan (Eds.), *Using appreciative inquiry in evaluation* (pp.75–84). San Francisco, CA: Jossey-Bass.

Rolfe, G. (2006) Validity, trustworthiness and rigour: quality and the idea of qualitative research. *Journal of Advanced Nursing,* 53 (3), pp.304-310.

Rorty, R. (1999) *Philosophy and social hope.* London: Penguin

Rossman, G. B. Rallis, S. F. (2003) *Learning in the field* (2nd ed.).Thousand Oaks, CA: Sage Publications, Inc.

Roth, J. Shanti, A. Leary, M. (2007) Insider action research. *Action Research,* 5 (1), pp.41-60

Royal College of Nursing (2012) *Advanced Nurse Practitioners. An RCN guide to advanced nursing practice, advanced nurse practitioners and programme accreditation.* London: RCN

Runciman, P. Dewar, B. Goulbourne, A. (2002) Newly qualified Project 2000 nurses in Scottish nursing homes: issues for education. *Nurse Education Today,* 22 (7), pp.593-601

Rush, K. McCracken, B. Talley, C. (2009) Nursing students' self-perceptions as insiders in the practice culture. *Nurse Education in Practice,* 9 (5), pp.314-321

Rush, K. L. Adamack, M. Gordon, J., Janke, R. Ghement, I. R. (2013) Orientation and transition programme component predictors of new graduate workplace integration. *Journal of Nursing Management.* Accessed online 01/08/13

Ryan, A. Tilbury, D. Blaze Corcoran, P. Abe, O. Nomura, K. (2010) Sustainability in higher education in the Asia-Pacific: developments, challenges, and prospects. *International Journal of Sustainability in Higher Education,* 11 (2), pp.106-119

Sapsford, R. Jupp, V. (2006) *Data collection and analysis*. London: Sage.

Sarason, S. B. (2004) Big change question: What is needed to resolve the social and critical issues affecting large scale reform? Macro change demands micro involvement. *Journal of Educational Change*, 5 (3), pp.289–302.

Savage, J. (2000) Ethnography and health care. *British Medical Journal*, *321* (7273), p.1400-1402

Savin-Baden, M. Major, C. H. (2004) *Foundations of problem-based learning*. McGraw-Hill International.

Schlossberg, N. K. Waters, E. B. Goodman, J. (1995) *Counseling Adults in Transition: Linking Practice with Theory. New York: Springer Publishing Company*

Scott, E. S. Smith, S. D. (2008) Group mentoring: A transition-to-work strategy. *Journal for Nurses in Staff Development,* 24 (5), pp.232-238.

Scott, E.S. Engelke, M.K. Swanson, M. (2008) New graduate nurse transitioning: Necessary or nice? *Applied Nursing Research,* 21 (2), pp.75-83.

Seale, C. (2007) *Qualitative Research Practice*, London: Sage

Seebohm, P. Barnes, J. Yasmeen, S. Langridge, M. Moreton-Prichard, C. (2010) Using appreciative inquiry to promote choice for older people and their carers. *Mental Health and Social Inclusion,* 14 (4), pp.13–21.

Senge, P. (1990) *The Fifth Discipline. The art and practice of the learning organization*, London: Random House.

Senge, P. Scharmer, C.O. Jaworski, J. Flowers, B. (2004) *Presence. Exploring profound change in people, organizations and society.* London: Nicholas Brealey Publishing

Senge, P. (2005) The theory and practice of the learning organization. Assessed online 9/07/13 http://ww.infed.org/thinkers/senge.htm

Shirey, M.R. (2006) Practice Authentic Leaders Creating Healthy Work Environments for Nursing Nurses. *American Journal of Critical Care,* 15 (3), pp.256-267

Sleegers, P. Kelchtermans, G. (1999) Professional identity of teachers. *Journal of Advanced Nursing*, 24 (3), pp.369–374.

Smith, J.A. Jarman, M. Osborn, M. (1999) *Doing interpretative phenomenological analysis. In Qualitative Health Psychology: Theories and Methods*, pp. 218–240 M. Murray and K. Chamberlain, editors. London: Sage Publications.

Smith, J. Osborn, M. (2004) Interperative Phenomenological Analysis in Breakwell, G. (ed) *Doing Social Psychology Research*. Oxford: Blackwell Publishers

Sole, D. Wilson, D. (1999) "Storytelling in organizations: the power and traps of using stories to share knowledge in organizations", *Training and Development,* 53 (3), pp.44-52

Somekh, B. Lewin, C. (2005) *Research methods in the social sciences.* Thousand Oaks: Sage Publications.

Sumsion, J. (2002) Becoming, being and unbecoming an early children educator: A phenomenological case study of teacher attrition. *Teaching and Teacher Education*, 18 (7), pp.869-885

Taylor, G.W. Ussher, J.M. (2001) Making sense of S&M: a discourse analytic account. *Sexualities,* 4 (3), pp.293-314

Thatchenkary, T. Metzker, C. (2006) *Appreciative Intelligence.* San Francisco: Berret-Koehler.

Thomas, J.W. Thomas, T.J (2006) The Power of Opposite Strengths: making relationships work. Austin, TX: Thomas Concept.

Thompson, S. (2011) Transition into practice. *Journal for Nurses in Staff Development,* 27 (6), pp.266-271

Thryso, L. Hounsgaard, L. Bonderup Dohn, N. Wagner, L. (2012) Newly qualified nurses – Experiences of interaction with members of a community of practice, *Nurse Education Today,* 32 (5), pp.551-555

Titchen, A. Manley, K. (2006) Spiralling towards transformational action research: Philosophical and practical journeys. *Educational Action Research,* 14 (3), pp.333-356

Tobin, G. Begley, C. (2004) Methodological rigour within a qualitative framework. *Journal of Advanced Nursing,* 48 (4), pp.388-396

Tourangeau, A.E. Cummings, G. Cranley, L.A. Ferron, E.M. Harvey, S. (2010) Determinants of hospital nurse intention to remain employed: broadening our understanding. *Journal of Advanced Nursing*, 66 (1), pp.22-32

Trajkovski, S. Schmied, V. Vickers, M. Jackson, D. (2013) Implementing the 4D cycle of appreciative inquiry in health care: a methodological review. *Journal of Advanced Nursing,* 69 (6), pp.1224-1234

Troxel, J. (2002) Appreciative Inquiry: an action research method for organizational transformation and its implications to the practice of group process facilitation. Partner, Millennia Consulting, LLC (Online) http://www.Consultmillenia.com/documents/ApprecativeInquiry   pdf Accessed, 24/12/2012.

Tuckman, B. (1965) "Developmental sequence in small groups". *Psychological Bulletin,* 63 (6), pp.384–99

Twycross A. (2002) Educating nurses about pain management: the way forward. *Journal of Clinical Nursing,* 11 (6), pp.705-714

Ulrich, B. Krozek, C. Early, S. Ashlock, C. H. Africa, L. M. Carman, M. L. (2010) Improving retention, confidence, and competence of new graduate nurses: results from a 10-year longitudinal database. *Nursing economics*, *28* (6), pp.363-375.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting (1986) *Project 2000: A new preparation for practice*. London: UKCC.

United Kingdom Central Council, Midwifery and Health Visiting (1993) *The Council's position concerning a period of support and preceptorship. Registrar's letter*, 1/1193. London, UKCC.

United Kingdom Central Council for Nursing, Midwifery and Health Visiting. (1999) *Fitness for Practice*. London: UKCC

Vygotsky, L. (1978) *Mind in society*. Cambridge, MA: Harvard University Press.

Walker, A. Earl, C. Costa, B. Cuddihy, L. (2013) Graduate nurses' transition and integration into the workplace: A qualitative comparison of graduate nurses' and Nurse unit Managers' perspectives. *Nurse Education Today*, 33 (3), pp.291-196

Wangensteen, S. Johansson, I.S. Nordstrom, G. (2008) The first year as a graduate nurse – an experience of growth and development, *Journal of Clinical Nursing*, 17 (14), pp.1877-1885.

Watkins, J. Mohr, B. (2001) *Appreciative Inquiry: Change at the speed of imagination.* San Francisco: John Wiley & Sons, Inc.

Weber, S. Mitchell, C. (1996) Drawing ourselves into teaching: Studying the images that shape and distort teacher education. *Teaching and Teacher Education,* 12 (3), pp.303–313.

Weisbord, M. (1994) Discovering Common Ground. San Francisco Berrett-Koehler Publishers

Wenger, E. (1998) Communities of Practice. *Learning Meaning and Identity* (sixth ed.), Cambridge University Press, Cambridge

Wenger, E. (1999) *Communities of Practice: learning, meaning and Identity.* New York: Cambridge University Press

Wenger, E. (2000) Communities of practice and learning systems. *Organization*, 7, (2), pp.225-246

Whitehead, B. Holmes, D. (2011) Are newly qualified nurses prepared for practice? *Nursing Times*, 107 (19-20), pp.20-23

Whitehead, B. Owen, P. Holmes, D. Beddingham, E. Simmons, M. Henshaw, L. Barton, M. Walker, C. (2013) Supporting Newly Qualified Nurses in the UK: A Systematic Literature. *Nurse Education Today*, 33 (4), pp.370-377

Whitney, D. (2004) Appreciative inquiry and the elevation of organizational consciousness. *Advances in appreciative inquiry*, 1 (1), pp.125-145.

Whitney, D. Trosten-Bloom, A. (2003) *The power of appreciative inquiry: A practical guide to positive change*. San Francisco, CA: Berrett Koe

Wieland, D.M. Altmiller, G.M. Dorr, M.T. Wolf, Z.B. (2007) Clinical transition of baccalaureate nursing students during preceptored, pregraduation practicums. *Nursing Education Perspective,* 28 (6), pp.315-321

Willig, C. (2001) *Qualitative Research in Psychology.* Buckingham: Open University Press.

Wilson, L. L. Bodin M B, Hoffman J, Vincent J (2009) Supporting and retaining preceptors for NNP Programs. *Journal Perinatal Nursing,* 23 (3), pp.284-292.

Winfield, C. Melo, K. Myrick, F. (2009) Meeting the challenge of new graduate role transition. Clinical nurse educators leading the change. *The Journal for Nurses in Staff Development,* 25 (2), pp.E7-13.

Wing, T. Regan, S. Spence Laschinge, H. (2013) The influence of empowerment and incivility on the mental health of new graduate nurses. *Journal of Nursing Management*, pp 1-12 accessed online 04/12/13

Winter, R, Munn-Giddings, C. (2001) *A Handbook for Action Research in Health and Social Care.* London: Routledge

World Health Organization (2006) *Working together for health*. Geneva: World Health Organization

Yang, J.T. (2008) Effect of newcomer socialisation on organisational commitment, job satisfaction, and turnover intention in the hotel industry. *The Service Industries Journal*, 28 (4), pp.429-443.

Zandee, D. P. Cooperrider, D. L. (2008) Appreciable Worlds, Inspired Inquiry. In P. Reason H. Bradbury (Eds.). *The SAGE Handbook of Action Research: Participative Inquiry and Practice* (Second Edition) (pp. 190-198). London: Sage Publications.

Appendix 1: Duchscher (2008) The stages of transition theory

Redacted due to copyright
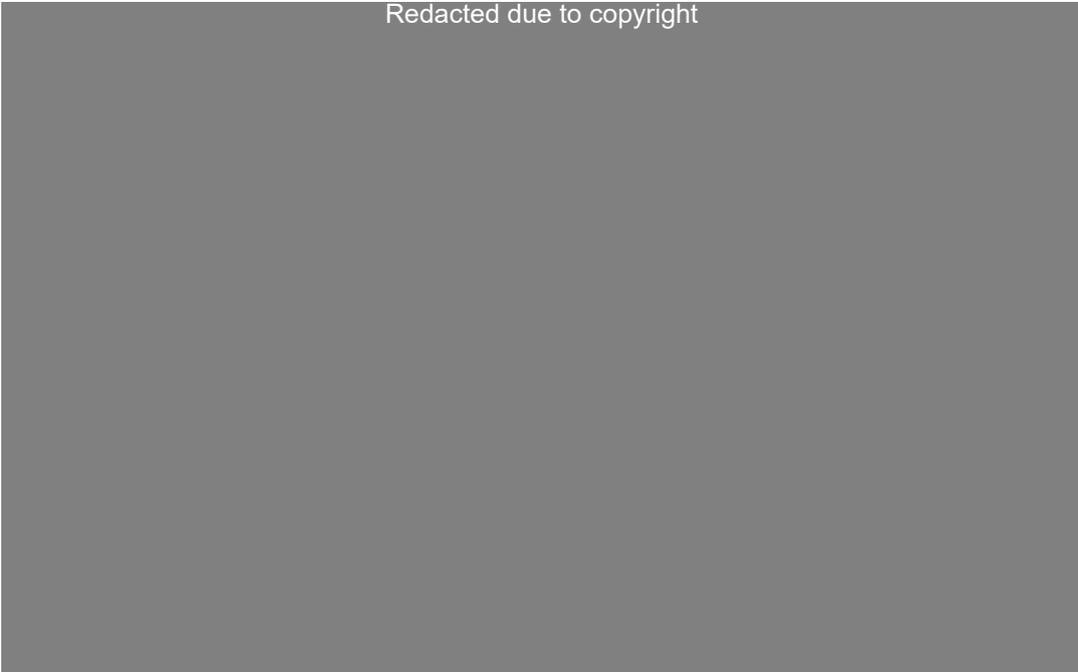
Appendix 2: Mini-Summit Event

Appreciative inquiry open space event – 25th June 2012

Appreciative inquiry open space event – 25th June 2012
Research question:

What constitutes *support* in meeting the needs of the neophyte registered nurse and the Healthcare organisation during the transition period?

Aims to:

A. Explore the concept of *support*, identifying what *support* involves when aligning the needs of the neophyte registered nurse and the Healthcare organisation during the transition period.
B. Examine the nature of *support; a*nd its relationship with cultural, social, personal, and work values, in creating a professional identity.

Workshop aim

Appreciative inquiry creates a framework to recognise and value the strengths and successes of an experience. In this case the transition period and the support mechanisms which have enhanced it. We will explore the assets and the potentials. The basic idea is to build organisations around what works, rather than trying to fix what doesn't. The approach is inclusive and acknowledges the contribution of you all. The method aims to create meaning by hearing your stories of successful experiences.By appreciating and inquiring we are able to combine a powerful approach to organisational change, and understanding. The workplace is recognised as a key area for gaining knowledge. This forum provides a positive platform for the experiences that give life within the organisation with a working understanding of its needs to share this experience.

Ground rules: norms, start and end on time, any question is a good question, treat each other respectfully, everyone is a learner, everyone is a teacher.

I want to explore the concept of support and how we align the needs of the team and the individual. The afternoon will work through the four D process

which is a framework exclusive to AI; **Define, discovery, Dream, Design.** Activities will be set for each stage of the process.

- **Any questions?**

The ultimate aim: the creation of a shared meaning of transition support

Identification of values, self, work and department/organisation

Opening activity - 20 mins

On a post-it please answer the following questions

Yellow post-it

1. What makes you feel part of/and valued within the team that you work in now?

Green Post-it

2. What does the word support mean to you (as a manager/NRN) POST-ITS

Pink Post-it

3. Identify a positive element of a career transition

Activity 2 - 10 mins

Discovery: Identifying the best of what is. This stage of the inquiry aims to both undertake an evaluation of the now experience and explore the possible through the positive.

You are invited to draw a picture individually of a positive supportive workplace experience when you felt absolutely at your best working as/with a newly registered nurse.

Activity 3 - 40mins

Working in independent participant groups (3/4's) to identify interpretations.

- Group: share your thoughts and interpretations about one another's picture, discuss the key themes and record them on flip chart. Identify a spokesperson to feed back. Then allow the individual to

talk about their picture about the high elements of their transition and the happy surprises.

- What do your pictures identify support during transition to be?

- What are the values for self, work and organisation that have come from this?

- Create a vision for transition

1. what was the most important story that came out of the discovery phase?
2. what have you learnt/felt so far?
3. list 1-3 themes or root causes of success explored today that have resonated with you?
4. which stories/strengths do you want to see preserved?
- Note what elements contributed to that success? (Put one element per post-it.)
Post elements on flip chart.

Activity 4 - Come together as a large group to discuss – 30 mins
Begin discussion with the following points:
- What can be said about the elements and clusters?
- What stands out? What has worked?
- Who and what is involved?
- What can we conclude from this activity?

- Point out that if we were an organization or community, we would have just created a list of internal resources upon which to build in the future.

Ask: How do we know we can recreate these situations? (Have done it once, can do it again)

Review - What is support, what are our best experiences of it working well?

Refreshments 15 mins

Remind participants that this phase builds upon what was "discovered" during the first stage of AI. So, it is important at this point to review strengths and themes from the DISCOVERY Stage.

Activity 5 – 40 minutes. Small group discussion and development of composite vision; 10 minutes to present; 10 minutes for questions and answers regarding the vision.

Dreams: We have just won the health and social care quality award for supporting new staff to the workplace.

- What has been said about the award as it is presented?
- What are the employers saying?
- What are the employees saying?
- What did it take to win the award?

Using the themes from the discovery stage explore the group dream

Groups:

Orange	Green	Yellow
Hilda (M2)	Janet (M4)	Dot (N4)
Cassie (N3)	Elsie (N5)	Marcia (M7)
Betty (N2)	Lucy (M6)	Gina (M1)
Kate (M5	Ada (N1)	Nadia (M8)

Participants meet in groups of 4/5 persons.
Identify a spokesperson and work through.

- In the small groups, all should LISTEN as each person describes her vision.
- Discuss similarities and differences – also note unique or unusual points.

225

- Using symbols, drawings, and words, each group should make a composite picture of their shared vision. Try to capture as many ideas in your picture as possible.
- Prepare to present back to the larger group.

After all have presented, begin a discussion with the following questions.

- What main ideas emerge from the visions?
- Do they reinforce existing strengths?
- How do the visions differ?
- Who are the stakeholders?
- Are significant aspects missing?
- Are the visions challenging, yet realistic?
- Achievable?
- Heavily dependent on outsiders?
- Does a shared "vision" emerge?

Engage the group in writing Provocative Propositions (Possibility Statements).

Activity 6 - 30 mins

Design: Full group participation
Making support real and consistent throughout the organisation.
Realising the dream

Appendix 3: Field notes

Define:

What does the word support mean to you?

NRN	Senior Nurse Manager
-Back up, someone to ask advice from, role model, someone that offers an opinion not bias -Where everyone works together to help each other improve their weaknesses and encourage/learn from strengths -Able to discuss issues/problems with senior managers where they agree/support my decisions -Firstly the person that you are seeking support from needs to be approachable. -Good support network -Being there for advice, allowing me to carry out my role and help reflect on difficult situations.	-To have a network of people who you can go to and discuss all aspects of everyday working good and bad -Included as part of the team -Supporting staff means listening, offering advice, providing extra staff if needed support for me means receiving positive feedback so I now I am on the right path -Open listening, encouraging challenging being there for each other -Network of people you can go to if you have a problem or need advice. People that are encouraging -Being listened to and valued -Being listened to working together to find solutions to problems. -Being offered advice, being encouraged to make decisions

What makes you feel part of/and valued within the team that you work in now?

NRN	Senior Nurse Manager
-Supported and encouraged -Supportive group of staff with a shared sense of a team Hard working, caring, fun, interested -Feedback from staff being in a position to offer advice and support. -Feeling that you are helping in some way. -Team work, working relationships, inclusion -Feeling wanted and needed.	-Listened to and accepting my decisions -Staff able to discuss issues/problems and also share good experiences, support each other -Team worker, friendly comments -Supportive ward environment, training, positive relationships -Share thoughts and ideas, comfortable, care for each other -A kind word of appreciation from members of staff a thank you -Being thanked being listened to being questioned

Appendix 3 continued

Identify a positive element of a career transition.

NRN	Senior Nurse manager
-Support offered from other managers and ward sisters -Respect/valued for what I do -Great mentor during preceptorship -To have gained a degree which enables me to support my practice on a day to day level, achievement -Preceptorship support from line manager, colleagues and team	-Strength of character, development, social skills -Broadening of knowledge – professional development -As newly appointed grade 6 having support of ward staff at meetings -Developing my confidence and communication skills, allowing me to goal set -Encouragement and supportive environment from colleagues -Feeling part of a working team -Constructive feedback. -Having a mentor other support network and colleagues

Appendix 3 continued Discovery Field Notes Collective Group feedback

Key learning	Root causes of success
Skill mix – balancing time with support Allowance for preceptee Understanding the needs versus the resources (core skills) Enabling NRN to move forward The need for self-awareness Relationship of trust Nature/nurture A need for a skill cluster for each area to identify to standards The art of nursing	Rounded team with a shared philosophy Tasks and standards Cultural influences Organisational needs analysis for NRN to complete A mentor who can empathise preparing the preceptors Understanding the curriculum
Stories to preserve and build on Organisational values – standards Structured pathways at present tick box rather than knowledge (not situated or embedded superficial/surface) Positive working environment – planning doing, evaluating Aligning mentor to NRN needs – constantly reviewing the process Clinical supervision Preparing the preceptor	**Important story** Racing to achieve Risk adverse – understanding the enormity Being an active participant in an understanding environment Benchmark experience by certain stage Positive outcomes Self-awareness Feeling equal – needed Right people involved and time Skills lab Clinical supervision Communication interaction and empathy Helping people feel valued – understanding who they are Helping people feel valued Respect for each other – what skills NRN has Understanding the expectations and the ability of NRN Joining very established team Routine and mastery Trust – values – encourage

Appendix 3 continued - Dream Field notes flip chart representing the outcome from the three groups

Orange Group	Green Group	Yellow Group
1.Innovative Evidence based Cost effective and efficient Patient focused/staff focused – island life childcare, terms and conditions Patient and staff are at the heart of what we do **2** increase recruitment and retention Increase staff satisfaction reduce sickness reduce stress – happier working environment Increase motivation increase safety – happier patients – increase outcomes Reduce risk – governance **3** we are happy, motivated, positive, autonomous enthusiastic and safe practitioners. Jersey preceptorship scheme is fantastic. **4** collaborative working Shared vision Following living (living) the dream	**1** prestigious Joint achievement Exemplary core standards Good representation of organisation 'Going the extra mile' for NRN – part of the team/NRN pre-empted/organised/individual/personal/social prep **2** wonderful organisation Pride ourselves on forward thinking Top of the range/state of the art/latest technology Highly skilled workforce Increased ratio degree nurses: patient care No recruitment/retention problems Exceptional educational facilities **3.** valued, encouraged Excellent conditions/pay Pension, medical/dental care Exceptional skill mix Good staff: patient ratio Annual Christmas bonus Increased standards of care **4** time, long hard work/feedback – patient/questionnaires reviewing services MDT and public committees Dedication Network with the JEP Research EBP Cost effective Recruited increased skills Strategic plan (Happy hospital drawing)	**1** Excellence, commitment, follow through, above and beyond, resources, cutting edge, envy, evidenced based **2.** Very happy, result of hard work, staff development - encourage retention whole workforce fit for purpose benchmarked. Aim to improve and evaluate **3** team effort, wide spread support valued user friendly ownership pride Sense of achievement, professional development Acceptance investment worthy evidence based **4** commitment, user group consultation, parameters. Research global pilot suitable handpicked change system

Appendix 3 continued Dream field notes continued

<u>Collective Group Feedback Dream</u>

Organised for arrival
Positive culture
Strategic plan – appraisal – increment – enhancement/standards/clinical supervision
Staff active participants
Hospital childcare – added staff advantages
Inclusive
Rewarding the mentor
Engaging NRN within the workplace/organisation (challenging)
New motivation new challenges
Resources

Design Field notes

<u>Collective Group Feedback Design</u>

Short term – focus groups of NRN staff/preceptors focus group/managers focus group on what it should look like

Listen to employees – working party
Interactive programme
elearning/wbl/education/projectworking/clinicalsupervision/standards/mandatory training/network for NRN
WEB design
Learning contact with manager and preceptor sign up
Preparing preceptors/workforce
Creating protected time.

Appendix 4: Participant Information Sheet, consent form and invitation letter to senior nurse managers

Nurse Manager

Researcher: Jenny Child

November 2011

13.11.10 V3

Research Title: Creating partnership; understanding and managing the role of *support* in aligning the needs of both the neophyte graduate staff nurse and the healthcare Service organisation during the transition period from newly registered to proficient nurse.

Dear participant

I would like to invite you to take part in a research study that I am undertaking. Before you decide to participate I would like to ensure that you understand what the research is about and how it will involve you. Please take time to read the attached information carefully, and discuss it with others if you wish. If you have any questions or want to know more, please do not hesitate to get in contact with me.

Should you wish to join this study after reading the information below, could you please complete the consent form on the last page giving your contact details. I aim to recruit six staff nurses who have graduated for nine to eighteen months, and six nurse managers.

Yours sincerely

Jenny Child
Lecturer
Researcher: Jenny Child
Institution: University of the West of England
Tel: 0117 328 8459
Email: Jenny.Child@uwe.ac.uk;

Creating partnership; understanding and managing the role of *support* in aligning the needs of both the neophyte graduate staff nurse and the NHS organisation during the transition period from newly registered to proficient nurse

Who am I?

I am a senior lecturer at the University of the West of England. I am undertaking this research as part of my Professional Doctorate in Health and Social Care supervised by Dr Brenda Clarke ▉▉▉▉▉▉▉ and Dr Kathy Pollard ▉▉▉▉▉▉▉.

Your participation in this study would be greatly valued; however, you are not required to participate and this will not affect your current or future career prospects in any way.

Background

What is the purpose of the study?

Moving from student to graduate staff nurse is a transitional period that is well recognised to be challenging. Despite the abundance of international literature over the past three decades demonstrating key issues, the experience of the graduate staff nurse does not appear to have positively changed. Nevertheless, support is known to play a crucial role during this period

Support is commonly provided in the form of preceptorship, and is currently high on the policy agenda. The Next Stage Review of the NHS (DH 2008) and Nursing and Midwifery Council's consultation on pre-registration education (NMC 2008) recommend preceptorship as a mandatory support period for the new graduate nurse. The NMC introduced preceptorship in 2004 to give newly registered nurses the opportunity to gain experience through 'one-to-one' support, having the advantage of a role model in practice for up to four to six months post-registration (Maben et al 2006). The rationale for this support period is that it will improve patient care by assisting new practitioners in developing clinical skills and encouraging workforce retention by supporting students in the transition to registered practitioner.

Why have you been invited to take part?

You have been invited to take part in this study because you are a nurse manager, working with new graduate staff nurse and have the experience to inform this research study.

What is involved in taking part in this research?

If you wish to be part of this research and are accepted you will be invited to attend a focus group. This meeting will be facilitated by the researcher and will explore the positive joint experiences of the new graduate staff nurse and senior nurse manager. The focus group will incorporate both the new graduate staff new nurse and the senior nurse manager participant groups. The new graduate staff nurse and nurse manager will undertake the first

aspect of meeting in their own specialist groups, after this the two participant groups will work together through the remainder of the focus group. This focus group will take approximately 3-4 hours and will be conducted in June 2012. The aim of the focus group is to identify the key learning issues that you have experienced when supporting the new graduate staff nurse. The researcher will ensure that both participant groups are comfortable with the joint participative working and that ground rules are set to ensure that a safe and trusting environment is maintained throughout the focus group experience. The researcher will ensure that all data gathered at the focus group will maintain your anonymity, and at no point will you be asked for information that could identify you.

Cooperrider and Srivastva's (1987) 4 D model will be followed to structure the focus group, taking the research through four aspects of inquiry. The first stage is Discovery, where the participant will engage in storytelling and sharing experiences of what has worked well in supporting the new graduate staff nurse. The second stage is Dream, envisioning what might be. Participants create a visioning statement linking the past Discovery experience of good practice to the Dream of even greater opportunity. The third stage is Design, identifying what is needed to create an ideal outcome to make the Dream reality. Finally, the fourth stage is Destiny, co-constructing the future, developing a strategy to manage the implementation.

If you wish to take part in this research study, could you initial each question and sign the attached consent letter. Although your participation in this study is extremely valuable to us, you can withdraw from the study at any stage through contacting the research team. If you have any questions about the study, or would like more information please feel free to contact my supervisors or myself.

Where will the focus group take place?
You will be contacted by the independent researcher and a mutually convenient meeting date and time will be given to you, the focus group will take place on the North Bristol Trust site. No travel costs will be paid.

What are the possible benefits and risks of taking part?
The possible benefits of participating in this research study is to positively inform the development of a collaborative partnership between one local NHS organisation and the Faculty of Health and Life Sciences, UWE in managing the support needs of both the new graduate staff nurse and the NHS organisation during the transition period. This is a challenging time for the new graduate staff nurse and the organisation, and therefore a new technology, techniques and emerging relationships are requiring a skilled and flexible workforce and understanding the cultural changes within hybrid imaging environments will provide a strategic overview for future patient services.

However, it is important to acknowledge that reflecting on your own working practice might stimulate feelings or experiences which are upsetting. Please contact your Trust counselling service if this should occur through the North Bristol Trust website, contacting your occupational health/Human Resources. Alternatively contact my Director of Studies (Brenda Clarke ▇▇▇▇▇▇▇▇) should you feel that the research has been conducted in harmful way.

Will my identity be protected?

Yes, all research data will be processed and stored safely in accordance with the Data Protection Act (1998). Individual participant research data, focus group interviews will be anonymous and given a research code. Any information which could identify you from the focus group transcripts will be removed so that you cannot be recognised. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher.

Thank you for taking the time to read this information.

![University of the West of England, Bristol logo]

Participant Number

Manager Consent Form
13/11/10v3

Research Title: Creating partnership; understanding and managing the role of *support* in aligning the needs of both the neophyte graduate staff nurse and the Healthcare Service organisation during the transition period from newly registered to proficient nurse.

Please initial each box and sign below.
1) I confirm that I have read and understood the participant information sheet dated [Date to be inserted here] for the above study.

2) I have had the opportunity to read the information sheet and, ask questions and have had any such questions answered to my satisfaction.

3) I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason, without affecting my career prospects

4) I agree to participate in the focus group & the use of digital recording equipment

5) I understand that direct quotes from digital recordings taken from the focus groups may be used in the doctoral thesis and publications, however, these will be anonymised and no individual participant will be identifiable.

6) I understand that the findings from the study will be shared within the nursing profession through external publication and conferences

7) I agree to take part in the above study

_____   _____   _____
Participants name   Date   Signature
_____   _____   _____
Researchers name   Date   Signature
When completed, one copy for the research participant and one copy for the researcher site file

236

Appendix 5: Participant Information Sheet, consent form and invitation letter to Neophyte Registered Nurses

NRN

Researcher: Jenny Child

November 2011

13.11.10 V3

Research Title: Creating partnership; understanding and managing the role of support in aligning the needs of both the neophyte graduate staff nurse and the healthcare Service organisation during the transition period from newly registered to proficient nurse.

Dear participant

I would like to invite you to take part in a research study that I am undertaking. Before you decide to participate I would like to ensure that you understand what the research is about and how it will involve you. Please take time to read the attached information carefully, and discuss it with others if you wish. If you have any questions or want to know more, please do not hesitate to get in contact with me.

Should you wish to join this study after reading the information below, could you please complete the consent form on the last page giving your contact details. I aim to recruit six staff nurses who have graduated for nine to eighteen months, and six nurse managers.

Yours sincerely

Jenny Child
Senior Lecturer
Researcher: Jenny Child
Institution: University of the West of England
Tel: 0117 328 8459
Email: Jenny.Child@uwe.ac.uk;

237

<u>Research Title:</u>

Creating partnership; understanding and managing the role of support in aligning the needs of both the neophyte graduate staff nurse and the NHS organisation during the transition period from newly registered to proficient nurse

Who am I?
I am a lecturer at   General Hospital. I am undertaking this research

as part of my Professional Doctorate in Health and Social Care supervised

by Dr Brenda Clarke (███████████) and Dr Kathy Pollard (███████

██████).

Your participation in this study would be greatly valued; however, you are not required to participate and this will not affect your current or future career prospects in any way.

Background

What is the purpose of the study?

Moving from student to graduate staff nurse is a transitional period that is well recognised to be challenging. Despite the abundance of international literature over the past three decades demonstrating key issues, the experience of the graduate staff nurse does not appear to have positively changed. Nevertheless, *support* is known to play a crucial role during this period

Support is commonly provided in the form of preceptorship, and is currently high on the policy agenda. The Next Stage Review of the NHS (DH 2008) and Nursing and Midwifery Council's consultation on pre-registration education (NMC 2008) recommend preceptorship as a mandatory support period for the new graduate nurse. The NMC introduced preceptorship in 2004 to give newly registered nurses the opportunity to gain experience through 'one-to-one' support, having the advantage of a role model in practice for up to four to six months post-registration (Maben et al 2006). The rationale for this *support* period is that it will improve patient care by assisting new practitioners in developing clinical skills and encouraging workforce retention by supporting students in the transition to registered practitioner.

Why have you been invited to take part?
The research is exploring the positive experiences of the new graduate staff nurse and the nurse manager. Therefore you have been invited to take part in this study because you have become a graduate staff nurse within the last nine to eighteen months, and have the experience to inform this research study.

What is involved in taking part in this research?
If you wish to be part of this research and are accepted you will be invited to attend a focus group. If you agree to participate in this research you will be

invited to join a focus group with other recently graduated staff nurses. The purpose of the focus group is to obtain your views and positive experiences of your own transition period to registered practitioner. Simultaneously a group of nurse managers (potentially one of yours) will also be in the focus group exploring the same themes from the managerial perspective. The new graduate staff nurse and nurse manager will undertake the first aspect of meeting in their own specialist groups, after this the two participant groups will work together through the remainder of the focus group. This focus group will take approximately 3-4 hours and will be conducted in March/April 2011. The aim of the focus group is to identify the key learning issues that you have experienced when supporting the new graduate staff nurse. The researcher will ensure that both participant groups are comfortable with the joint participative working and that ground rules are set to ensure that a safe and trusting environment is maintained throughout the focus group experience. The researcher will ensure that all data gathered at the focus group maintains your anonymity, and at no point will you be asked for information that could identify you.

Cooperrider and Srivastva's (1987) 4 D model will be followed to structure the focus group, taking the research through four aspects of inquiry. The first stage is Discovery, where the participant will engage in storytelling and sharing experiences of what has worked well in supporting them into their staff nurse role. The second stage is Dream, envisioning what might be. Participants create a visioning statement linking the past Discovery experience of good practice to the Dream of even greater opportunity. The third stage is Design, identifying what is needed to create an ideal outcome to make the Dream reality. Finally, the fourth stage is Destiny, co-constructing the future, developing a strategy to manage the implementation.

If you wish to take part in this research study I ask if you could initial each question and sign the attached consent letter. Although your participation in this study is extremely valuable to us, you can withdraw from the study at any stage through contacting the research team. If you have any questions about the study, or would like more information please feel free to contact my supervisors or myself.

When and where will the focus group take place?
You will be contacted by the independent researcher and a mutually convenient meeting date and time will be given to you, the focus group will take place on the North Bristol Trust site. No travel costs will be paid. The focus group will take approximately 3 – 4 hours and will be conducted in March/April 2011

What are the possible benefits and risks of taking part?
The possible benefits of participating in this research study is to positively inform the development of a collaborative partnership between one local NHS organisation and the Faculty of Health and Life Sciences, UWE in managing the support needs of both the new graduate staff nurse and the NHS organisation during the transition period. This is a challenging time for the new graduate staff nurse and the organisation, and therefore a new technology, techniques and emerging relationships are requiring a skilled and flexible workforce and understanding the cultural changes within hybrid imaging environments will provide a strategic overview for future patient services.

However it is important to acknowledge that reflecting on your own working practice might stimulate feelings or experiences which are upsetting. Please contact your Trust counselling service if this should occur through the North Bristol Trust website, contacting your occupational health/Human Resources. Alternatively contact my Director of Studies (Brenda Clarke ████████████) should you feel that the research has been conducted in harmful way.

Will my identity be protected?

Yes, all research data will be processed and stored safely in accordance with the Data Protection Act (1998). Individual participant research data, focus group interviews will be anonymous and given a research code. Any information which could identify you from the focus group transcripts will be removed so that you cannot be recognised. A master list identifying participants to the research codes data will be held on a password protected computer accessed only by the researcher.

Thank you for taking the time to read this information.

NRN Consent Form   Participant Number ☐
13/11/10v3

Research Title: Creating partnership; understanding and managing the role of *support* in aligning the needs of both the neophyte graduate staff nurse and the Healthcare Service organisation during the transition period from newly registered to proficient nurse.

Please initial each box and sign below.
1) I confirm that I have read and understood the participant information sheet dated [Date to be inserted here] for the above study.   ☐

2) I have had the opportunity to read the information sheet and, ask questions and have had any such questions answered to my satisfaction.   ☐

3) I understand that my participation is voluntary and I am free to withdraw at any time without giving any reason, without affecting my career prospects   ☐

4) I agree to participate in the focus group & the use of digital recording equipment   ☐

5) I understand that direct quotes from digital recordings taken from the focus groups may be used in the doctoral thesis and publications, however these will be anonymised and no individual participant will be identifiable.   ☐

6) I understand that the findings from the study will be shared within the nursing profession through external publication and conferences   ☐

7) I agree to take part in the above study   ☐

_____   _____   _____
Participants name   Date   Signature
_____   _____   _____
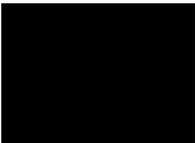Researchers name   Date   Signature

When completed, one copy for the research participant and one copy for the researcher site file

241

Appendix 6: Pre Mini-Summit participant letter

UWE BRISTOL Faculty of Health and Social Care

14 June 2012

Researcher: Jenny Child

Research Title: Creating partnership; understanding and managing the role of *support* in aligning the needs of both the neophyte graduate staff nurse and the healthcare Service organisation during the transition period from newly registered to proficient nurse.

Dear

Thank you for consenting to join this research study. The focus group will take place in room 1 of the education centre, and we will start at 1pm and close at 5pm. Timings are crucial with this activity therefore the start and finish times will be tightly managed. I appreciate how valuable your time is, and your responsibilities in managing it, however it is an essential aspect of the research that there are the agreed participants present, so your presence is valued.

The focus group will have both senior nurse managers and newly registered nurses attending. The focus group time will work through a variety of activities which will explore the support processes which have worked well for the organisation and the student during the newly registered nurse's transition. The activities will use interactive discussions based on your knowledge and experience to collate the findings.

Refreshments will be available throughout the session.

If you have any questions about the research process please get in touch and I will be happy to discuss this with you.

Many thanks for your support

Jenny Child
Lecturer

Appendix 7: Confirmation of NRES ethics approval

South West 3 REC
Whitefriars
Level 3, Block B
Lewin's Mead
Bristol BS1 2NT
Email: uhb-tr.SouthWest3@nhs.net

Telephone: 0117 342 1335
Facsimile: 0117 342 0445

16 February 2011

Ms Jenny Child
Room 2C17
Faculty of Health and Life Sciences
University of West of England
Glenside Campus, Blackberry hill
Bristol   BS16 1DD

Dear Ms Child

Study Title:	**Creating partnership; understanding and managing the role of support in aligning the needs of both the neophyte graduate staff nurse and the NHS organisation during the transition period from newly registered to proficient nurse.**
REC reference number:	**10/H0106/71**

Thank you for your letter of 16 January 2011, responding to the Committee's request for further information on the above research and submitting revised documentation.

The further information was considered in correspondence by a sub-committee of the REC. A list of the sub-committee members is attached.

Confirmation of ethical opinion

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form, protocol and supporting documentation as revised, subject to the additional conditions specified below.   *Amended documentation should be lodged with the Ethics office prior to commencement of the study.*

Ethical review of research sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

Conditions of the favourable opinion

The favourable opinion is subject to the following conditions being met prior to the start of the study.

Management permission or approval must be obtained from each host organisation prior to the start of the study at the site concerned.

For NHS research sites only, management permission for research ("R&D approval") should be obtained from the relevant care organisation(s) in accordance with NHS research governance arrangements.   Guidance on applying for NHS permission for research is available in the Integrated Research Application System or at http://www.rdforum.nhs.uk.

Where the only involvement of the NHS organisation is as a Participant Identification Centre (PIC), management permission for research is not required but the R&D office should be notified of the study and agree to the organisation's involvement. Guidance on procedures for PICs is available in IRAS. Further advice should be sought from the R&D office where necessary.

Sponsors are not required to notify the Committee of approvals from host organisations.

Other conditions specified by the REC

- The participant information sheets need to be supplied on headed notepaper, and bear version number and date.
- There are separate information sheets for staff nurses and nurse manager - these should be headed as such.
- In the PIS for staff nurses, on page 1, in the last paragraph, the first sentence has been duplicated: this needs to be deleted.
- There are two identical consent forms: they should be headed "staff nurse" and "nurse manager".
- In both consent forms, the word "doctorial" should be "doctoral".
- There are two letters of invitation: again, these should be headed appropriately.

It is the responsibility of the sponsor to ensure that all the conditions are complied with before the start of the study or its initiation at a particular site (as applicable).

You should notify the REC in writing once all conditions have been met (except for site approvals from host organisations) and provide copies of any revised documentation with updated version numbers.

Approved documents

The final list of documents reviewed and approved by the Committee is as follows:

Document	Version	Date
Response to Request for Further Information	letter	16 January 2011
Participant Information Sheet: Nurse Manager ***	1 (given by RECC)	16 January 2011
Letter of invitation to participant ***	3	13 November 2010
REC application	3.0	22 September 2010
Supervisor CV		
Participant Information Sheet: New graduate staff nurse***	2 (given by RECC)	16 January 2011
Protocol	1 (GIVEN BY RECC)	31 August 2010

Evidence of insurance or indemnity	Ins. Cert.	16 July 2010
Investigator CV		24 September 2010
Participant Consent Form***	3	13 November 2010
Covering Letter		
Letter from Sponsor	UWE	22 September 2010

***See above.

Statement of compliance

The Committee is constituted in accordance with the Governance Arrangements for Research Ethics Committees (July 2001) and complies fully with the Standard Operating Procedures for Research Ethics Committees in the UK.

After ethical review

Now that you have completed the application process please visit the National Research Ethics Service website > After Review

You are invited to give your view of the service that you have received from the National Research Ethics Service and the application procedure. If you wish to make your views known please use the feedback form available on the website.

The attached document *"After ethical review – guidance for researchers"* gives detailed guidance on reporting requirements for studies with a favourable opinion, including:

- Notifying substantial amendments
- Adding new sites and investigators
- Progress and safety reports
- Notifying the end of the study

The NRES website also provides guidance on these topics, which is updated in the light of changes in reporting requirements or procedures.

We would also like to inform you that we consult regularly with stakeholders to improve our service. If you would like to join our Reference Group please email referencegroup@nres.npsa.nhs.uk.

10/H0106/71	**Please quote this number on all correspondence**

With the Committee's best wishes for the success of this project

Yours sincerely

Dr Pamela Cairns
Chair

Enclosures: "After ethical review – guidance for researchers"

Copy to: ██████████████

●●●

South West 3 REC

Attendance at Sub-Committee of the REC meeting on 11 February 2011

Committee Members:

Name	Profession	Present	Notes
Dr Pamela Cairns	Consultant Neonatologist	Yes	
Dr Margrid Schindler	Consultant Senior Lecturer	Yes	

Appendix 8: A reflection on the initial ethics process

The experience of undertaking the good clinical research module and then preparing for the ethics application process brought clarity and direction to my study. My exploration moved from methodology, creative thought, to the why, how and so what of my work. This revived my project, awaking my interest in the opportunities that this style of working could bring to a long unsolved aspect of the transition for the NRN, and indeed employing organisation. This was an important shift in my personal development, opening up the possibilities of the research process in what had felt like a limited process. There appeared to be so much that I felt was obvious and therefore wanted to just move forward. However, the two learning experiences made me realise that my thinking and knowledge had moved forward and not necessary reached others. I was motivated towards action and now more focused towards the opportunities that my approach to this research exploration could bring. I had become concerned that there was a stasis in my subject area, which could result in reader and employer exhaustion. In unpicking the intricacies of my project I really felt that the methodological approach of appreciative inquiry could offer a new insight into managing this workforce need.

Initially, I had concerns that my inquiry was going to be seen as the same again, not only in using a form of action research but also within the subject area. However, in bringing the positive nature of the inquiry and making the participants work through the data I realised that the participants were not only sharing stories, the generative and creative thinking, but also developing it. This is an area that I enjoy opening up participant thinking and the challenge that it brings to the role of the facilitator.

The Good clinical practices and ethics committee processes enabled me to work through the issue of power, hierarchy, and facilitation which have now become influential features to the research study. The potential hierarchy could influence conversation and the participant sense of safety. Therefore the structure of the 4D framework used in AI became an important feature focusing the generative and affirmative approach. The facilitator role has a

responsibility to empower the participants, giving all an equal voice to create an active appreciative action plan.

In having a single data collection episode I felt that there was even greater pressure on me to gain the best outcome from the mini-summit. This made it crucial that I brought the right people together and that the time available was used efficiently. The mini-summit plan needed to be carefully prepared and managed through the 4 D framework.

Creating the participant information sheet and consent forms has helped to structure the data collection. This process has allowed me the time to understand the preparatory requirements, and consider the recommendations made for a successful intervention and how to get the best from the data collection episode. Time will obviously be given to the preparation of this material and careful time management given to the mini-summit itself, noting the key elements of each stage. Considering the potential hierarchy and safety issues, I will follow advice on having a first stage individual activity which will enable the participants to explore their own thoughts before they get influenced by the group, in addition they will have time to gain context and confidence in their own understanding of the situation, appreciating their individual power within the process.

Appendix 9:- Confirmation of University Ethics

University of the
West of England
BRISTOL

Faculty of Health & Life
Sciences
Glenside Campus
Blackberry Hill
Stapleton
Bristol   BS16 1DD

Tel: 0117 328 1170

Our ref: JK/lt

24th November 2011

epartment
spital

Dear Jenny

Application number: HLS/11/12/158
Application title: Creating partnership; understanding and managing the
role of support in aligning the needs of both the neophyte graduate staff
nurse and the NHS organisation during the transition period from newly
registered to proficient nurse

Your ethics application was considered by the Faculty Research Ethics
Committee and based on the information provided was given a favourable
opinion.

You must notify the committee in advance if you wish to make any significant
amendments to the original application.

Please note that all information sheets and consent forms should be on UWE
headed paper.

If you have to terminate your research earlier than planned, please inform the
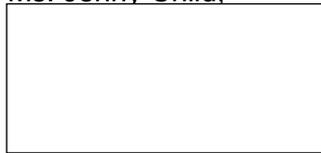Faculty Research Ethics Committee within 14 days, indicating the reasons.

Please notify the Faculty Research Ethics Committee if there are any serious
events or developments in the research that have an ethical dimension.

Appendix 10: Confirmation of local ethics
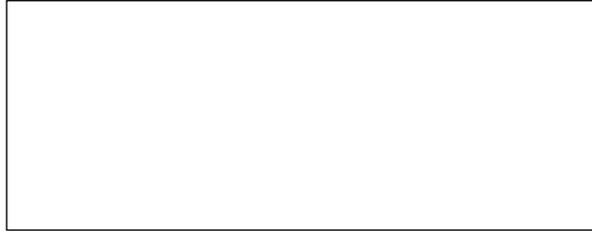
Ms. Jenny Child,   1st November, 2011

Our ref: MT/ELG 1.11.11

Dear Ms Child,

Project: Creating partnership; understanding and managing the role of support in aligning the needs of both the neophyte graduate staff nurse and the NHS organisation during the transition period from newly registered to proficient nurse.

Thank you for your application and for attending the recent meeting of the Ethics Committee to present your research proposal.

On behalf of the Committee, I am pleased to confirm a favourable ethical opinion for the above research based on the information provided in the application and your excellent presentation to the Committee.

I would also like to convey the Committee's best wishes for the success of this project.

Yours sincerely

Revd Maureen Turner,

Appendix 11: Reflexivity – Managing the Internal facilitator experiences

The use of reflexivity within qualitative research is to analyse the role played by the researcher throughout the research process (Mason, 2006). It provides a valuable means of supporting claims of reliability and trustworthiness (Rolfe, 2006) but also researcher positionality (Cousin, 2010). My pre-conceptions, biases and beliefs would undoubtedly impact on the data collection, interpretations made and new construction of meanings discovered. The relevance of keeping a research journal to record my emotions, ideas and responses was therefore vital to maintaining good research practice and participant relations. However, this made it ever more relevant to consider the ethical issues attached to the process and to ensure confidentiality at all times.

Practice development is inherent in the action research genres and reflection is closely linked with its application. Manley and McCormack (2003) suggest that reflection enables the researcher to own their position, understand their experience and identify skills for future development. This resonates with the important role reflection had on my research journey. The diary became my safe place, somewhere that I could admit my feelings and ideas, gaining understanding of who I was, and the influence I had, and key areas which I needed to and continue to develop.

There are three modes of action research technical (improving organisations) practical (improving own practice) and emancipatory (changing a system). Although each will have a different approach to the subject studied, it is not in the methodologies that the three modes of action research differ but through my application and the underlying assumptions and world views of the participants studied. It is this that creates the variation in the outcome (Grundy, 1982) highlighting the influence that I and the participants have, making it ever more important that we have a collaborative and reflective partnership. It is for this reason that the nature of reflexivity is addressed throughout the thesis, inclusive of the appendices, where examples from field notes and diary entries have been shared. However, here I explore some significant events which both

challenged my assumptions and practice, requiring me to incorporate support processes into my doctoral journey. This exploration has helped me to both appreciate and understand the wider issues relating to insider researcher perspectives in the research journey.

Good research practice – testing my plan:

Acknowledging my experience and perceptions of the transition process was an early important consideration. I had a history of personal career transitions, and had also made it a focus of my professional work. I was conscious of Macbeth's (2001, p.35) advice on the *'examination of place, biography, self and other to understand how they shape the analytic exercise'*. I could not escape that my underlining epistemological position would be influenced by my history. This was evident in an excerpt of my journal following a pilot interview. I had arranged to test my mini-summit plan through a recorded interview with a senior nurse manager. When replaying the recording I realised that I was very eager to develop the discussion. I felt that I had played too dominant a role in the interview, and was annoyed that I had misused the research opportunity to hear the participant's voice. Exploring this incident became important learning for me, both in my researcher and professional facilitator role. In particular it highlighted the relevance of my research position on the study.

The reflexive process initially helped me to appreciate how isolated I felt within my new professional community, illustrating the significant influence that my personal transition was having on me. I was enjoying the opportunity to explore my knowledge and interest with a like-minded colleague. Although this realisation was important I was still left with a feeling of self-doubt, concerned about my ability to conduct the study. When returning to the principles of facilitation (Bushe, 2007) and good research practice, I realised how I had used my passion and enthusiasm to build a good rapport with the aim of obtaining thick and rich data to influence the process (Holloway, 2005). I was communicating with the participant rather than being a 'stranger' within the process (Holloway, 2005). Furthermore, Holstein and Gubrium's (1997, p.114) work suggests that '*meaning is not merely elicited by apt questioning nor transported through respondent replies; it is actively and communicatively assembled*

in the interview encounter'. This balanced my anxiety of being a novice in the research process, appreciating that I could be part of the available research tools, working collaboratively with the participant rather than a potential threat to its objectivity (Cousin, 2010).

The process of qualitative research recognises that previous experience (epistemology) is vital to generating meaning and understanding of the world. Thus, my participation in the research process involved understanding the setting that I had become part of, which Mason (2006) views as an 'epistemological privilege'. I recognised this privilege, aware that it was both supporting my research and professional role, which introduced me to the professional community in a unique way. The pilot exercise challenged my understanding, moving the activity from simply 'good research practice' and 'testing my plan' to appreciating how vital and potentially influential my role was to the research process. It was at this stage that the research reflective journal became instrumental to my research practice. It gave me the opportunity to scrutinise my research strategy realising the opportunity that it gave me to enhance my research practice, quality checking my work to enable a trustworthy and rigorous account (Meyrick, 2006).

Facilitation – a challenge

The mini-summit approach is one method within AI (Ludema *et al*., 2003) and one which enabled me to use my extensive facilitation experience. As a facilitator I had an instrumental role in the research process, using participant stories to generate new knowledge and ideas. Grundy (1982) would suggest that this is influenced by my ability to inspire. Therefore my experience and background were crucial in giving me the confidence to explore this methodological approach. The decision to bring two distinct participant groups together, NRN and senior nurse manager potentially presented a power imbalance, making it a key consideration in my study plan. Although I was excited by the experiences and ideas that could potentially emerge, I was conscious that an open forum could stifle debate with participants concerned about how they would be viewed (Patton, 2002; Green *et al*., 2003). I was researching a small community which could potentially expose them further. Therefore my primary concern was

to maintain their safety making this a key consideration throughout the pre-event planning, information giving and mini-summit introduction (Ludema *et al*., 2003). This concern was further captured in a diary entry where I had not only observed the initial anxiety of the senior nurse managers to articulate and record their thoughts, but had also been approached by two senior nurse managers mid event. They were concerned for the NRNs and how they may feel about speaking in the presence of senior nurses.

I had observed the active and vocal nature of the NRNs, finding them more at ease with the process, happy to both record their stories and speak out, and at times dominating the discussion. Much could be considered about the manager reaction, initially challenging my role as facilitator to reconsider the group psychological safety. Naively I had thought that my careful planning and the positive methodology would to some degree support group dynamics, in addition the focus on each having subject experience would balance the potential powerbase. I had incorporated Faure's (2006) five key functions of the summit: process; positive; valuing participants; creating personal connections; reducing differences and reducing anxieties into my preparation confident that I had prepared carefully. Reflecting on the first half of the mini-summit, I realised that nurse managers adopted a greater focus on the problems, presumably as they were more comfortable/familiar with this approach.

This was a turning point, as it was here that the mini-summit could have lost its collaborative objective, with hierarchal behaviours unsettling the power balance. I was there to facilitate a progressive developmental culture (Grundy, 1982); this could not be achieved if there was tension between the two groups. I actively decided against openly discussing the raised concern. Instead I returned to my organisational responsibility (ibid), revisiting the objectives and agreed ground rules of the mini-summit, reminding the group of their role and responsibilities within the process while acknowledging the mixed participation. The post break mixed participant group activity complimented this approach, apparently freeing them from the problem-centric comfort to a powerful forum of shared debate. It was here that the mini-summit departed from a functional exercise of group activity into innovation, where inhibitions calmed and new trusting relationships of opportunity and excitement developed. The

focus on discussing possibilities removed the potential limits allowing the participants to play. This willingness to open up and to share experiences were taken as signs of participants being active and engaged in the study process. Further confirmed through one NRN recorded as saying *'I am really enjoying myself today; I had not expected it to be so interesting and so much fun.'* I can assume that my facilitation role, where I used an open and easy manner was successful in creating an interactive and progressive forum. This confirms to me that this was a constructive and enjoyable experience for those involved. The challenge of this incident would be of no surprise to Faure (2006), who suggests that the AI summit method is not for the inexperienced or faint hearted. I found this the most challenging mode of facilitation, requiring an attentive and flexible approach.

Researcher positionality

My role within the study site, theoretically positioned me as an 'insider' researcher (Meyer, 2006) which had the potential to influence the research process, particularly so during the mini-summit event. I had been in post for nine months prior to the mini-summit, actively involved in corporate events, teaching and coaching. Although this familiarity made collaboration easier I needed to maintain a keen awareness that I did not miss the remarkable in what appeared everyday (Reed, 2007). Although relationships were beginning to form I was still viewed as an unknown entity with some intrigued and enthused at having a new educationalist, and others suspicious of my presence. This created an additional challenge to facilitating the process of data collection, which I reflected upon as part of my preparation.

My anxieties were allayed during the second half of the mini-summit when the level of engagement, ideas and innovative contribution flourished. However, with this I also recognised that there were times when some participants were attempting to draw me into contentious organisational scenarios. I was aware is that any familiarity from me at this stage could jeopardise the aims of the process (Lincoln and Guba, 1985). Although DeLyser (2001) explains that this kind of difficulty is not uncommon when familiar with context and participant, I needed to balance a positive rapport with progressing the discussion. At times I struggled to manage my

emotions when participants shared their opinions about my department and organisational processes. Although the comments were not directed at me, and I in part agreed with some of their views, participants were seeking a reaction to gain an understanding of my position, making it essential that I remained detached. Adam (2013) identifies this as entanglement as the day to day professional role and researcher role merge. Participants would attempt to pull me into their thinking, by saying, *'but you will have seen this'* or *'you already know that'.* This aspect of the data collection process was unsettling, creating a potential tension. Although it enabled a closeness to data sources adding depth to the study it also compromised aspects of my professional role.

This scenario helped me to realise the difficulties in separating professional and researcher roles. The mini-summit was in effect showcasing my professional skills making it easy to fall into work mode rather than that of researcher. Although Adam (2013) appreciates the uncomfortable nature of this scenario, she also views it as a means to enriching the data collection process. However, by taking a reflexive approach at this stage enabled me a *'self-aware analysis of the intersubjective dynamics'* between me and the participants (Finlay and Gough, 2003 p.ix). This gave me time to make sense of the discussion, working through the relevance it had to the study I was also thankful for my years of experience as an educationalist and facilitator in being able to avoid making comment or judgement, and putting on my different hats throughout the research process (Roth et al., 2007).

Managing the data

I relate well to Reed's (2007) observation to the cumbersome nature of raw data when not organised. The magnitude of the data analysis phase was an overwhelming and the process an isolating experience. My research diary became a well-used resource at this stage, grounding me through my decision making, understanding and thoughts (Savin-Baden, 2004). Reading back I was surprised by how much I had forgotten within an event or how a train of thought had reached its natural conclusion. Reed (2007) suggests that a diary moves the data analysis process from mechanistic to the synthesis of meaning, this would be true of my experience. The more I

recorded my thoughts it somehow stimulated more ideas. Inductive analysis suggests that patterns and themes emerge from the data (Patton, 2002) however; I came to appreciate how data analysis was a deeply reflexive process.

I also managed my isolation by discussing the process with a fellow doctoral student who was at a similar stage with her data analysis. It was through these two approaches that I was able to ensure that the means of action and analysis were not a distinct entity but a process of one informing the other. Although I recorded the decisions made at this time and the process I undertook in my diary, it was not possible to verify the extent to which my assumptions, values and experiences had sub-consciously influenced the process.

My journey

The process of undertaking my own professional transition while completing this doctorate both generated challenges and opportunities. My frustrations continue about the lack of organisational appreciation of the bespoke support needs of the new employee, both emotionally and professionally. However, I celebrate the fact that I have had this shared experience with the participants, feeling that this unique element has not only influenced my study but further energised my enthusiasm for the subject of support for the NRN.

For me reflexivity enabled me to balance my insider and outsider perspectives, with each episode building my understanding of the event and my part within it. I found my role as internal facilitator challenging, however, it gave me the opportunity to look at my practice both professionally and as a novice researcher. I used my research diary to record, to make sense and to self-develop. It was through this process that I was able to see the unique nature of my research approach and the influence it had on the research journey. In addition reflexivity enabled me to address the influence of my own subjectivity and enhance the trustworthiness of my research study.

Appendix 12: Initial themes, sub-themes and core themes from data

Initial theme	Example	Sub-theme	Example	Core theme
Friendly environment	*Friendly and enabling*	**Role Boundaries**	*Expectations of what was expected of me* *Positive working environment – planning doing, evaluating.*	**Emotional environment**
Positive relationship	*Right type of mentors*	**Matching**	*Every different person is going to need supporting in a different way* *Aligning preceptor to NRN needs – constantly reviewing the process*	**Emotional environment**
Positive Interactions	*Only as good as the people who are working on it*	**Safe learning**	*Needing conversation for a light bulb to go off* *Enabling NRN to move forward*	**Learning environment**
Knowledge & development	*A mind-set when you are at University* *Everyone's knowledge is different*	**Knowing self**	*Not understanding our systems and how we work to slowly understand them* *A need for a skill cluster for each area to identify the standards*	**Learning environment**
Appreciative & inclusive environment	*Give and receive*	**Fitting in**	*Making them feel part of the team from the offset* *Being an active participant in an understanding environment*	**Safe environment**
Facilitative network	*Mentor who is understanding*	**Preceptorship preparation**	*You learn whether you want to be like that nurse or not* *Preparing the workforce for mentorship*	**Learning environment**
Authentic Communication	*Positive feedback*	**Relationships**	*Who you can speak to for advice on certain things more than others.* *Rounded team with a shared philosophy – right people involved*	**Emotional environment**
Safety	*Nurturing*	**Safety**	*Somebody is there that you know is much more experienced than you* *Interactive and blended learning approach*	**Safe environment**
Support network	*Highly skilled workforce*	**Transition Resources**	*Significant investment* *Spend the time to do the preparing*	**Strategic environment**
Relationships	*Can always speak to a manager, someone who …knows their stuff*	**Shared Knowledge**	*You can always go back to your research* *Learning contract with manager and preceptor sign up*	**Safe environment**
Preparation	*First impressions*	**Organisational engagement**	*.. the whole hospital has the responsibility beyond the mentor & beyond the ward, they should take a key interest* *Strategic plan – appraisal, increment, enhancement, standards, clinical supervision*	**Strategic environment**

Appendix 13: A checklist of criteria for good thematic Analysis

Process	No.	Criteria
Transcription	1	the data have been transcribed to an appropriate level of detail, and the transcripts have been checked against the material for 'accuracy'.
Coding	2	Each data item has been given equal attention in the coding process.
	3	Themes have not been generated from a few vivid examples (an anecdotal approach).
	4	All relevant extracts each theme have been collated
	5	Themes have been checked against each other and back to the original data set.
	6	Themes are internally coherent, consistent, and distinctive.
Analysis	7	Data have been analyzed – interpreted, made sense of – rather than just paraphrased or described.
	8	Analysis and data match each other – the extracts illustrate the analytic claims.
	9	Analysis tells a convincing and well-organized story about the data and topic.
	10	A good balance between analytic narrative and illustrative extracts is provided.
Overall	11	Enough time has been allocated to complete all phases of the analysis adequately without rushing a phase or giving it a once over lightly.
Written report	12	The assumptions about, and specific approach to, thematic analysis are clearly explicated.
	13	There is a good fit between what you claim you do, and what you have done – i.e. described method and reported analysis are consistent.
	14	The language and concepts used in the report are consistent with the epistemological position of the analysis.
	15	The researcher is positioned as active in the research process: themes do not just 'emerge'.