Doctorate in Professional Studies (Health)

**An Incremental Approach to Continuing Professional Development for
Registered Nurses**

**A project submitted to Middlesex University in partial fulfilment of the requirement
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CHAPTER 1: INTRODUCTION: Project background and context

1.1 Quality and standards in the NHS

Following election in 1997 the labour government demanded that NHS organisations demonstrate their accountability for continually improving the quality of service provision and safeguarding high standards of care by creating an environment in which clinical care will flourish (Scally and Donaldson, 1998). This need for change arose from a perceived public concern regarding extreme differences in the quality of care provided in different parts of the country. McSherry and Pearce (2002) suggest that the reasons for this perception of declining standards and quality were never fully addressed but propose:

> The reasons for this perception could be that healthcare professionals and the public are more informed, better educated and more interested in health related issues and want high quality service provision. Alternatively, quality and clinical standards have taken a backseat to other financial and resource management issues. (McSherry and Pearce, 2002, p 2)

Unfortunately several high profile accounts of well publicised lapses in professional performance and failure to provide satisfactory levels of care on an organisational level, give weight to McSherry and Pearce's alternative view. Most notable amongst these were the Report of the Healthcare Commission investigation into outbreaks of Clostridium Difficile at Maidstone and Tunbridge Wells NHS Trust (2007) and the Care Quality Commission (CQC) investigation (2009) and Independent Inquiry,(Francis, 2010) into the Mid Staffordshire NHS Foundation Trust.

Maidstone and Tunbridge Wells NHS Trust was heavily criticised by the Healthcare Commission (2007) regarding its handling of a major outbreak of *C. difficile* in its hospitals between April 2004 and September 2006. In its report, the Healthcare Commission estimated that about 90 patients *"definitely or probably"* died as a result of the infection. At the time of the investigation the Trust was attempting to deal with serious financial pressures and reorganisation of services whilst progressing capital development plans. But during the previous three years the medical and surgical wards at the trust had a history of low staffing levels and a relatively low proportion of qualified nurses. The commission reported numerous strategic and care delivery failings, and during the investigation 26 patients and their families contacted the Healthcare Commission regarding the quality of received care:

> They told us that when patients rang the call bell because they were in pain or needed to go to the toilet, it was not always answered, or not in time. A particularly distressing practice reported to us was of nurses telling patients on some occasions to "go in the bed," presumably because this was less time-consuming than helping a patient to the bathroom. Some patients were left, sometimes for hours, in wet or soiled sheets, putting them at increased risk of pressure sores. Families claimed that tablets or nutritional supplements were not given on time, if

at all, or doses of medication were missed. Wards, bathrooms and commodes were not clean and patients had to share equipment such as zimmer frames which were not cleaned between use (Healthcare Commission, 2007 p4)

The investigation team also indicated that infection control issues were identified as early as 2005 as the national survey of staff carried out by the Healthcare Commission revealed that compared to typical results the Maidstone and Tunbridge Wells NHS Trust was underperforming. It appears that insufficient action had been taken by the Trust to promote the uptake of infection control training. Despite training being mandatory in the Trust, between September 2005 and October 2006 only 51% of clinical staff had attended.

The CQC investigation into the Mid Staffordshire NHS Foundation Trust (2009) concluded that to meet the requirements to become a Foundation Trust it had improved its finances, largely through reduction in front line nursing and medical staff, but it did not manage operational and managerial issues effectively. Continuing professional development for nurses was viewed as inadequate and the investigation reported significant failures to deliver fundamental nursing care. These included inadequate provision of basic hygiene and nutritional needs and frequent failure to conduct observations and identify that the condition of a patient was deteriorating, or act on the results. The subsequent independent enquiry (Francis, 2009) reported numerous accounts of failure to provide appropriate care to vulnerable patients. The investigations of both Trusts depict situations whereby the Trust Boards appear to have been focused on financial problems to the detriment of staffing levels and in-service training and this resulted in patient safety and the quality of clinical care being compromised.

The need for clear national standards for health care had already been acknowledged by the last Labour government in "A First Class Service (DH,1998) but became a highly publicised issue when the Kennedy Report on the Bristol Royal Infirmary (2001), identified that from a public or patient's-eye-view there were no agreed standards on what to expect from the NHS. The government responded by introducing Standards for Better Health (DH, 2004), which were revised in 2006, establishing the core and developmental standards that all NHS organisations are required to take into account when planning, providing and commissioning healthcare. Increased inspection with annual publication of results followed. These results had a significant impact on the public perception of Trusts and their potential for recognition as a NHS Foundation Trust (DoH 2002), whereby decision making is devolved locally with less centrally imposed controls.

In the final report of the NHS Next Stage Review, entitled 'High Quality Care for All' (DH, 2008) which provided a future vision for the NHS, Lord Darzi applauded the Labour governments achievements in the investment of extra resources, giving freedom to the frontline through the creation of NHS Foundation Trusts, and by ensuring more funding followed patient choices. However, he adds that the NHS has had to face up to significant variations in the quality of care provided and the vision set out in his report aimed to develop an NHS that has effective, personal and safe care at its heart. In order to further remove the constraints of central government control and place power increasingly in the hands of employees, the newly elected Conservative and Liberal Democrat coalition government announced that all Trusts should become Foundation Trusts within three years (Department of Health 2010).

The focus of the coalition government's policy for the NHS has been to address what are viewed as its greatest challenges. These include responding to the demands of an ageing population, advances in medical technology and rising public expectations. In addition it was the view of the new government that the NHS was stifled by bureaucracy that blocked creativity and innovation of staff and that it does not deliver outcomes comparable to the best health services internationally. Patients were not seen to be at the heart of decision making about their care and services were viewed as process rather than outcome driven (DH, 2010). All of this within a much tighter financial environment in which the NHS was planning to achieve efficiency savings of £20 billion through Quality, Innovation, Productivity and Prevention (QIPP) plans. A stated aim of the coalition government is to:

> *make the NHS more responsive to patient's changing needs while being more resilient to future funding pressures.* (DH 2010, p13)

The coalition government's approach to addressing the perceived challenges is diagrammatically represented below.

Figure 1 - The Coalition Approach to Addressing Problems in the NHS<u>DH, 2010 p20</u>

A major change will be the creation of commissioning consortia comprising groups of clinicians who will work alongside their local communities to shape health services to meet the needs of patients. It is envisaged that commissioning decisions will result in a reassessment of the services offered by NHS organisations and how they will provide them. This will in turn require on-going workforce review and planning to ensure that they possess appropriate capacity and the capability required to deliver reconfigured services in effective and efficient ways.

1.2 Workforce planning and development in the new NHS

During the 1990s the government's expectations of the role and function of nurses and midwives was changing. This was marked by the publication of 'Junior Doctors: The New Deal' (DoH,1991), which indicated a need to make better use of nursing and midwifery skills, and was reinforced by the declaration of the Chief Nurse for England's 10 key roles for nurses in the NHS Plan (DOH 2000). Consequently the development of new registrants and experienced nurses needed to be addressed to meet the challenges of modernising the NHS. It has long been recognised that professional learning and development of competence extends well beyond the period of initial

professional education (Benner, 1984) and that the work environment is an important factor in lifelong learning for clinically based professionals and as such should be recognised as a critical element in continuing professional education (Eraut, 1994, Burton and Jackson, 2003). This principle has been captured in the NHS regulatory framework, Standards for Better Health (DH,2004b) as Core Standard 11, which requires that:

> *Health care organisations ensure that staff concerned with all aspects of the provision of health care*
>
> *a) are appropriately recruited, trained and qualified for the   work they undertake;*
>
> *b) participate in mandatory training programmes;*
>
> *c) participate   in   further   professional   and   occupational   development commensurate with their work throughout their working lives* (DH, 2004, p13)

However since the formation of the coalition government in 2010 the emphasis placed on lifelong learning has not been as explicit as that expressed by the previous Labour government. In the White Paper, Equity and Excellence: Liberating the NHS (DH 2010) the coalition government espoused that quality cannot be delivered through top down targets but by focusing on outcomes, giving real power to patients and devolving power and accountability to the frontline. Subsequently the government introduced the Quality, Improvement Productivity and Prevention assurance process(Department of Health, 2010), with the aim of the NHS saving £15 billion by 2015. The coalition government' proposals in Equity and Excellence: Liberating the NHS (Department of Health 2010) clearly indicate a move towards education and training that supports QIPP:

> *The key lesson from recent NHS history and international experience is that effective alignment of service development with financial and workforce planning enables high quality care and greater productivity. Critical to this is excellent education and training that is integrally linked into scientific and technological advances and enables everyone in the healthcare team to acquire capabilities and skills to provide new models of personalised care.* (Department of Health, 2010, p13)

Implicitly this statement is supportive of lifelong learning, or more precisely career long employment specific learning, as it clearly states the need for employees to continually develop their knowledge, skills and behaviours in order to keep pace with the technological, scientific and sociological changes whilst improving effectiveness, efficiency and productivity . The Department of Health position may have been influenced by an earlier Kings Fund report, NHS Workforce Planning:

limitationsand possibilities, (Imerson, Buchan and Xavier, 2009). This report predicted that the survival of the NHS in a future constrained financial situation would require new thinking that embraces the need to develop effective teams that possess the skills and flexibility to adjust to the changing healthcare needs of the population, and the ability to work with new technologies to deliver new models of care. In this report it was also suggested that a flexible approach to workforce planning and development should be adopted that does not seek longterm precision but enables the current workforce to adapt to an inherently unpredictable healthcare environment.

1.3 The project setting

This report relates to a project undertaken at a University Teaching Hospital Trust located in the north of England. The Trust has an annual income of £400+ million and employs over 7000 staff. Approximately 2000 of these are registered nurses and midwives. The Trusts two sites provide a wide range of secondary and tertiary health care services for local and sub-regional populations. During the tenure of the labour government the Trust estate grew exponentially and the building of modern facilities for cancer care; heart disease; general surgery and teaching centres for the local Medical School are on-going. However the Trust as a whole has not been exempt from government targets for activity, financial balance and improvement to meet national health care standards. These targets provide a challenge to all NHS Trusts to meet workforce requirements and to ensure that staff are fit for the purpose of delivering high quality care.

1.4 An incremental approach to continuing professional development

Since 1998 a framework for promoting and supporting attainment of knowledge, skills and attitudes that demonstrate professional practice had been evolving by the nursing and midwifery professions in the Trust. This model was called Systematic Education and Training for Practice but was widely referred to in the Trust as 'STEPs'.

The need to develop STEPs was brought into focus through concern, raised by senior nursing staff in the Trust, that a significant number of newly qualified staff were ill prepared in the fundamentals of patient care and lacked safe clinical and general management skills. These concerns were neither new nor isolated to experienced staff as a number of authors identified that newly qualified nurse themselves felt unprepared for the role (Kramer, 1974. Charnley,1999. Gerrish, 1990 & 2000). Nor was this problem particular to the British healthcare system as American and Australian studies raised similar concerns regarding the pre-registration preparation of nurses (Allen, 1998. Chang and Hancock, 2003)

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Limitations in pre-registration education and its failure to prepare nurses for post registration roles were clearly demonstrated in a comparative study by Gerrish (1990). Gerrish concluded that providers of pre-registration nurse education should do more to support students to develop clinical, organisational and developmental skills. However, in a repeat of her 1990 study Gerrish, (2000) demonstrated that student nurses still felt inadequately prepared for the staff nurse role. This situation may be explained by Eraut's, (1994) proposal that initial professional education is not conceived in the context of lifelong learning and attempts to include all the knowledge needed for a lifetime in the profession are extremely inefficient.

1.5 Degree level education and the 'Nursing and Midwifery Council (NMC) Standards for Pre-registration Nursing Education'

The NMC Standards for Pre-registration Nursing Education (NMC,2010) confirmed degree level education in nursing as the minimum requirement for entry onto the first level of the professional register. These standards relate to competencies that student nurses must acquire by the end of their three-year degree programmes before applying to be registered in one of the four fields of nursing. The four fields are adult, mental health, learning disabilities and children's nursing. The core and field competencies are set out in four domains: professional values, communication and interpersonal skills, nursing practice and decision making and leadership, management and team working. The domains comprise a generic and field standards and competencies to be met in the student's intended field of practice.

1.6 Preceptorship

In addition to concerns regarding pre-registration nurse education the Nursing and Midwifery Council (2006) and the Department of Health (2010) have highlighted the need for preceptorship for newly registered nurses. The NMC (2006) strongly recommended that all new registrants should have a period of preceptorship upon employment by which they would be provided with support and guidance that enabled them to make the transition from student to accountable practitioner. More recently the Department of Health has published a 'Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals' (DH, 2010), which defines preceptorship as:

> *A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of lifelong learning.* (Department of Health 2010b, p11)

This framework was produced primarily as a resource for personnel in NHS organisations with responsibility for establishing organisational systems for the management and development of the

nonmedical workforce (DH 2006). It addresses the responsibilities of the newly registered nurse, midwife and preceptor, the duration of preceptorship and preparation of preceptors. In particular this framework provides a standard for preceptorship (See box 1)and guidance on the design and implementation of preceptorship systems.

Box 1 - The Department of Health Preceptorship Standard

The standard contains the following elements:
Systems are in place to identify all staff requiring preceptorship.
Systems are in place to monitor and track newly registered practitioners from their appointment through to completion of the preceptorship period.
Preceptors are identified from the workforce within clinical areas and demonstrate the attributes outlined in the box (see right).
Organisations have sufficient numbers of preceptors in place to support the number of newly registered practitioners employed.
Organisations demonstrate that preceptors are appropriately prepared and supported to undertake the role and that the effectiveness of the preceptor is monitored through appraisal.
Organisations ensure that their preceptorship arrangements meet and satisfy professional regulatory body and the KSF requirements.
Organisations ensure that newly registered practitioners understand the concept of preceptorship and engage fully.
An evaluative framework is in place that demonstrates benefits and value for money.
Organisations publish their preceptorship framework facilitating transparency of goals and expectations.
Organisations ensure that evidence produced during preceptorship is available for audit and submission for potential verification by the NMC/HPC.
Preceptorship operates within a governance framework.

Department of Health, 2010, p16

Nevertheless, whilst preceptorship is strongly recommended it is not mandatory in England. However this may change in the foreseeable future as the Health Chief Nurse (England) and Chief Health Professions Officer (England) announced, in the foreword to the preceptorship framework, that consideration is now being given to making preceptorship mandatory for all newly registered nurses, midwives and allied health professionals. Furthermore In partial preparation for this change they announced that Flying Start Scotland (2005), a multiprofessional, web based, electronic preceptorship programme was being tested in a range of NHS organisations and higher education institutions with a view establishing the programme as an optional model for employers (DH 2010b).

Recently the Willis Commission on Nursing Education (2012) has also voiced strong support for the full implementation of the NMC recommendation that newly qualified nurses undergo a post qualification preceptorship period of consolidation in order to promote safe, high quality care.

1.7 Flying Start (England)

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In 2009 the Department of Health initiated a pilot for an on-line national development programme for all newly qualified nurses, midwives and allied health professionals in NHS England. This programme, which was an adaptation of Flying Start Scotland (2005) is designed to aid learning and assist registered nurses, midwives and allied health professionals in England to embed professional standards into their practice during their first year in professional practice. It contains 10 learning programmes; each providing a variety of interactive work based learning activities that are all linked to the NHS KSF. It is intended that this programme, when fully implemented will assist in the creation of either electronic or paper evidence for the NHS Knowledge and Skills Framework (KSF) development review

1.8 Background to the development of STEPs

In light of the previously identified concerns regarding pre-registration nurse education and lack of a standardised approach to preceptorship the decision was taken to develop STEPs as a model for preceptorship and ongoing support for new registrants in the Trust before further developing the STEPs framework to include specialty specific and advanced elements of care. This approach appears to be supported by Eraut (1994) who states:

> *the first two or three years after qualifying are probably the most influential in developing the particular personalised pattern of practice that every professional acquires.* (Eraut,1994, p11).

The STEPS project was initiated in the belief that achievement of excellence in clinical practice could be attained through a structured, incremental approach to attainment of appropriate knowledge, skills and attitudes. The long term vision was a framework for career development across the novice to expert continuum (Benner, 1984). In its original form this framework was based on the 10 characteristics of expert practice as described by the English National Board (ENB 1991). The model had not been formally evaluated but its potential was recognised locally as a vehicle for promoting lifelong learning and improving compliance with the Trust's target for completion of annual appraisals and personal development plans. For these reasons the introduction of STEPs was identified as a key objective of the Trust's five year Nursing and Midwifery Strategy (2003).

However, in May, 2003, the Department of Health published "The NHS Knowledge and Skills Framework and Development Review - Working Draft" (DH, 2003) and instructed that following full implementation NHS organisations would be expected to use this framework and therefore should not develop new competency frameworks. The following year the full NHS Knowledge and Skills

Framework and Development Process, (Department of Health, 2004a) known widely as the NHS KSF was published and implemented .

The STEPs approach is congruent with the NHS KSF as it provides the basis for review; planning; learning; evaluation and career planning. The NHS KSF describes six core dimensions that occur in all NHS jobs, and an additional 24 specific dimensions. The application of the both types of dimensions is used to identify the knowledge and skills required for all jobs / roles included in the Agenda for Change final agreement, and therefore exclude doctors, dentists very senior managers, (DoH, 2004a). The NHS KSF requires that individuals provide evidence that the requirements of their job/role are met, but it does not provide guidance for individuals regarding how to bridge the gap between existing abilities and those required by the job/role. This presented both an opportunity and a challenge as I believed that the development of a model that embraces and promotes lifelong learning in the workplace, whilst demonstrating achievement against the NHS KSF, could be beneficial to individuals, professions and organisations in which they work. However this would require a major overall of the STEPs framework. The activities undertaken in collaboration with nursing teams to determine a framework that would assist in the delivery of the NHS KSF, whilst recognising the development needs of individuals and clinical nursing teams are detailed in Chapter 5.

In essence the vision for STEPs framework that emerged from these activities was a skills escalator approach (see appendix 1) comprising three stages, or steps. STEP 1 would focus on supporting nurses during the transitional period immediately following registration. In particular the aim of STEP1 was to ensure the integration of theory, relating to fundamental aspects of care, into practice. STEP 2 would progress aspects of STEP 1 to a more advanced level but also focus on specific aspects of care that have relevance to individual specialties. A long term aim was to develop STEP 3, which would support the development of clinical management skills.

During the period in which STEPs has been developed and implemented a number of National initiatives have been aimed at improving preparation of student nurses for the demands of modern healthcare and to support their move into professional practice. These include the movement towards an all graduate profession, publication of standards for pre-registration nursing education, promotion of preceptorship and the creation of the Flying Start e-learning programme.

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1.9 The scope of this project report

I believe that healthcare organisations have an obligation to recognise and support initiatives that foster integration of theoretical knowledge and clinical experience to provide more robust models of continuing professional development with the aim of providing excellence in care delivery. Due to the scale of work entailed in fulfilling the overall vision for STEPs, this project report details action research undertaken regarding the development of a preceptorship model for new registrants. This initial component of the framework, entitled STEP 1, is of critical importance as professional learning and development of competence extends well beyond the period of initial professional education (Benner, 1984) and work based learning should be recognised as a critical element. This report also addresses implementation of STEP1 and outlines subsequent developments in regard to embedding high standards of care into the practice of new registrants.

1.10 Summary of chapter 1

My final project continues the theme of my overall doctorate programme, that of professional and practice development within the clinical environment, and it supports the notion of the work environment as an important factor in lifelong learning for clinically based professionals. The long term goal of developing the STEPs Framework is to design, introduce and evaluate an incremental model for learning and development in clinical practice, which spans the novice to expert continuum. However, due to the scale of the overall vision for STEPs this project report relates to the development and implementation of the model in relation to new registrants. Figure 2 indicates the connections between the principal components of this project.

CHAPTER 1 – Introduction

National Context

Local Context

An Incremental Approach to
Continuing Professional Development

CHAPTER 2 – Project Aims &
Objectives

Aims of the STEP 1 Development
Project

Background to the Development of
STEP 1

Objectives of the STEP 1
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The Product

Research Questions

Role, Authority, Capability of the
Researcher

CHAPTER 3 – Critical Review
of Literature

Lifelong Learning & Work-based
Learning

NHS Reform & Lifelong Learning

Competency & Performance

Chapter 4 – Research Approach Design &
Methodological Considerations

Chapter 5 – Project
Activity

Chapter 6 – Results &
Findings

Chapter 7 –
Discussion of Results

Chapter 8 – Rollout
Innovations & Future

Chapter 9 – Conclusion, Recommendation, & Personal Reflections

Figure 2 - The principal components of the project

Chapter 1 has provided a brief introduction to evolution of the STEPs programme against a backdrop of national, local and professional developments. These contextual elements are addressed in more detail in subsequent chapters **Chapter 2** details the project aims and objectives, the intended product, the research questions and my role authority and capability to undertake the study. **Chapter 3** presents an exploration of government policy and strategy for lifelong learning in the NHS and literature related to concepts relevant to the project. This includes lifelong learning and work based learning, communities of practice, competency, performance and Agenda for Change. **Chapter 4** consists of a discussion of the research approach design and methodology. Philosophical and ethical perspectives that underpin this project are also addressed here. In **Chapter 5**I present the project activities, including development of the STEPs framework in compliance with NHS KSF requirements; implementation in the three pilot areas and the collection, transcription and analysis of data. The research findings are detailed in **Chapter 6, and Chapter** 7 is a discussion of the findings, relevant research literature; the shifting focus of the action research and the emerging values that influenced these changes. **Chapter 8** details the rollout of STEP 1 and further development of the steps programme and **Chapter 9** closes this report with my conclusions, recommendations and personal reflections.

CHAPTER 2 – AIMS, OBJECTIVES AND RESEARCH QUESTIONS

2.1 Introduction to Chapter 2

Further to the background to the initiation of STEPs and in particular Step I in the previous chapter, I will now set out the aims, and objectives of the STEP 1 development project. I will also identify the research questions and discuss the pragmatist perspective on which they are based, prior to demonstrating my credentials and authority to undertake this work.

2.2 The aims of the STEP 1 development project

The aims of this project are to develop, refine and implement STEP1 as a preceptorship programmefor new registrants; promote lifelong learning and provide evidence of performance in the workplace, whilst complying with the requirements of NHS Knowledge and Skills Framework and Review Process (DoH, 2004a). Despite the need to adhere to these requirements the underlying principles in developing STEP 1 are to provide a vehicle to assist the new registrant to integrate knowledge acquired during pre-registration education into clinical practice; strengthen the development of professional identity and uncover tacit knowledge embedded in clinical practice. It is also intended that undertaking STEP 1 will aid the new registrant by facilitating her/his entry into a 'community of practice in which learning is situated in the workplace (Lave and Wenger, 1991) The concepts of communities of practice and situated learning are explored further in chapter 3.

2.3 Research questions and objectives of the STEP 1 development project

The overarching research question is 'What impact and meaning would implementation of the STEPs framework have for newly registered nurses and teams in which they work?'

Supplementary questions that are fundamental to this study are:

1. What are the perceptions of new registrants and their managers regarding STEP 1 as a vehicle for assisting to integrate knowledge acquired during pre-registration education into clinical practice?

2. Does the STEPs model assist new registrants to identify and address their learning needs?

3. Is STEP1 a useful tool for supervising and assessing the performance of new registrants?

4. What is the impact of the implementation of STEP 1 on the provision of support for new registrants?

To address the research questions the following three objectives were determined by which I would:

- collaborate with new registrants and the clinical teams in which they work, to produce, implement and evaluate a preceptorship programme that meets the requirements of the preceptorship standard (Department of Health, 2010) and the NHS KSF (Department of Health, 2004).

- elicit how the approach to competency development illustrated by this framework is viewed by programme participants and wider nursing teams in which they work.

- conduct an initial qualitative assessment of the effectiveness of STEP1 in assisting entrants on the NMC professional register to achieve specified practice requirements.

2.4 Pragmatism and the research questions

As stated above, the overarching research question I asked myself was "What impact and meaning would implementation of the STEPs framework have for newly registered nurses and teams in which they work?"This question sits philosophically within the American tradition of pragmatism.

The Concise Oxford Dictionary defines pragmatism as a philosophy that evaluates assertions solely by their practical consequences and bearing on human interest and to be pragmatic is to deal with matters with regard to their practical requirements or consequences. William James (1907) postulated that intellectuals aim to reach a state of stable equilibrium epistemologically and therefore to them reaching a true idea of anything is:

> …to have obeyed your categorical imperative, and nothing more need follow on that climax of your rational destiny.(William James, 1907, p77).

However, a pragmatist according to James (1907) asks what difference will something being true make in anyone's life. Essentially, to pragmatists such as Peirce, James and Dewey (Howe, 1988; Cherryholmes, 1992, Robson, 2002) truth is 'what works'. As I subscribe to this view I identified the project questions and objectives with the pragmatist question of 'what works' in practice firmly in my mind.

2.5 Product

The product of this project will be an evaluated model of support and assessment of performance of new registrants that promotes the integration of theory and practice in the clinical setting. The model will embrace an incremental or skills escalation approach to achieving and maintaining competency

within the context of lifelong learning and assist in demonstrating achievement against the NHS KSF. Whilst the content of STEPS is oriented to the nursing profession it is intended that the framework is developed in such a way that the content can be adapted to meet the contextual needs of other staff groups. Ultimately the STEPs framework should be beneficial to individuals and the professions in which they work. The process of refashioning the STEPs framework and developing the initial phase of the framework is detailed in Chapter 5.

Initially the programme will be paper based but alternative forms of delivery to enhance access and eventual utilisation by all Trust staff will be explored based upon the views of users. In parallel, opportunities for allowing easier updating of material enabling e-learning and compilation of an on-going record of achievement will be explored.

During the development period conference papers will be submitted with the objectives of disseminating information regarding STEPs and progress of the project. Through this avenue I will encourage constructive critique and advice that may contribute to the quality of the product. It is also intended that subsequent to conclusion of the action research phase and implementation throughout my home Trust a series of academic papers will be submitted for publication in appropriate journals.

2.6 My role, authority and capability to undertake the study

My position during the period of this study was Assistant Director of Nursing / Divisional Nurse Advisor. The role required that I work both within the Nursing Directorate; the Division of Critical Care and the two Surgical Divisions. Primarily my role was to support the Director of Nursing in developing and driving the strategic direction for nursing and midwifery in the Trust. Specifically I led on policy development, education and practice development medicines management. In this role I managed Practice Placement Facilitators and Clinical Skills Coordinators.

My role in Critical Care and the two Surgical Divisions management teams was to provide leadership in clinical and service development. This included membership of project boards for the delivery of a £29.5 million cardiology and cardiothoracic development and a £12.5 million elective surgery development. I have provided the senior professional support and guidance to clinical and managerial nurses in these divisions and previously directly managed all Practice Development Nurses within the Trust. During this period I also developed and led the implementation of a professional and practice development programme for nurses working at the Mbarara University Hospital, Mbarara, Uganda, on behalf of the Tropical Health Education Trust. These roles afforded me opportunities to develop a high degree of expertise in the leadership of practice development.

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This report demonstrates the leadership and direction I have provided during the on-going development of the STEPs programme. The development of STEP 1 for newly registered nurses would require that I engage directly with large numbers of professional staff, over a prolonged period to procure a shared vision for supporting new registrants in translating their theoretical knowledge into practice. In the absence of a dedicated team to develop and implement the programme I initially recruited a small core group of staff that managed their time and commitments to contribute to this project. These volunteers believed this was an important development that would, over time, provide benefits for patients, individual staff members and the organisation. As the development and implementation of STEP 1 has been a long term venture the membership of this core team has periodically changed and this has required me to maintain my involvement in all aspects of the project. Further to this I secured the input of a large number and range of professionals with specialist skills and knowledge to assist in the writing of each element of STEP1. Subsequently I led and directly participated with a team of senior nurses and clinical governance staff to map these STEP 1 elements against the NHS Knowledge and Skills Framework. I then engaged with senior staff across the Trust to produce and enact a strategy for implementing STEP 1 across the nursing, services. I personally conducted action research aimed at refining and further developing STEP1.

2.7 Summary of chapter 2

In this chapter I have related the research questions and demonstrated how they sit philosophically within a pragmatist perspective. I have projected what the expected product will be and how the results of the various aspects of the project will be communicated and learning shared. Finally I have provided a resume of my experience and capability to lead the development and implementation of a sustainable model for assessment of competence and performance that gives assurance of safe practice.

CHAPTER 3 - CRITICAL REVIEW OF THE LITERATURE

3.1 Introduction to chapter 3 - Concepts relevant to the literature review

In the first instance my literature search was restricted to gaining a greater understanding of national policy regarding post–registration education and particularly the labour government strategy regarding lifelong learning. This was achieved through a detailed search of Department of Health publications between 1998 and 2005. A later search of Department of Health literature between 2010 and 2013 allowed me to compare the current coalition government plans for restructuring the NHS and resultant implications for lifelong learning in the NHS with those of the previous labour government. In addition at the outset of this project I undertook an initial a search of the Cumulative Index to Nursing and Allied Health Literature to identify concepts relevant to continual professional development in nursing, particularly for new registrants.

Concepts relevant to the professional development of new registrants in the workplace identified in this search included lifelong learning, work based learning, communities of practice, competency and performance. It is appropriate to explore the literature relating to these concepts in particular their relationship to government policy and strategy for the NHSand the impact of these on the development of an incremental approach to continuing professional development. The remainder of this chapter providesa synopsis of literature,that I have reviewed, relating to these concepts.

Prior to establishing my research plan I also explored research textbooks and nursing research journals to review researchmethodologies, explore their potential for contribution to my project and aid development of my research plan. My exploration of research methodology literature and its influence on choice of research approach, design and methodology is detailed in chapter 4.

3.2 Lifelong learning and work-based learning

Lifelong learning has been defined as:

> thecombination of processes throughout a lifetime whereby the whole person – body (genetic, physical and biological) and mind (knowledge ,skills, attitudes, values, emotions, beliefs and senses) – experiences social situations, the perceived content of which is then transformed cognitively,, emotionally or practically (or through any combination) and integrated into the individual person's biography resulting in a continually changing (or more experienced person)
> (Jarvis, 2007, p1)

This definition supports the view that it is inappropriate to speak of 'total mastery' or a 'competence plateau' beyond which further development of one's knowledge, skills and attitudes is unnecessary.

The view that learning is an essential lifelong endeavour is not new and has been widely discussed in educational literature over the last century (Lindeman, 1926. Yeaxlee, 1929. Faure,1972. Wain, 1987.Eraut, 1994, 2007. Eraut et al, 1998. Tight. 1996, Smith, 2004, Field 2000, 2004, 2006.Jarvis, 2007). As long ago as 1926 Lindeman, (cited by Smith 2004) held that the whole of life is learning, therefore adult education can have no ending, and Yeaxlee (1929) emphasised that lifelong learning combined with service, is as valuable as food and exercise for personal growth and development of citizenship.

However, motivations for learning throughout ones lifespan have changed from the principles of personal development and social service to concern for personal advancement and economic development. Transformation in management and organization in the workplace, including flattening of structures and multi-skilling, married to a focus of consumption and lifestyle has bound policy on lifelong learning with skills and competitiveness (Smith, 2004. Field, 2006, Jarvis, 2007). However, Field (2006) emphasises that in addition to economic factors, social and cultural changes have led to profound transformation of personal biographies in regard to home, leisure, consumption and relationships. Similarly, Schuller and Watson (2009) maintain that due to greater geographical and social mobility and more frequent family and job changes, life patterns are becoming more complex. Therefore adults must acquire ever greater skills and knowledge to gain and maintain success, fulfilment and independence.

A move towards self-direction is also seen as individuals rely less on traditional institutions and authority figures, such as church leaders, teachers and parents, to guide their behaviour and see value in lifelong learning (Field, 2000). To Tight (1996), individuals are, or can become, self-directing and he portrays the scope of lifelong learning extending beyond formal educational institutions to include all agencies, groups and individuals involved in any kind of learning activity. In addition many people live in 'knowledge' or 'informational 'societies which requires them to weigh up a colossal range of contradictory information when considering their options. These changes have been cited as contributing to a wider process of 'reflexive modernisation (Giddens,1991. Beck,1992). In brief this refers to individualizing tendencies brought about because social relationships are becoming disembedded from specific contexts associated with habit and tradition, hence choice and reflection become significant. Field (2006) identifies globalisation; symbolic tokens and expert systems as causes of disembedding as:

> *First , globalizing tendencies not only foster a degree of standardization but also encourage individuals to compare what appears to work perfectly well in other contexts. Second 'symbolic tokens' such as money, but also specialized languages*

of science and business of are increasingly spanning all kinds of localized boundaries, and thanks to information technologies they do that not only in space but also in time. Third, expert systems, or rationally structured orders of knowledge are growing in importance and are increasingly important to wide ranges of citizens. (Field, p69, 2006)

It may be concluded that myriad changes and greater unpredictability, requires us to actively make decisions about what we plan to do with our lives. This has led to a shift in behaviour whereby many adults actively engage in different forms of learning that relate to the active ways in which people accommodate new knowledge into their everyday lives (Field, 2004), enabling them to understand, adapt to and shape change (Schuller and Watson, 2009)

3.3 Lifelong learning as a mechanism for exclusion and control

Despite a widespread appreciation of the benefits of lifelong learning, because of the shift to a knowledge based economy and what may be termed reflexive individualisation, lifelong learning is also viewed as a potential mechanism for exclusion and control (Field, 2006. Jarvis, 2007). It has been argued that whilst lifelong learning may function as cultural action for freedom in less affluent societies, this may not be the case in western society where it may act as a mechanism for enhancing capitalist society. Jarvis (2007) maintains that despite the apparent use of reflective methods of teaching and learning being employed in many lifelong learning projects:

> *…the need to be liberated, to be free to think and criticise and to act in and against the current global situation the affluent outcomes of global capitalism is rarely discussed within the context of lifelong learning – in this sense learning has been domesticated and those who are satisfied with their high standard of living are entrapped within the outcomes of global capitalism* (Jarvis, 2007. p194)

This could possibly be linked to cultural dispositions identified by Hofstede's (1980) multinational study of workers which revealed high levels of individualism in western countries but high levels of collectivism in less developed countries, a weak orientation to the long term in the west but a much stronger one in eastern Asian societies. Later Hofstede (1998) also developed a cultural framework specific to an organisational context and identified a range of dimensions, for example employee orientation versus job orientation and normative orientation versus pragmatic orientation that could influence the success of a company. Furthermore these national and organisational factors may further influence tendencies towards individualisation and attitudes and behaviours towards learning (Field, 2004).

Whilst lifelong learning empowers some people, issues relating to access to knowledge and individualisation also creates inequalities for others. Schuller and Watson (2009) have established that government, employers and individuals in the United Kingdom spend an estimated £55 billion on lifelong learning; however current arrangements favour the young and already advantaged. They warn that the demographic shift to an older, more dependent population is leading to greater social and economic exclusion as many people lack the skills to cope with growing health, social, technological and economic change.

Individuals with the lowest levels of skill in a knowledge based economy are less likely to find paid employment as they have limited capacity to constantly update. In a four and a half year study, LaValle and Finch (1999) found inequality of access to organised learning between employed and unemployed respondents. Ninety percent of those in work had done some organised learning compared to forty seven percent of the unemployed. Another survey, conducted by Beinart and Smith (1998) suggested that professionals and associate professionals had the highest levels of participation in non-vocational and vocationally – oriented learning. It is worth noting that a number of academics (Coffield, 2000. Field, 2000, Jarvis, 2007) ascribe uptake by these groups to the demands of employers, statutory bodies and professional organizations rather than through a desire to learn. Field, (2000) identifies that amongst the power and control mechanisms exerted on employees contract compliance, regulatory frameworks and statutory requirements are viewed as the three main culprits. Reporting on a study of the National Health Service,Hewison (2000) points out that opportunities for lifelong learning are often viewed as a threat or an obligation imposed by employers.

Despite the issues of exclusion, power and control, which could be debated *ad infinitum*, it is widely held that learning has to be supported and encouraged throughout life. Indeed, the Nursing and Midwifery Council mandates that registrantsmust take part in appropriate learning and practice to keep knowledge and skills up to date and maintain competence and performance throughout their working life (NMC, 2010).

3.4 Lifelong learning in professional practice

Lifelong learning in professional practice starts with the experiences of new entrants to a profession who learn on the job, by observation, absorption and practice and this continues throughout their career (Burton and Jackson, 2003). During this time learning has to take place alongside the duties of daily work, therefore It takes place outside formal educational settings and is linked to the work

role by three different processes: learning for work; learning at work and learning from work (Seagraves et al, 1996). Eraut (1994) states

> *Although many areas of professional knowledge are dependent on some understanding of relevant public codified knowledge found in books and journals, professional knowledge is constructed through experience and its nature depends upon the cumulative acquisition, selection and interpretation of that experience.* (Eraut, 1994, p20)

It can be concluded from Eraut's statement that professional knowledge cannot be characterised in a manner that is independent of the context in which it is learned, how it is learned and how it is used.

Work based learning accommodates many kinds of learning in addition to the formal learning of codified knowledge and can be *informal, incidental, interpersonal and interactive* (Hunter, Spence et al, 2008)*.* Marsick and Watkins (1990), maintain that work based learning occurs when an autonomous learner gains understanding from experience and this may occur either informally or incidentally. Incidental learning is a by-product of other activities, for example, social interactions or accomplishment of tasks and the learning is often taken for granted, tacit or unconscious. Further to this, Hunter et al (2008) identify that:

> *Interactive and interpersonal learning and the transfer of knowledge includes codified and tacit knowledge as well as intuitive understandings of 'how we do things here* (Hunter, Spence, McKenna and Iedema. 2008, p657)

 However, Eraut (2004) does not differentiate in this way but maintains that informal learning is one end of a continuum that extends between informal and formal learning. Further to this he identifies that the majority of learning in the workplace is informal and involves a combination of learning from other people and learning from personal experience. He does however distinguish three levels of intention as implicit learning, reactive learning and deliberate learning. The former relates to acquisition of knowledge independently of conscious attempts to learn and in the absence of explicit knowledge about what was learned. Reactive learning is intentional but is near spontaneous as it takes place during action when there is little time to think. The third level of intention, deliberate learning, is more considered and includes both learning where there is time set aside to meet a definite learning goal and learning resulting from deliberate activities such as reflection on past actions, planning and problem solving that primarily have a clear work-based goal.

Interest in lifelong learning in nursing was triggered by the expansion of nursing roles and advancing technologies (Gopee, 2002) but gained impetus following the publication of 'Post Registration

Education and Practice' (UKCC, 1997), whereby nurses were required to demonstrate on-going education in order to re-register. However, the terminology can be confusing as adult education, recurrent education, continuing education and continuing professional development are often substituted for lifelong learning (Gopee, 2001). Whilst formal post–registration education can be accessed through university courses and conferences, there is a growing body of literature indicating that work based learning is important.

3.5 The purposes and benefits of work based learning

Educational and healthcare literature abounds with explanations of the purpose of work based learning (Eraut, 1994. Boud and Garrick, 1999, Raelin, 2000. Gray et al 2004) but can be summarised as improving performance for the benefit of the organisation; improving learning for the benefit of the learner and improving learning as a social investment (Boud and Garrick, 1999). Through work based learning, development of self and personal growth may enhance enterprise and citizenship but performance and teamwork are also claimed to be improved (Boud and Garrick, 1999). Shared and collective activity often results in knowledge creation (Raelin, 2000) and this may explain why work based learning is important to 'learning organisations' (Senge 1990). Through investment in human capital and provision of an environment that promotes the creation of social capital, learning organisations encourage the talent of individuals and teams so that the organisation itself begins to shape its future (Gopee, 2002). Increasingly employees are required to develop higher level skills of analysis, evaluation and synthesis, learn about learning itself (Gray et al, 2004) and become reflective practitioners (Schon, 1983, 1987). It is argued that due to reflection on work practices, problem solving and action these abilities are more likely to be gained in a work environment than in a classroom (Raelin, 2000).

3.6 The working environment as a catalyst for learning

The workplace is seen as having a vital role to play in fostering learning. (Vygotsky, 1978, Marton andRamsden, 1988, Eraut, 1994, 1995, Gear, 1994. Spouse, 2001, Gray, 2001.Glass et al, 2002, Burton and Jackson, 2003. Gray et al. 2004) and the importance of the work environment as a catalyst of learning in healthcare has long been the subject of research (Orton, 1981, Ogier. 1982, Fretwell, 1982. Melia, 1987, Hart and Rotem, 1994. Davidson and Elliot, 2008).

To Vygotsky (1978) an individuals' immediate context or environment, or "Zone of Proximal Development' (Vygotsky, 1978, p86) is the arena which provides challenge that results in a dynamic process of learning and development, whereby previously internalised learning becomes a set of tools for new learning and thinking (Vigotsky, 1978. Marton and Ramsden, 1988. Matthews and

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Candy, 1999). This constructionist perspective emphasises the relationship between individuals and the social and cultural perspectives in which they act (Garrick, 1999). This is particularly pertinent to new registrants in nursing as what they learn is experiential in the workplace and differing from learning in the university as it is applied and immediate (Davidson and Elliot, 2008) Therefore, learning requires intellectual effort to be made in an encouraging situation, but this is difficult to accomplish in an action oriented environment (Eraut, 1995).

Learning at work relies on three main sources, media, people and experience, each being used for a variety of purposes and often in combination with each other (Eraut, 1994). Access to learning materials, such as databases and journals, can be problematic and where they are available the pressure of work often limits uptake by staff. Colleagues may offer different knowledge and perspectives, psychological support and motivation but many practitioners have not acquired the ability to describe their taken-for-granted practices and need opportunities to reformulate their practice before they can share it. This may be hindered as attempts to learn in the workplace may be viewed as an admission of un-knowingness and there is a risk of loss of status amongst colleagues (Spouse, 2001). Furthermore, the divide between individualistic, enterprise-focused and socially focused conceptions have created misunderstandings between employers and academics about the validity of work based learning (Boud and Garrick ,1999) and Garrick (1999) identify that :

> *the constructivist perspective is, however, yet to provide a comprehensive account of the different types of knowledge which are constructed or how these may be deployed in goal directed activities of workplaces.* (Garrick, 1999, p223)

These issues may in part explain why education priority is invariably given to theory over practice (Boud and Garrick. 1999), and why much continual professional education is delivered away from the workplace, remaining separate, unintegrated and therefore minimally used professional knowledge (Eraut, 1994) leading to a theory-practice gap. Despite recognised difficulties workplace learning is beginning to be recognised more than an adjunct to formal study in an educational institution, and necessary for the achievement of praxis (Eraut, 1994, Burton and Jackson, 2003. Gray et al, 2004).

3.7 Praxis

Praxis is theory and practice that are interrelated, integrated, and dialectical in nature (Jones, 1997). Through informed action, simultaneously the action and the knowledge that informs it (Carr and Kemmis, 1986), theory or philosophy, become integrated into the social reality of practice (Bawden, 1989). It has been suggested that inherent within praxis is reflection upon practice toward the refinement of theory and improvement of practice. Reflection is simply thinking, but in the context of

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discovering nursing practice knowledge it takes on the connotation of being a purposeful, conscious, and conscientious. Reflection-in action and reflection on-action (Schon,1983.) provides a means of exploring, challenging and refining existing knowledge to provide direction for decision making in practice. However, some authors believe reflective processes can also entrench prejudices or reinforce errors of thinking (Burnard,1995. Richardson,1995. Thorne,1997), therefore achievement of expert practice knowledge not only requires foundation of substantive formal knowledge, and critical thinking skills (Benner et al, 1996. Paul and Heaslip, 1995. Thorne, 1997) but as Thorne, (1997) contends:

> *…the value of appreciating a dialectic between thought and action, between knowledge and values and between science and opinion, becomes apparent only when each of the components has achieved a certain level of sophistication* (Thorne ,1997 p xiii)

3.8 Communities of practice

One approach to addressing concerns regarding work-based learning is the development of 'communities of practice' through which individuals, groups and organizations are focusing on improving practice. Communities of practice have been defined as:

> *….groups of people who share a concern, a set of problems or a passion about a topic and who deepen their knowledge and expertise in this area by interacting on an on-going basis.* (Wenger, McDermott and Snyder, 2002, p4)

Wenger (2006) emphasizes that this definition accommodates but does not assume intentionality and notes that learning can be the reason the community comes together or it may be an incidental outcome of members' interactions.

The development of shared practice may be more or less self-conscious, but not everything called a community is a community of practice. A community of practice as opposed to say, a neighbourhood community, displays three crucial characteristics. As shown below in Table 1 these characteristics are the domain; the community and the practice.

Table 1 - Characteristics of a Community of Practice

The domain	The identity of a community of practice is defined by a shared domain of interest. Members possess a shared competence that distinguishes them from other people. They value their collective competence.
The	In pursuing their interest in their domain, members engage in joint activities and discussions, help each

community	other and share information. They build relationships that enable them to learn from each other.
The Practice	Members of a community of practice are practitioners. They develop shared resources, stories, tools, ways of addressing recurring problems – in short a shared practice.

(Adapted from Wenger, 2006, p1)

Communities of practice are known by many names including learning networks, thematic groups or tech clubs (Wenger, 2006). Nursing link networks are a popular way of developing practice in areas such as infection control and tissue viability in hospitals. These networks are in fact examples of communities of practice as they exhibit the three essential elements that Wenger (2006) maintains constitute the concept. These networks can emerge formally or informally, both as entities within single organisations and groups formed across organisational and geographical boundaries.

Communities of practice help organisations at a conceptual level by giving managers the understanding that knowledge is a strategic asset that resides with practitioners. Communities of practice are a medium for peer-to-peer learning and when properly integrated in the workplace, put responsibility for knowledge management where it belongs, with practitioners (Wenger 2011).

3.9 Communities of practice and situated learning

The development of 'communities of practice' has its roots in 'Situated Learning' a term coined by Lave and Wenger (1991) whilst researching different types of apprenticeship. However, Smith (2004) identifies that the concept of situational learning is not new and cites Eduard Lindeman (1929) who argued that for adults:

> the approach…..will be via the route of situations not subjects…In conventional education the student is required to adjust himself to an established curriculum; in adult education the curriculum is built around the student's needs and interests.
> (Lindeman, 1929, p6)

This researcher take the stance that learning is social and comes from experiencing daily life rather than being viewed as having a beginning and an end, is separated from our daily life and is the result of teaching. In a foreword to Lave and Wenger's book, 'Situated Learning: legitimate peripheral participation', William F. Hanks writes:

> Rather than asking what kind of cognitive processes and conceptual structures are involved, they ask what kinds of social engagements provide the proper context for learning to take place. (Lave and Wenger, 1991)

The apprenticeships studied by Lave and Wenger (1991) included Liberian tailors, Yucatan midwives, US Navy quartermasters, meat cutters and non – drinking alcoholics. Their study revealed that a common thread existed between these groups and that individuals initially join and learn at the periphery of communities. Learning, viewed as a situated activity, refers to a process of gradually increasing participation in the socio cultural activities of a group. Apprenticeships are usually thought to be a relationship between a master and apprentice. However, Lave and Wenger observed learning taking place mostly with journeymen and more advanced apprentices as over time they become more engaged and active in the community's culture; a practice they denoted as 'legitimate peripheral participation'. Through this social process a persons intention to learn is engaged, the meaning of learning is configured and the learning of knowledgeable skills takes place (Lave and Wenger, 1991) through observation, imitation and practice (Nonaka and Takeuchi, 1995). Such learning communities exist even where formal apprenticeships were not in place and the term 'community of practice' was coined to denote a community that acts as a living curriculum for the apprentice or newcomer. However, learning in communities of practice is not limited to novices and most of us have experience of belonging to communities of practice in work, school, home or in relation to our hobbies (Wenger etal, 2002).

3.10 Facets of the nature of knowing

In contrast to most formal education which involves knowledge that may be abstract and out of context, situated learning is an integral and inseparable aspect of social experience resulting, and existing as a residue of actions, thoughts and conversations. Proponents of communities of practice pronounce tacit, social, and dynamic dimensions as important facets of the nature of knowing. Communities of practice are also viewed as repositories for 'social capital, which has been characterised as a feature of social groups which facilitates coordination and cooperation for mutual benefit and leads to behavioural change and influences knowledge sharing. This results in increased performance and development and maintenance of long-term organisational memory.To social theorists such as Putman (2001) and Bourdieu (2005) the notion of social capital emphasises the real value communities possess for their members (Costley, 2010). Wenger et al (2002) state:

> *Communities of practice do not reduce knowledge to an object . They make it an integral part of their activities and interactions, and they serve as a living repository for that knowledge.* (Wenger, McDermott and Snyder,,2002. p9).

A key component of epistemology as applied to situated learning and therefore to communities of practice is the concept of tacit knowledge. That is to say we are all aware that *"we know more than we can tell"* (Polyani 1967 p4) as tacit knowledge is difficult to verbalise. Tacit knowledge is

personal knowledge that may be used uncritically as people are confident that it works well for them (Eraut 2004), but Hannabuss (2000) maintains that there are several levels of tacit knowledge. Below explicit knowledge there is conscious tacit knowledge. Which relates to the personalised impressions and symbols that we know exist and float around explicit knowledge and are assumed to be useful, when made explicit in making choices and decision making. Underneath this lies unconscious tacit knowledge which:

> *…may well 'cover' or 'relate' to the same or similar areas of knowledge and understanding, memory and logical inference, intuitive connectedness and foresight which conscious tacit knowledge covers and relates to (and by that token explicit knowledge openly deals with)* (Hannabuss, 2000, p403)

It follows that for tacit knowledge to be usable it must be identified and made explicit (Nonaka & Takeuchi, 1995, Hannabuss, 2000). Iterative social interaction is viewed as critical to tacit knowledge being made explicit as through this engagement knowledge skills, and attitudes are acquired (Wenger et.al. 2002. Stasser et al, 2000. Hannabuss, 2000. Koskinen et al, 2003. Wenger, 2006).It has been advocated that face to face interaction provides the medium for knowledge transfer, making tacit knowledge explicit and thereby enhancing decision making and creation of new knowledge, (Stasser,2000.Koskinen et al, 2003).Ryan and O'Connor (2012) cite Tsoukas' (2003) proposition that an explanation for knowledge creation that:

> *'…new knowledge comes about not when the tacit*
> *becomes explicit, but when our skilled performance, our praxis-is punctuated in*
> *new ways through social interaction'* (Tsoukas, 2003 cited in Ryan and O'Connor, 2012, p1)

This implies that tacit knowledge arises not only from implicit acquisition of knowledge but also from the processing of that learning and is often context related (Nonaka & Tackeuchi, 1995. Eraut, 2004). This appears to be particularly important in relation to obtaining, processing, and communicating information from distinct knowledge domains. Shared experience is viewed to be essential for acquisition of tacit knowledge as this facilitates understanding whereas making sense of information in isolation from associated emotions and specific contexts is nonsensical *(Nonaka and Takeuchi 1995).*

Sense making is the process of constructing filtering, and framing situations by which people interpret things and make sense of their situation, and develop plausible ways of addressing things, including their own subjectivity (Hannabuss, 2000). Hannabus (2000) maintains that narrative, in the form of storytelling has a unique function in eliciting tacit knowledge. He proposes that when people

talk about situations and events they relate things from their perspective and this will be pervaded by self-reference and self-concept, and these are intrinsically related to personal identity. It follows that sense making is closely allied to tacit knowledge as through sense making people define and share their realities thereby making them extrinsic (Weick, 1995). The point at which awareness of unconscious tacit knowledge dawns is termed by Hannabuss (2000) as the meta-knowledge point but is commonly referred to as an 'aha' experience.

Whilst knowledge is gained and disseminated through social interactions it is stored by teams, networks and organisations through the development of cognitive constructs called Transactive Memory Systems (TMS) TMSs are the collective knowledge possessed by teams and pertain to discrete knowledge domains (Ryan and O'Connor, 2012).. They are important for the acquisition and sharing of team tacit knowledge because they enact 'collective minds' of teams. However the frequency and quality of social interaction is determined to be more important to learning and sharing of tacit knowledge in teams, networks and organisations than is transactive memory.

Organisational theorists generally consider knowledge the key to success (Toffler, 1990. Quinn, 1992, Drucker, 1993, Hannabuss, 2000) but Wenger et al (2002) maintain that continual expansion of science and technology results in the shortening of its lifespan. To maintain competitive advantage, organisations need to keep their knowledge on the cutting edge, deploy it and leverage it in operations and spread it across the organisation. Accordingly, knowledge is considered too valuable for companies to leave to chance and organizational management of knowledge needs to be intentional (Nonaka & Takeuchi, 1995). This is no less true of the NHS than it is of commerce as it is reshaped to meet the challenges provided by the coalition government through the publication of 'Equity and Excellence: Liberating the NHS (DH, 2010). It could therefore be construed that development of communities of practice, that increase social interaction, create Transactive Memory Systems and make tacit knowledge explicit, should be encouraged and supported in the NHS.

3.11 The downside of communities of practice

Despite being a foremost proponent for the development of communities of practice Etienne Wenger himself advocates that they should not be romanticised as they too have a dark side. Whilst personal engagement and focus on learning are the hallmark of healthy communities of practice, they can be petty parochial and exclusionary (Wenger, 2011). Wenger, McDermott and Snyder (2002) consider that the downsides of communities of practice often occur when they are functioning too well in certain respects and present as extreme presentations of its strengths. A shared view

regarding the domain, group identity, established relationships and practice are valuable assets for shared learning. However if these qualities become unbalanced they can also lead to avoidance of learning, stagnation and disintegration of the community of learning. For instance the intimacy of a tight knit community can be a barrier to attracting newcomers, members may be reluctant to critique each other and implicit assumptions may go unchallenged and new ideas ignored or blocked.

Whilst traditional organisations can be bureaucratic, rife with political conflict, and focused on counterproductive measures, it is important to note the benefit organisations give to communities of practice:

> *Just as communities can provide a context for practitioners' learning and professional identity, organizations can provide communities with a context of large-scale performance challenges, complex coordination, and deliberate management of resources (Wenger, 2011, P4)*

Communities of practice and organisations seemingly both have bright and dark sides and replacement of organisations is not advocated, therefore productive integration could enable them to function together in ways that are mutually beneficial (Wenger etal, 2002).

3.12 Psychological contract

A further influence on an individual's performance is the relationship between the employee and their employer as this affects the formers perception of what is expected of them. As a result of observations and interviews with factory workers Argyris (1960) concludes that a relationship built upon the employers respect for the norms of employee's informal culture, had a stronger influence on performance and attitudes than their formal contract of employment. Argyris (1960) refers to this relationship as a psychological work contract and Levinson (1962) saw this unwritten agreement as a summary of the employees and the organisations expectations. However, it is difficult to proclaim that a view represents an organisation which is comprised of many individuals, each with their own views and expectations (Rousseau, 1990. Schalk and Freese, 1993), and the collection of valid and reliable data to substantiate an espoused organisational view is difficult. On this basis it is suggested that the employees mental schema of the mutual obligations existing with their employer actually forms the psychological contract (Rousseau, 1995) and Anderson and Schalk, 1998 suggest that :

> *An employee weighs his or her obligations towards an organisation against the obligations towards them as an employee and adjusts behaviour on the basis of critical outcomes (Anderson and Schalk, 1998, p640)*

These mental models are viewed as evolving overtime, are based upon what behaviours provide positive results, and once formed are both enduring (Rousseau,1995) and contribute to a mutually beneficial relationship (Shore and Shore (1995).

3.13 NHS Reform and Lifelong Learning

The policy framework supporting the lifelong learning in the NHS has been evolving over a number of years and is closely linked with the previous labour government's plans for better provision of services through quality improvement and improved access (Department of Health, 2000).

The White paper, 'The New NHS Modern, Dependable (DH, 2007**),**positioned clinical quality as a central tenet of government policy by placing the duty of providing clinical excellence on local healthcare organisations. However, the vision for lifelong learning in the NHS was first made explicit with the publication of the consultation paper 'A First Class Service: Quality in the New NHS' (Department of Health, 1998) in which the government set out the strategy for setting, delivering and monitoring standards in the NHS. The main elements of this clinical governance framework are identified in figure 3.

Clear Standards of Service

Prof. Self-Regulation

Clinical Governance

Lifelong Learning

Public Patient & Involvement

National Performance Framework -Commission for Health Improvement , National Patient and User Survey

MONITORED STANDARDS

National Institute for Clinical Excellence.

National Service Frameworks

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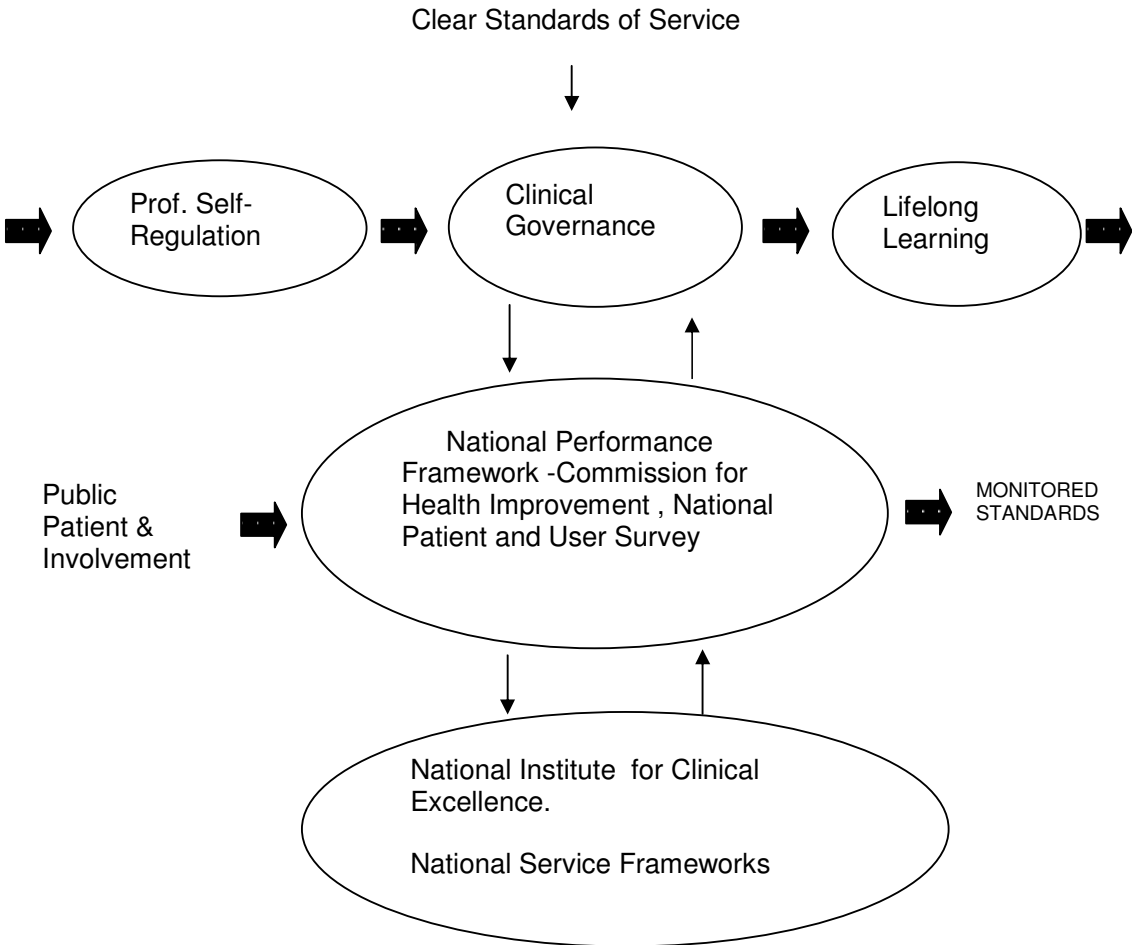
Figure 3 - Clinical Governance framework. (**Department of Health, A First Class Service, p8)**

This policy linked lifelong learning and continuing professional development (CPD) with professional self-regulation and clinical governance, identifying these as being central to delivering quality care. This connection was based on the premise that managers and practitioners should review learning needs and organise continuing learning data from clinical practice to inform the CPD process. Subsequent policy documents (Department of Health, 2001, 2003a, 2004) repeatedly directed that CPD in the NHS should be a partnership between the individual and the organisation with the aims of delivering high quality services through the delivery of national improvement programmes, meet individual career aspirations and learning needs as far as possible and provide equal opportunities for all staff members.

3.14 The Coalition Government Strategy for Education and Training for the NHS

As discussed briefly in chapter 1 the coalition government, elected in 2010,has not been as explicit as the last Labour government in its support for lifelong learning. Whilst the former government emphasised a skills escalation approach which included core literacy and numeracy skills teaching for adults wherever necessary, the coalition government directly link education and training to improvements in productivity, patient outcomes, and a focus on skills and knowledge to provide safe, effective care at all times (Department of Health, 2012). In "Liberating the NHS: Developing the Healthcare Workforce: From Design to Delivery" (2012) a new system for education and training which confers much of the responsibility for planning and developing the healthcare workforce to healthcare employers was proposed for implementation in 2013. The central components of this system are Health Education England (HEE) and the Local Education and Training Boards (LETBs). Health Education England (HEE) is being created to provide national leadership on planning and developing the healthcare and public health workforce to:

> ..ensure *that the health workforce has the right skills, behaviours and training, and is available in the right numbers, to support the delivery of excellent healthcare and health improvement.* (Department of Health, 2012 p19)

HEE will be responsible for allocating and accounting for NHS education and training resources and for authorising and supporting the development of LETBs.

LETBs are intended to be the vehicle for assessing the impact of changing service needs on the workforce. They will also be responsible for identifying local priorities for planning and commissioning education and training that changes the shape of the workforce, ensuring that new skills are developed to meet future service demands. LETBs are expected to achieve this by consulting with and responding to the views of patients, local communities and staff and will be held to account for this through Health Education England. The government intends workforce development plans to be locally driven. However a Strategic Operating Framework will set out medium and long-term goals and underpin the relationship and resource allocation arrangements between HEE and individual LETBs (DH 2012).

3.15 An NHS framework for lifelong learning

Ideological stances not withstanding there has clearly been a drive by successive governments towards a structured nationwide approach to the promotion of career long professional development over the last two decades.

Despite repeated allusions to lifelong learning by the government (Department of Health, 1998, Department of Health 1999a, Department of Health, 1999b, Department of Health, 2000) the first strategy for lifelong learning in the NHS was not published until 2001. 'Working Together-Learning Together' (Department of Health, 2001) detailed lifelong learning as one of four central elements of the NHS Plan (Department of Health, 2000) for delivering patient centred care and service improvements. The other elements were expansion and development of the workforce; modernisation of pay and contracts and development of a modern regulatory framework to ensure enhanced public protection.

The scope of 'Working Together-Learning Together' included learning and development opportunities from adult literacy and numeracy skills and vocational training, through to pre and post registration education and development. The use of formal and informal approaches to training and education were also advocated. Employees wishing to develop their careers and make an increasing contribution to improvements in service would be able to progress through a model described as a 'skills escalator' (see appendix 1). Skills escalation would be supported by a job evaluation scheme and knowledge and skills framework linking pay progression to the demonstration of defined role criteria. However, this pledge is reminiscent of the rhetoric accompanying the introduction of clinical grading which promised improved pay related to certificated professional development. The reality was that reward for knowledge and skills was not immediate but relied on the availability of more senior positions. Such opportunities were also limited

by the existing level of available skilled individuals relative to existing need, financial constraints and the subjectivity of recruitment decisions by managers.

3.16 Agenda for Change

The publication of 'The Agenda for Change' (Department of Health, 1999) heralded the first major overhaul in pay, career structures and terms and conditions of employment since the creation of the National Health Service (NHS). Subsequently 'A Modernised NHS Pay System' (Department of Health, 2002b) and 'Agenda for Change Proposed Agreement' (Department of Health, 2003b) laid out a package of proposals for a new pay system for the NHS.

'Agenda for Change' (Department of Health, 1999), supports the human resources strategy set out in 'Working Together' (DH, 1998) which is aimed at ensuring that the NHS has a quality workforce, in the right numbers, with the right skills, diversity and flexibility to deliver the governments service objectives. The underlying premise being that in order to achieve this aim the NHS should work together and with other organisations to maximise the contribution of staff through greater involvement and participation in service development. The job evaluation scheme and knowledge and skills framework alluded to in 'Working Together-Learning Together' (Department of Health, 1999) would evolve into major components of Agenda for Change (1999) as details of these reforms emerged.

3.17 The Job Evaluation Scheme

Job evaluation was devised specifically for the NHS, and was espoused as a method of assessing all jobs consistently across the NHS to ensure equal pay for equal value. For the first time all NHS staff, with the exception of Doctors, Dentists and Trust Directors, are accommodated within a single job evaluation framework. Mapping of the requirements of non-medical roles against specified criteria would produce points and an accumulative score that would determine allocation to a pay band (DH, 2003b). Appendix 2 provides an example of a job evaluation for a qualified nurse working at band 5 of the job evaluation framework (DH, 2003b p97).

The Job Evaluation framework focuses primarily on the complexity of roles and their impact on clinical outcome rather than solely on managerial responsibility, and in general the incremental points in each pay band are more numerous than in the previous clinical grading system. Benton (2003) believed that in the previous nursing and midwifery clinical grading system, nurses were reluctant to move to another specialty once they had progressed to the top of a pay band as they feared losing their grade. Contrary to Benton's view, I believe movement by experienced nurses may have actually resulted from frustration at their professional responsibility and expert practice

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going unrewarded due to lack of opportunity for promotion in their preferred clinical specialty. As the new pay bands provide a greater range of financial increments, the potential for retaining advanced expertise in a preferred specialty would be attractive to many staff. Reduction in the movement of staff would negate costs associated with re-educating staff into new nursing specialties and this, is likely to be a significant, but unwritten, driver underlying the job evaluation scheme.

3.18 The NHS Knowledge and Skills Framework (NHS KSF)

The NHS Knowledge and Skills Framework (NHS KSF) was first published as a working draft (Department of Health, 2003) and subsequently as a final document entitled 'The NHS Knowledge and Skills Framework and Development Review Process'(Department of Health, 2004b). This framework was lauded as a key strand in NHS pay modernisation under the Agenda for Change initiative (Department of Health, 2003). It would form the basis of development review for staff, including review planning, learning and evaluation, career progression and pay progression (Department of Health, 2003a).

The stated purpose of the NHS KSF is to invest in the development of individuals and teams to increase effectiveness and to promote equality and diversity. This framework (see appendix 3) comprises six core dimensions and 24 specific dimensions that apply to some but not all posts, and are described as four themed groups. These are health and wellbeing; estates and facilities; information and knowledge; and general. All dimensions have an identifying descriptor and four levels of complexity accompanied by indicators of how knowledge and skill need to be applied at that level. These levels and indicators are described as being crucial to development of role outlines against which individual performance review would be conducted. The NHS KSF is linked to the revised pay structure at pay band gateways. Gateways are points on the pay band where assessment of knowledge and skills will be made against the detailed role outline. The foundation gateway determines the individual's progress after 12 months in the role and the second gateway confirms that the individual is meeting the full demands of the post as expressed in the NHS KSF role outline.

3.19 Benefits and Limitations of Agenda for Change

Agenda for Change, particularly the NHS KSF, could significantly influence future manpower planning, if applied to all healthcare professions. Through the mapping of knowledge and skills, within multidisciplinary teams against the needs of patient groups, the creation of new roles and/or the planning of professional development could be grounded in the understanding of local need. Chris Beasley, the incumbent Chief Nurse for England appeared to share this view, as she

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maintained that 'Agenda for Change' could influence service redesign, as opportunities for utilising and rewarding the skills for non-registered groups could result in greater team working and the dissolution of barriers and bunker mentality that have hindered innovation and service development by 'keeping everyone in their place' (Beasley et al, 2005). However, she did not comment on the exclusion of doctors from these radical changes. It appears that an opportunity to challenge the political dominance of the medical profession was missed, as doctors appear to be exempt from a declared intent to dissolve barriers and promote equality. This omission could easily result in the rate of change in the NHS being determined by the agenda of a select group intent on protecting its status and associated privileges.

However, the job mapping exercise was mechanistic as roles and not individuals were job matched. Large numbers of staff were assimilated into the new pay spine in this way and the abilities and level of competence that individuals possess were disregarded. National profiles are available for a large number of roles, thus providing individuals the opportunity to plan their own development by identifying gaps in their own capabilities against role options to which they may aspire. However, lifelong learning is compromised, as CPD programs are seen to be best managed by employers (Department of Health 1998, 1999a), with educational partners and trade unions occupying a occupying a participative role. It is therefore incongruous for the NHS KSF to be linked to the pay structure as left in the hands of target driven managers, working under increasing financial pressure, it could become a 'performance management' tool focused on the delivery of efficiency targets. The drive to deliver efficiency could lead to a reductionist approach that delivers outcomes more akin to those of training than education. Training, the acquisition and mastery of skills through practice, is a fundamental component of education. But education also embraces information acquisition, familiarisation with social norms, thinking and problem solving. Education has been defined as a

> *…learning process which deals with unknown outcomes, and circumstances which require a complex synthesis of knowledge, skills and experience to solve problems. Education refers its questions and actions to principles and values rather than merely standards and criteria.*(Gibbs, Brigdon, and Hellenberg, 2004, p5)

To focus on training, excluding other facets of the educational process would be to revert to 'Taylorism' (Morgan, 1978, Boud and Garrick, 1999) whereby managers should do all the thinking planning and design of work, and workers should be trained to carry out tasks competently and without question. In addition, the NHS KSF is viewed to be the key to realising the many potential benefits of Agenda for Change however it has not been fully implemented in all Trusts as some

managers view it as cumbersome. Trusts that have integrated the NHS KSF into their management systems are assessed as being better placed to review performance (National Audit Office, 2009)

NHS policies stress the need for organisational cultures that encourage staff to be fully involved in service modernisation. But, for this to occur staff need to gain knowledge of their organisation and 'how things work', in order to negotiate their changing work environments instead of merely surviving change (Garrick, 1999). The training versus education debate is also pertinent to the concept of competency development.

3.20 The NHS KSF, Competency and Performance

The need for change to competency based pay progression as a means of promoting and supporting lifelong learning and career progression was made explicit in 'Agenda for Change (Department of Health, 1999) and stressed in subsequent documents (Department of Health, 2000, 2001). It is interesting to note that the term 'lifelong learning' is not used in the NHS KSK, which has an espoused aim of identifying development potential and gaps in an individuals knowledge and skills. Furthermore the concept of competence is not directly addressed, however linkage was made with existing and emerging competency frameworks, including regulatory requirements / competencies, National Occupational Standards and Quality Assurance Agency benchmarks. As the NHS KSF includes the requirement for appraisal, the concept of performance appears to be important.

Performance and competence have a confused relationship (Watson, 2002) and the lack of clarification of the relationship between these two concepts is hindered by lack of agreement on a definition of competence. Messick (1984) differentiates between the two concepts advocating that competence refers to what a person knows and can do under ideal circumstances performance refers to what is actually done under existing circumstances. Further to this Gonczi (1993) maintains that performance is directly observable, whereas competence is not, but is inferred from performance

3.21 Defining competence

> *Where many try to rubbish the term competence it is unlikely that they would rubbish the term incompetence in the same way.* (Eraut, M.1998, p127)

As Eraut (1998) indicates we all have a notion of incompetence, that is, we recognise it when we see it and Hannabuss (2000) maintains that there are many states of knowing connected to competence and incompetence. These include knowing that you know or a state of conscious competence; knowing that you do not know or conscious incompetence; not knowing that you know

or unconscious competence and not knowing that you do not know or unconscious incompetence. . Nevertheless, competency remains a poorly defined concept and to some is no more than a lack of incompetence (Watson, 2002). The wide range of definitions has long been discussed in the educational literature (Coit-Butler, 1978, Short, 1984, Gonczi, 1993, Eraut, 1994) and latterly has emerged as an issue of debate in the nursing literature (Runciman, P. 1990), Girot. 1993, While, 1994, Bradshaw, 1997,1998, Mustard, 2002; Zhang, 2002 Watson, 2002). Rule 18 of the 1983 Nurses, Midwives and Health Visitors Act specified nine competencies as requirements for registration, and consequently the term was used extensively in subsequent nursing curricula. Despite the term being dropped in favour of outcomes in the 1989 Nurses, Midwives and Health Visitors Act the growing usage of competency in higher education has ensured that competency remained on the nursing agenda in the moves towards full integration with higher education (Milligan,1998).

A difficulty in defining competence appears to be that based upon their own values, beliefs and experience individuals may have differing perceptions of the concept from their own perspective (Chambers, 1998).

The World Health Organisation defines competence as "the ability to carry out a certain professional function, which is made up of a repertoire of professional practices". This broad definition is not particularly helpful as before someone can be viewed as competent in a role, a nurse or teacher for example, there needs to be an agreement on what it is to be a nurse or teacher (Short, 1984). Eraut (1994) concurs with this view in that he advises that it necessary to examine how normative agreements are constructed and asserts that the question that should be asked is not only how competence is defined in general but also in particular situations. Miller et al (1988) suggest that competence can defined in two ways as it be equated with performance of a particular skill or task but it can also be described as a 'state of being'. The latter being a psychological construct, integrating cognitive, affective and psychomotor skills that affect the level to which an individual performs.

Whilst competence as a psychological construct is difficult to observe Runciman (1990) suggests that it can be seen through the individual's competent performance. Further to this Messick explains that :

> *Competence embraces the structure of knowledge and abilities, whereas performance subsumes as well the processes of accessing and utilizing those structures and a host of affective, motivational, attentional and stylistic factors that influence the ultimate responses.* (Messick, 1984, cited by Eraut, 1994, p178

Eraut (1994) refers to these factors as capability and goes beyond Messick to espouse that the term can indicate an individuals current abilities or it can relate to a person's potential to perform in the future. In addition to these internal factors, a person's ability to perform can be affected by the individuals perception of the expectations of the organisation; expectations of work colleagues; expectations of reference groups such as professional organisations and their own expectations, that is, own role image (Benne and Bennis, 1959). Harrington and Theis (1968) suggest the attitudes and expectations of superiors; the nature of the work assignment and the quality and amount of work related communications also affect performance.

3.22 Conceptualising competence

It has been argued that the competence vocabulary results in confusion and misinterpretation as a consequence of competence being assumed to be a descriptive concept rather than a normative concept and it being regarded as a thing or an activity rather than a quality or state of being (Short, 1984). Short (1984) attempted to capture the diverse meanings of competence in the following four conceptualisations:

1. Performance can be measured for competence regarding specific behaviours.

2. Competence can be viewed as a command of pertinent knowledge and /or skills.

3. Competence may be seen as indicative of a degree of capability deemed sufficient in a particular activity.

4. A holistic conceptualisation of competence includes knowledge, skills, attitudes, performances and levels of sufficiency.

In the first two of these conceptualisations performance and competence are closely related but are viewed separately and in a reductionist way but the fourth conceptualisation depicts competency as incorporating first three concepts.

Gonczi et al (1994) conceptualises competence in the following three ways that are not dissimilar to those detailed by Short: (1) task based or behaviourist requiring direct observation of practice (2) general attributes of the practitioner essential for effective performance requiring generic competencies to be instilled into practitioners and finally (3) as bringing together a range of general attributes such as knowledge, skills and attitudes in such a way that they address the needs of the practitioner. To Gonczi competency is not a mere performance of tasks, as it requires a combination of attributes, elsewhere referred to as capability or generic competence underlying

some aspect of professional performance they do not in themselves constitute competence. But what is meant by general attributes? Researchers into management competency (Otter, 1989, Schroder, 1989) have focused on determining average from excellent managers by identifying attributes or generic competencies that are not situation specific. In the field of medicine, Norman (1985) provided a model of competence that includes clinical skill, knowledge and understanding and technical skill but also refers to problem solving and clinical judgment and interpersonal attributes. Similarly Maatsch (1990) presents a model of general clinical competence in emergency medicine comprising of three interrelated constructs: medical knowledge; clinical problem solving and a general competence factor. The latter incorporates intelligence; motivation; learning skills; general knowledge base and personality.

3.23 Nursing competencies

In nursing Zhang et al, (2002) identify ten general competencies that affect performance. These are interpersonal understanding; commitment; information gathering; thoroughness; persuasiveness; compassion; comforting; critical thinking; self-control and responsiveness. It can be seen that these competencies relate to the broad categories of motivation, personality and learning identified by Maatsch. However unlike Maatsch, knowledge and technical skills were not regarded as general competences but as threshold competencies, indicating that they are necessary to meet various job requirements but do not guarantee effective performances. Zhang identified the 'good' nurse as one that uses critical thinking skills to accurately assess the patient's symptoms and situation. Conversely, following a study of 200 cases of incompetent care, Mustard (2002), identified lack of thoroughness and self-control as major contributors of poor performance. The Oxford Concise Dictionary defines self control as power to control one's external reactions however, in relation to competency, it is more usefully described as a tendency to choose a larger, more delayed reinforcer, over a smaller, less delayed one (Logue,1988). For example, omitting hand washing following patient contact in order to move onto another task instead of acting positively to reduce healthcare acquired infection can be viewed as a lack of self-control.

3.24 Sufficiency of competence in nursing

The third conceptualisation of competency provided by Short (1984) raises the subject of sufficiency. The Oxford Concise Dictionary defines sufficiency as adequate resources or ability, which if applied to competency could be seen as positive in that care delivery will be satisfactory. However, competence is not a static concept but is judged in relation to the complexity of the task or role. As Eraut (1994) states:

> *Where there is a need for extra quality or expertise the description 'competent' is tantamount to damning with faint praise; but for routine tasks competence may be preferable to excellence if it resulted in a quicker cheaper service.* (Eraut,1994. p166).

Contrary to Eraut's view of sufficiency Watson (2002) considers the concept to be anti-educational and detrimental to development of expert practice. Other authors (Pearson, 1984. Benner,1984. Dreyfus and Dreyfus, 1986) view competence as the midway stage in an individual's professional development. Dreyfus and Dreyfus (1986) present a 5 stage model for the development of expertise that emphasises perception and decision making rather than routine action and endorses the existential perspective that:

> *Human understanding was a skill akin to knowing how to find one's way about in the world, rather than knowing a lot of facts and rules for relating them. Our basic understanding was thus a knowing how rather than a knowing that.* (Dreyfus and Dreyfus, 1986, p4)

They claim that perception and understanding are not grounded in the capacity for picking up rules, but in developing flexible styles of behaviour. See Box 2 for a summary of the Dreyfus Model of Skill Acquisition

Box 2 - Summary of Dreyfus Model of Skills Acquisition

Level 1 Novice
- Rigid adherence to taught rules or plans
- Little situation perception
- No discretionary judgement

Level 2 Advanced Beginner
- Guidelines for action based on attributes or aspects (aspects are global characteristics or situations recognizable only after some prior experience)
- Situational perception still limited
- All attributes and aspects are treated separately and given equal importance

Level 3 Competent

- Coping with crowdedness
- Now sees actions at least partially in terms of long -term goals
- Conscious, deliberate planning
- Standardized and routine procedures

Level 4 Proficient
- See situations holistically rather than in terms of aspects
- See what is most important in a situation
- Perceives deviation from the normal pattern
- Decisions less laboured
- Uses maxims for guidance, whose meaning varies according to the situation

Level 5   Expert
- No longer relies on rules, guidelines or maxims
- Intuitive grasp of situations based on deep tacit understanding
- Analytic approaches used only in novel situation or when problems occur

• Vision of what is possible
(Eraut 1994, p124)

Benner, (1984) has presented a comprehensive account of the application of the Dreyfus model to describe the nature of nursing expertise across seven domains. The competent nurse according to Benner has moved out of the novice stage and passed through what she describes as the advanced beginner stage possessing marginally acceptable performance. The competent nurse demonstrates conscious deliberation and planning which help achieve efficiency and organisation but lacks the speed and flexibility of the proficient nurse or the intuitive grasp of situations possessed by the expert nurse. It is generally accepted that the new registrant's ability equates to that of an advanced beginner. In contrast, to merit recommendation for appointment by the Bar Council all of the stated competencies must be demonstrated to a standard of excellence (General Council of the Bar, 2010), and this would seem to imply expert practice. However, competence, according to Benner (1984), is reached after two to three years in clinical practice following registration and that expert practice is derived from an enormous background of experience.

Benner's model is in my opinion complemented by the model of competency development put forward by Elkin (1990) in which people are seen to develop many of the core competencies that allow long-term employment in the post after they have taken up an appointment. Elkin's model incorporates two aspects that are not explicitly featured in other models of competency; they are (a) recognition that competence continues to develop following appointment to a post and (b) a model of career progression.
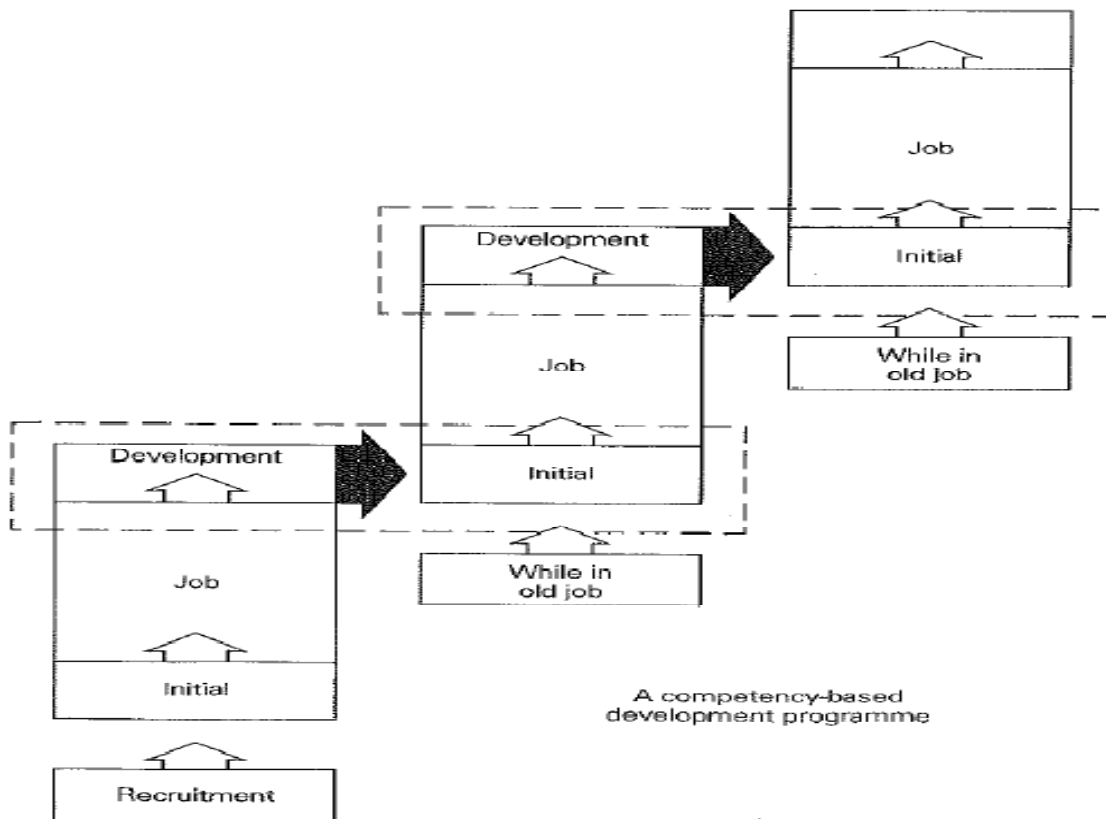
Figure 4 - Elkin's Model of Competency Development (cited in Eraut, 1994, p180)

Further to this Elkins maintains that when competence has been achieved the individual may aspire to further growth by acquisition of developmental competencies that may be an important, if not essential factor in gaining promotion to a more senior post. Both of these factors feature prominently within the NHS KSF framework and are fundamental principles of the STEPs framework.

3.25 Summary of Chapter 3

The introduction of the NHS KSF demonstrates an intention to draw out general aspects that show how individuals need to apply their knowledge and skills within their role and therefore, allied to the 'Job EvaluationFramework', appears to be more concerned with performance than with competence. I accept Newble's (1992) assertion that greater attention should be given to performance if a practitioner will be moving into an unsupervised situation. This view is corroborated through studies (Zhang, 2002, Mustard, 2002), which suggest that whilst the 'state of being' may be constant competence is not always highly correlated with performance. It is apparent that nursing practice is

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complex requiring combinations of knowledge, attitudes, values, performance and skills which, in my view, make the debate between competence, as either a cognitive or a performance related concept redundant and leads to over intellectualisation. However, it is clear that whilst it is not the sole indicator of what future performance will be, practitioners are required to be in possession of core attributes in order to achieve a dialectic that enables efficient and effective performance during and beyond transition from student to staff nurse.

A persons work can be affected by a number of cognitive, emotional, and contextual factors, not least the attendance to legal or psychological contracts and informal networks or communities of practice. Therefore, I believe it is better to adopt the integrated approaches portrayed in Short's (1984) fourth conceptualization, in which competence includes knowledge, skills, attitudes, performances and levels of sufficiency. This conclusion has particular relevance to the need for development of programmes such as the STEPs programme in light of the context of national policy, but with cognisance of the need to create a milieu that promotes and enables access to tacit knowledge held by practitioners.

The speed of implementation of the NHS plan (2000) and a myriad of associated directives, followed by constant assessment of organisational performance against quantifiable targets was brutal. As a result, the time for clinical leaders and their teams to engage in careful, proactive planning for learning opportunities and effective delivery of support in developing competency was diminished. It is also my view that formal education alone will not deliver the vision for lifelong learning as identified in this literature review. The development of STEP 1 is an attempt to deliver one pragmatic solution for supporting transition from student to staff nurse by providing structured support in practice by experienced nurses; identifying the work based learning needs of new registrants and enhancing integration of theory into practice whilst working towards demonstration of the predetermined NHS KSF performance criteria. Additionally STEPs could be a useful tool for demonstrating to new registrants the relationship between what they achieve in clinical practice and attainment of the NHS KSF indicators, levels and dimensions required for Agenda for Change incremental pay progression. The above considerations underpinned by pragmatism, are reflected in the rationale for the research approach, design and methodology chosen for the STEP 1 project.

CHAPTER 4: RESEARCH APPROACH, DESIGN AND METHODOLOGY

4.1 Introduction to Chapter 4 – Research Framework

This chapter is concerned with my rationale for adopting the chosen research approach, qualitative design and methodology for this project. Philosophical, ethical and methodological issues are also considered in detail.

4.2 Philosophical considerations

As identified in chapter 2 this study is philosophically aligned within a pragmatic tradition, however it is also necessary to position this work with an epistemological perspective. Guba and Lincoln (1986) identify three types of research; these are positivistic, interpretive and critical research epistemologies.

The positivist research approach of searching for existence of a constant relationship between variables can be relatively straight forward, given the ability of the researcher to control the conditions of experiments when dealing with natural world objects in laboratory settings. However, interpretive researchers maintain that people are conscious, purposive and attach meaning to what is going on around them and this impacts on their behaviour (Denzin and Lincoln, 2000.) Therefore when people are the subject of study in asocial context constant conjunction is so uncommon as to be virtually non – existent (Robson, 2002). Interpretive, naturalistic, or constructivist labels are often used interchangeably to describe qualitative research. McSherry, Simmons and Abbot, 2002, provide a useful broad description stating that:

> *Qualitative research is research that tells stories. That is not to say it tells falsehoods or fictions; what it does is to try to make sense of what is going on from the perspective of participants.* (Abbot in McSherry, Simmons and Abbot, 2002, p30)

However, the term constructivism is useful as it identifies a paradigm in which the underlying principle is that reality is socially constructed(Robson, 2002) and whilst knowledge is viewed as an individual construction, it can be subject to consensus as *reality and knowledge of reality are co-created from a mutual understanding that arises from lived experience.* Costley et al maintain that:*The role of the researcher is regarded as a participant who seeks to give voice to the experiences and perceptions of other participants* (Costley, Elliott and Gibbs, 2010).

Denzin and Lincoln (1998) identify three interconnected generic activities that define the qualitative research process which go by a number of different labels including 'theory, method and analysis' and 'ontology, epistemology and methodology'. The latter are branches of philosophy. Ontology has

been described as the branch of philosophy concerned with the 'nature of reality or what is there to be known? Epistemology deals with the origin, nature and limits of human knowledge, whilst methodology is the more practical branch of philosophy that deals with methods systems, and rules for the conduct of enquiry (Guba and Lincoln, 1989). These labels encapsulate the personal biography of the gendered researcher who speaks from a particular class, racial, cultural and ethnic community view. A fourth label, 'axiology' is added by Vashnavi and Keuchler (2009) and asks "what is of value".

It has been argued that qualitative researchers are less likely to establish the truth of conclusions than their positivist counterparts but this view is rigorously challenged. The counter argument is that when properly conducted in circumstances which allow for rigour, qualitative research is as rigorous as quantitative research as neither style finds it easier or more difficult than the other to establish truth (McSherry et al 2002)

As this study would be an attempt to develop STEP 1 and to elicit what impact implementation would have on those individual nurses and nursing teams in which they work, it is situated philosophically within the qualitative / constructivist domain. The framework for this project incorporates an action research approach to develop STEP 1, whilst utilising a case study design and qualitative methods. Data was collected through formal, informal and focus group interview and constant comparative analysis to assess the impact of its implementation on individuals and nursing teams. The outputs of this exercise would assist in identifying appropriate further development / changes to STEP 1.

4.3 Research Approach –   Action Research

As already identified a framework for continuing professional development for junior nurses had been evolving in the Trust for some time before the publication of the NHS KSF (DH, 2003. DH, 2004) and therefore a number of assumptions may have been formed by the project team regarding the structure and implementation of a programme that ensures support in attaining acceptable levels of competence and professional practice. The publication of the NHS KSF provided the impetus to question whether the project team's assumptions were in alignment with the perceived needs of individuals and the nursing teams to which they belong. A useful tenet in bringing about change is not to assume that your version of change is the one that could or should be implemented and that you should be prepared to change your view of what should be, through interaction and exchange of ideas with others concerned (Fullan,1982) Therefore an approach to developing STEPs needed to be identified which would encourage interaction with practitioners, provide opportunities for

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assumptions to be challenged and to encourage joint decision making. An initial review of qualitative research literature (Chein, Cook and Harding,1948. Whyte 1984,1991. Carr and Kemmis, 1986.Titchen and Binnie, 1993.Greenwood, 1994. Robson, 2002.)suggested to me that the requirement for collaboration between researchers and practitioners and for the participation of practitioners in decision making were generally seen as fundamental to action research The potential for this being an appropriate approach led me to further explore literature pertaining to action research

4.4 Action Research – Definition and Scope

Rapaport's (1970) definition of action research is frequently quoted in literature on the subject:

> *Action research aims to contribute to both the practical concerns of people in an immediate problematic situation and to the goals of social science by joint collaboration within a mutually acceptable ethical framework.*(Rapaport, 1970, p499).

Rapaport's definition revisits the view of two pioneers of action research, John Collier (1945) and Kurt Lewin (1946) that action research leads to action which creates knowledge or theory about that action and necessitates a different approach to pure scientific research which is intended to describe, understand and explain but not to change. Both Lewin and Collier viewed the major goals of action research as creating a change in practice and to develop or refine existing theory. Lewin (1946) is generally credited for introducing the term 'action research' to denote a pioneering approach towards social science research, which combined generation of theory with changing the social system through the researcher acting on or in the social system. Lewin characterised action research as comparative research on the conditions and effects of various forms of social action and research leading to social action through the development of deeper insights into the laws that govern social life. Robson (2002 supports the view thataction research is an applied social science approach which regards supporting and engineering change as an integral part of the research process. However, these views require to be challenged as the pursuit of universal laws of human behaviour and social change engineering may not be valid and appear patriarchal (Hart and Bond, 1993). The language Lewin used in describing theoretical aims and methods of social science appear positivistic and maybe considered incompatible with the aims and methods of social or educational science (Carr and Kemmis, 1986). Nevertheless the cyclical or spiral process of planning a change; acting and then observing what happens following the change; reflecting on these processes and consequences and then planning further action and repeating the process as described by Lewin (1946) is viewed as the basis of all action research (Meyer, 1993, McNiff,

1996,2002) and is often viewed as a spiral or cyclical to highlight the iterative process as illustrated in figure 5.
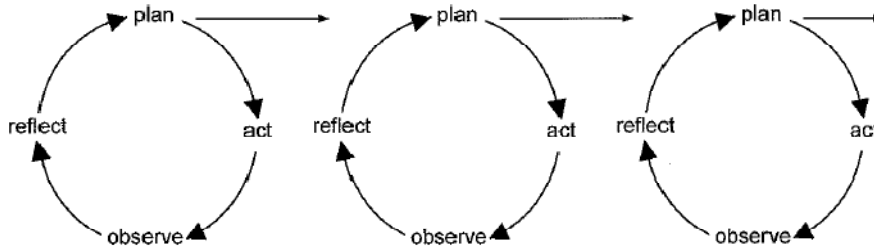
Figure 5 - Action Research Four Stage Spiral. Cited in McNiff et al (1996)

McNiff (2002) identifies systematic action and the practitioner's learning as the two crucial factors to action researchand states that:

> the process can be shown as a spiral of cycles, where one issue forms the basis of another and, as one question is addressed, the answer to it generates new questions. This can be seen as the „processes of developing practice" and forms the basis of the notion of improvement of professional practice (McNiff,2002 p. 2).

4.5 New paradigm research

Since the 1940s the approach to action research that relied heavily on the consultancy approach led by external researchers prescribing practice has been replaced in educational and nursing research by a 'new paradigm' perspective whereby practitioners are encouraged to act as researchers by systematic reflection on their everyday practice (McNiff, 1988. Meyer,1993). It is postulated that this is best be achieved through collaboration with participants in self-reflective enquiry (Titchen and Binnie, 1990) and Meyer (1993) highlighted a growing emphasis in nursing for Schön's (1987) concept of 'reflection- in- action' to produce professional knowledge more appropriate to practice. New paradigm research is not neutral or value free but is a supporting and questioning initiative (Reason, 1998) based upon respect for the integrity of individuals, and as the approach is more personal and interpersonal than methodological, it represents a humanistic philosophical approach to research (Meyer, 1993). Carr and Kemmis (1986) also link action research with Habermas's critical social science which rejects positivistic research and emphasises the need for democratic participation and self-reflection amongst practitioners leading to theory development based upon the meanings and interpretation of participants. This type of research is often brought into question as

being unscientific and more akin to professional and personal development than research based practice, a position that reflects a male dominated society with a historical tradition of positivist science (Meyer, 1993)

Whilst the purpose of action research is generally accepted as being to generate change and to generate theory (Elliott, 1981, McNiff, 1988, Whyte, 1991), it is clear from the work of other authors (Carr & Kemmis, 1982. Holter and Schwartz–Barcott, 1993, Meyer, 1993, Titchen and Binnie,1993 Greenwood 1994, Hart and Bond,1995)that action research should also be context related and developmental for all those involved, including researchers themselves The creation of strong links between research and practice are also viewed as fundamental to aims of advancing knowledge and the improvement of human welfare (Marrow, 1998). Stanley (1990) uses the term 'praxis' to denote the use of research strategies that enable changes in practice, and Kemmis (1982) viewed praxis as 'informed committed action' that is the outcome of reflection. This has implications for the development of researchers themselves as it is critical in action research for researchers and participants to question tacit knowledge (Polyani, 1967) through development of the abilities of reflecting on and in action' (Schön, 1987). Adelman (1983) argues that 'participatory' action research could provide a way of bringing together two different trends, that of individual reflection and that of organisational and group development (Hart and Bond, 1993). The focus on doing things with people rather than on people with the intention of professionalising, and empowering individuals with the potential for facilitating change are incorporated into a more recent definition, by Carr and Kemmis (1986) of action research than that provided by Rapaport (1970)

> *Action research is a form of self – reflective enquiry undertaken by participants in social situations in order to improve the rationality and justice of their own practice, their understanding of those practices, and the situation in which those practices are carried out. (*Carr and Kemmis,1986, p162)

4.6 Action Research as Science

In their seminal paper entitled 'An assessment of the scientific merits of action research' Susman and Evered (1978) maintain that action research is scientific albeit epistemologically different to positivistic research. They also contended that positivistic research based on the natural sciences has failed to generate knowledge that aids solution of problems faced by organisations. Kikkala and Munnaka (1993) share this view in regard to nursing, arguing that reliance on empirical data has in fact caused problems as research solutions following the empiricist tradition offer only limited opportunities to focus on the central research objects of nursing. It may be contended that as positivistic research methods and techniques became more sophisticated a marked gap has arisen between research and utility (Hart and Bond, 1993). Susman and Evered (1978) argued that by

limiting methods to what is claimed as value free, logical and empirical, positivist science produces knowledge, that when applied to organisations may only inadvertently serve and sometimes undermine the values of organisational members. Since the seventeenth century science has consisted of unitising and generalising and the major strategy for identifying 'truth' has been objectification through decontextualisation, but this approach cannot adequately address human action as the relationship of the person and the situation and content of the situation are overlooked (Benner and Wrubel, 1989). In nursing, reliance on empirical data has in fact caused problems as research solutions following the empiricist tradition offer only limited opportunities to focus on the central research objects (Kikkala and Munnaka, 1993) and may be seen as less useful for the purposes of organisational problem solving. This results in a dilemma for which action research is well placed to address as in addition to its utility it can also be validated as a science. Action research cannot be viewed as scientific when measured against criteria used for empirical research, as it is epistemologically different. Therefore it should be measured by criteria from different philosophical positions, which may include praxis; hermeneutics; existentialism; pragmatism; process philosophies and phenomenology (Susman and Evered, 1978).This differing epistemology yields a different kind of knowledge to positivistic research, a knowledge that is situational and develops the capacity of an organisation's members to solve their own problems (Chein, Cook and Harding,1948, Susman and Evered, 1978. Carr and Kemmis, 1986).

4.7 Action Research Categorisation and Typology

Action research' has been described in so many contradictory ways that the underlying pattern is obscured and leaves the impression that it is amorphous (Hart and Bond, 1995) and this is compounded by the variation between the names and definitions of action research provided by various authors (Lewin, 1946, Chein, Cook and Harding,1948. Carr and Kemmis, 1986. Holter and Schwartz – Barcott 1993, Hart and Bond, 1995). I am drawn to agree with Hart and Bond (1995) who believe that there is a lack of precision in terms, which is in their view an enduring feature of social research and is not exclusive to 'action research'. However, these differences do appear essentially semantic as all the categorisations in the literature generally illustrate differences in the degree of collaboration of researcher and subject. Nevertheless the variations in describing types of action research can be confusing.

With the intention of clarifying what is meant by 'action research, Hart and Bond (1995) have drawn upon broad traditions identified in the 'action research literature, including Lewin's experimental approach, organisational change, community education and nursing to identify a typology for 'action research'. They identify a typology comprised of four types of action research and seven

distinguishing criteria. Hart and Bond suggest that the types and criteria are used as a matrix toillustrate the underlying philosophy of an action research project (see appendix 4)

The four types of action research illustrated by Hart and Bond are viewed as ranging between two models of society. Experimental action research depicting rational social management assuming a consensus model of society lies at one end of the scale; empowering action research portraying a structural change and conflict model of society lies at the other end of the scale. Two more types, organisational action research and professionalizing action research, sit between these two poles. The experimental approach as described by Hart and Bond resembles the scientific 'cause and effect' research approach (Lyon, 1998) and is similar to the 'technical-collaboration model described by Holter and Schwartz – Barcott (1993). Both models are aimed at validating an identified intervention, based on a pre-determined theoretical framework, and are time limited, task focused and researcher led. The core concern of the organisational approach is to solve problems and overcome resistance to change through the application of change strategies. It is predominantly a top down approach because the problem is defined by the most powerful group involved, and is generally most relevant to management or social science interests. The professionalising type is grounded in practice and reflects the aspirations of professions such as nursing, social work and teaching to develop a research base and enhance their status in comparison with professions such as law and medicine. The professionalising type resembles participant action research as described by Chein, Cook and Harding (1948) as the researcher and practitioner collaborate in identifying a problem, diagnosing causal processes and determining potential solutions. This leads towards improvement by the professionals on and behalf of the user.

Hart and Bond's organisational and professionalizing approaches do however appear to be encompassed in what Holter and Schwartz-Barcott's term the mutual collaborative approach. This approach is based upon historical and hermeneutic philosophy and the focus of collaboration is mutual understanding as it brings the researcher and practitioner together to identify problems and their possible causes and to seek appropriate solutions.

Hart and Bond's 'empowering' type focuses on developing practice / person centred theory through an anti-oppressive position, in relation to working with vulnerable groups and is most closely associated with approaches to community development . At first glance the 'empowering'type appears to equate to the enhancement approach detailed by Holter and Schwartz-Barcott, however, the latter is aimed at improving professional practice at the level of organisational and cultural change rather than addressing existing power relationships or the involvements of users. The

enhancement approach is therefore more akin to the organisational and professionalizing types described by Hart and Bond (1993). Hart and Bond's empowering type also bears some similarity to what Chein, Cook and Harding (1948) regard as the only true form of action research, 'experimental action research'. The experimental action research approach requires the researcher and client to collaborate in all or nearly all phases to set up an experiment for taking an action and evaluating its consequences. However, the 'empowering' type appears to be philosophically most closely akin to what Carr and Kemmis (1986) regard as emancipatory research and Lewins' 'participative action research'. The latter differed from other forms described by Lewins in that communities are involved in making decisions about remedial action.

Whilst criteria depicting action research had been alluded to by other writers, Hart and Bond(1993) provide a comprehensive list which includes

(1) Educative base (2) Individuals in groups (3) Problem focus (4) Change intervention (5) Improvement and involvement (6) Cyclical process (7) Research relationship, degree of collaboration

 Importantly Hart and Bond demonstrated how each criterion varies in relation to the particular type of action research in which it is located. However, in my view the major contribution Hart and Bond make to action research literature, and the fundamental difference in their approach to that of other authors, is their assertion that during the life of an action research project the approach may move from one category to another as it progresses through the spirals of the action research process. Component parts such as the setting,people, attitudes and protocols inform this movement. The shift from one type to another may be either part of a planned series of discrete cycles or in response to the context in which the action research is taking place and as part of the political nature of action research. Therefore the position the researcher takes up will influence the manner in which change takes place. The further one moves from the planned and controlled processes of Hart & Bond's experimental category towards an empowering approachwhich promotes active engagement by others in the process, change occurs that is more reflective of the political nature of social life.

I believe that the research question that should determine the method to be used as:

…the question being asked determines the appropriate research architecture, strategy and tactics to be used, not tradition, authority, experts, paradigm or schools of thought (Sackett and Wenberg, 1997, p:1636)

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However I support the view that it is wise to be sceptical of positivist science when the participant is, like the researcher, a self-reflecting human, when relationships between participants are influenced by definitions of the situation, or when the participant has been involved in defining the problem to be solved (Susman and Evered ,1978). Action research is an applied social science approach that regards collaboration, education and advancement of knowledge as integral to the research process. Further to this experience and knowledge possessed by both the researcher and participants are drawn upon to suggest ways of effecting desirable change and to monitor changes. Fuller and Petch (1995) suggest that action researchers could involve the subjects of research in the development of ideas about what to study and through collectively identifying topics and priorities democratise the research process. This will increase ownership and commitment to successful completion of the project by participants.

For these reasons I view action research as the appropriate approach for developing this project. In particular, as I became more conversant with Hart and Bond's typology it appeared to me that viewing my project within this multidimensional framework would encourage acknowledgement of the setting and political context in which the project is conducted. This project is aimed at developing and refining the STEPs programme across a variety of clinical settings with input from a large number of participants including staff nurses, clinical managers, trade union/professional organisation representatives and senior managers. It therefore seemed to me that on-going review using this multidimensional framework would assist me to clearly depict the reality of the setting including the impact of various individuals and groups on the trajectory of the project as it evolves. I also believed that these considerations and reflection of the political context of the project would assist me to reflect on and articulate my philosophical values in relation to directing this project as it evolved.

4.8 Rationale for utilisation of a qualitative study design

Whilst action research seemed to be an appropriate approach to the development of the STEPs programme I wished to understand the impact of the project and the implementation of STEPs upon individuals and the teams in which they worked therefore I believed it important to explore the project from a phenomenological perspective. That is, to recognise that each individual selects how they respond to the same stimuli and therefore reality is how each individual interprets and makes sense of the world (Fox, Martin and Green, 2007, Costley, Elliot and Gibbs, 2010)

The use of a study design that is essentially qualitative appealed to me as difficulties of positivistic science when dealing with humans has long been debated (Dilthey, 1910. Susman and Evered,

1978). Dilthey (1910) suggested that studies of humans become accessible through the depiction of the relationship between life, expression and understanding in order to acquaint man with himself.

It is through qualitative approaches, such as case study, rather than more objective and scientific studies (Susman and Evered, 1978) that we are likely to connect epistemologically with the reader and thus to that person a basis for generalisation (Stake, 2000). Clearly empirical investigation to discover or validate laws is entirely appropriate but tacit knowledge derived through the recognition of similarities and differences of objects, issues and events through experience is also a form of generalisation. Experience leads to perceptions of how things are, why they are and how individuals feel about them and how these things are likely to be in other situations familiar to them. Eraut (1994) provides a useful illustration of the development of tacit knowledge using the teaching profession as an example. He writes

> *Teachers early experiences in professional practice are characterised by gradual routinisation and this is necessary in order for them to be able to cope with what would otherwise be a highly stressful situation with a continuing 'information overload'. This routinisation is accompanied by a diminution of self consciousness and a focus of perceptual awareness on particular phenomena.*(Eraut, 1994, p111).

It is easy to see how this example also applies to other professions. Through verbalisation tacit knowledge may become propositional knowledge. These 'naturalistic generalisations', whilst not derived through empirical method resulting in formal, scholarly generalisations they are intuitive and inductive. Furthermore as naturalistic generalisation more often leads to expectation and action it is this type of generalisation elicited from participants that will inform the study, supply narrative and result in conclusions (Stake and Trumbell, 1982. Stake, 2000).

Case study research has been described as a qualitative method that investigates a contemporary phenomenon within its real life context (Yin, 1994, 2009. Gilham, 2000), and copes with a technically distinctive situation using multiple sources of evidence (Robson, 2002). It is commonly used in many fields including psychology, social work, education and nursing to expand knowledge of phenomena relating to individuals, groups, and organisations (Bromley, 1986. Yin, 2009)

Gilham (2000) defines a case as

> …*a unit of human activity embedded in the real world that can only be studied or understood in context.* (Gilham, 2000. p1).

Cases may be individual people or social units of various kinds and whilst the number of cases may be small (possibly a single case) the number of variables involved is large (Yin, 1994, 2009. Burns

and Groves, 1997,). The environment or context in which a study takes place is often difficult to isolate from the study itself, but boundedness and behaviour patterns are useful in specifying the case. In seeking what is common or particular about a case the researcher may draw on (a) the nature of the case (b) the case's historical background (c) the physical setting (d) other contexts (e.g. economic, political, legal and aesthetic) (e) other cases through which this case is recognized (6) the informants through whom this case can be known (Stake, 1995). Data is usually gathered by interview and/or observation and reports are written in an informal style that is interspersed with verbatim quotations and illustrations (Mitchell, 2000. Stake, 1995, 2000).

4.10 Case study types

Yin (199,2009) lists four applications for case studies. They are explanation, in which causal links in real life interventions are sought; description of an intervention and the context in which it occurred; illustration through description of certain topics within an evaluation; and to enlighten situations in which an intervention has no clear, single set of outcomes. However, Stake (1995) identifies three types, intrinsic, instrumental and collective, which relate to the purpose of the case study. In intrinsic case study the prime purpose is not to develop theory, although this may potentially follow, but to develop deep understanding of a particular case. Despite semantic differences it appears to me that the intrinsic type most closely resembles Yin's descriptive or illustrative applications.

As the overarching research question is 'What impact and meaning would implementation of the STEPs framework have for newly registered nurses and teams in which they work?'the purpose of this case study is essentially intrinsic, rather than instrumental in nature. Unlike instrumental case study research the case is not selected to represent or provide information about other similar cases (Bryar, 1999) or because it illustrates a particularly trait or problem. Nor is the purpose of intrinsic case study to come to understand some abstract construct or generic phenomenon, such as literacy or teenage drug use (Stake, 2000a), as in instrumental case study. It is undertaken because of intrinsic interest in a particular case such as an individual, community, organisation event or curriculum. Stake's third purposive category is collective or multiple case study design which allows for comparison between cases   relating to a specific topic.   The case(s) can be any 'bounded system'; an institution, a programme, a responsibility or population. (Stake, 2000b). Therefore it is apparent that the purpose of my case study is both intrinsic and collective.

Relationships between the concepts constructivism, phenomenology and my choice of an intrinsic /collective case study design are demonstrated below in figure 6.

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Philosophical Paradigm

Constuctivist (or naturalistic)
Approaches that sit within this paradigm regard reality as being individually and socially constructed. The researcher is regarded as a participant who seeks to give voice to the experiences and perceptions of other participants

Methodological Approach

Phenomenonology
This methodological approachfocuses on gaining understanding and insight into the subjective experience of individuals. Through discussion and dialogue limitations in current thinking, actions or policies may become known and thinking widened and/or alternatives developed (Costley etal, 2010). Phenomenological principles can usefully inform numerous forms of research including case study and action research.

Research design

Intrinsic/Collective Case Study
Such a research design reflects an interest in a particular case for example community, event, curriculum or project. This design also facilitates presentation of projects and sequences of actions as well as drawing out points that may be interesting and valuable to a wider audience. For example comparison of how new registrants and nursing teams identified problems, sought solutions and implemented change via the action research cycle.

Figure 6 - The relationship between Collectivism, Phenomenonology and the Intrinsic/Collective research design used in this study.

In my opinion, collective or multiple case studies provides the most suitable design choice for this project as a number of cases are explored in order to yield more extensive information and comparison of cases is potentially fruitful; particularly when the researcher is interested in exploring the same phenomenon in a diversity of situations (Munhill & Boyd, 1995). I believe a multiple case study design facilitates documentation of how new registrants and nursing teams use experience and knowledge to (a) suggest ways of identifying solutions to problems and (b) how desirable change is implemented through the action research cycle. I believe this to be true as through careful attention to consistency my intention is to refine the analysis and interpret data from a variety of settings. . It can be argued that case studies can have general relevance even whilst not providing a sound basis for conventional scientific generalization (Stake, 2000a. Yin, 2009). Whilst moving

towards a level of abstraction which stops short of theory development the case study design should enable the drawing of general conclusions and formulation of recommendations.

The value of this type of study is that it provides full and thorough knowledge of the particular. What is required of case study researchers is not that they provide generalisations, but that they capture the unique features of the case. This requires that the target case is described correctly and Stake emphasises that case study:

> ..is distinctive in the first place by giving prominence to what is and what is not 'the case' – the boundaries are kept in focus. What is happening and deemed important within those boundaries (the emic) is considered vital and usually determines what the study is about, as opposed to other kinds of studies where hypotheses or issues previously targeted by the investigators (the etic) usually determine the content of the study. (Stake, in Gomm, Hammersley and Foster, 2000b, p23)

Reviewing Stakes' propositions Hammersley and Gomm (2000) conclude:

> …. a case is a bounded system that exists independent of enquiry, and he emphasizes the importance of respecting the boundaries of the case .(Gomm, Hammersley and Foster, 2000, p 8)

4.11 Rigour – validity, reliability and generalisability

Validity, reliability and generalisability are recurring issues regarding the rigour of qualitative research (Lincoln and Guba, 1985. Mathers and Huang, 1998) and case study research is no exception (Bromley, 1986. Yin, 1994, 2009, Stake, 2000, Norrie, 2004). Whilst case study research has been disdained as a soft option, lacking rigour compared to experiments or surveys, it is argued that the reasons for poor case study research can be traced to a 'sloppy' investigator who has not followed systematic procedures or introduced bias which skewed the findings and conclusions (Bromley, 1986. Yin, 2009).

The term validity, in broad terms, determines the extent to which an instrument measures what it was developed to measure; reliability is the degree to which the instrument gives consistent results and generalisation is the ability to apply findings to a wider population than the sample studied. However, the relevance of validity, reliability and generalisation in qualitative research has been questioned), as it is based on different assumptions to positivist research (Lincoln and Guba, 1985. Mathers and Huang, 1998. Lincoln and Guba (1985) argue that:

> We are so imbued with the tenets of science that we take assumptions utterly for granted. So much so that we almost cannot comprehend other ways of thinking and

when other ways are suggested we are inclined to shut our ears, feeling that to merely listen to them is, quite literally heresy.(Lincoln and Guba, 1985, p 8-9).

Slevin and Sines (2000) identify that a number of authors suggest that quantitative language should be avoided in qualitative research as the two paradigms have different philosophical roots (Appleton, 1995. Hinds et al.1990, Holloway and Wheeler, 1996). Similarly, Lincoln and Guba (1985) emphasise the need to establish truthfulness in qualitative enquiry and identify credibility, dependability, transferability and confirmability as being analogous terms to be used instead of positivist language.

4.12 Credibility

Amongst the criteria for assessing the strength of any qualitative research project, concern for trustworthiness regarding the way evidence is produced for the credibility of the research to be assessed is paramount (Shipman, 1988). It is the duty of the case study researcher to demonstrate that the study is conducted in a way that establishes that the methods used are clearly illustrated and justified and the subject of enquiry accurately identified and described. Numerous techniques are cited as useful for improving credibility (Mathers and Huang, 1998, Silverman, 2000.). However, checking the data with those from whom it was attained has been said to get the heart of credibility (Guba and Lincoln, 1981), and findings are seen to be tautologically credible if participants believe them from their several perspectives (Shipman, 1988, Robson, 1993)(see 4.23)

Through the case study design and methodology I endeavour to demonstrate credibility through detailed description of the cases, the setting and the study participants (Mathers and Huang, 1998), the use of multiple sources of information, establishing a chain of evidence (Yin, 1994, Silverman, 2000) and reviewing draft reports by key informants (Guba and Lincoln, 1981, Silverman, 2000) and exposing analysis and reports for peer review on a continuous basis for the duration of the Study (Robson, 2002).

4.13 Dependability

Proving the reliability of a case study project by demonstrating that if a later investigator repeated the study the findings and conclusions would be the same (Politi et al, 2001) is problematic and Yin (1994) maintains that this is not a completely resolvable issue. By definition any case is unique and cannot be repeated as the social world is in constant change (Mathers and Huang, 1998, Norrie, 2004). In a healthcare context service provision is frequently adjusted, wards are opened and closed or the physical environment may alter due to refurbishment or reprovision, also staff change as they may leave, be promoted or are assigned different duties and in addition over time attitudes may

change and therefore the researcher must attempt to account for changes. The research process should be open and for this reason I recognise the need to provide an audit trail

4.14 Transferability

Transferability, or the degree to which findings can be demonstrated as applicable in a different setting, is a direct function of similarity, or fittingness between the researched context and the user's context (Lincoln and Guba, 1985, 2000). Whilst Mathers and Huang (1998) advise caution about making claims for other settings, I support the view that the burden of proof is actually on the reader rather than on the original researcher to decide whether the findings are applicable to cases other than those studied by the researcher (Lincoln and Guba 2000). I do not, however believe that this relieves me of the responsibility to be meticulous in the reporting of the study as the case study researcher should endeavour to provide a 'thick description' about the context of the enquiry; the objective being to provide anyone interested in the possibility of transferability with a sufficiency of information on which to make that judgement (Geertz, 1973)

Lincoln and Guba (1985) describe a fourth criterion, confirmability, as a corresponding concept to objectivity and mark a change in focus from the objectivity of the researcher to the adequacy of the process and whether the findings flow from the data. Confirmability is apparent when credibility, transferability and dependability have been met**.**

4.15 The Research Setting

Three cases were identified for study in order to enhance the amount of data collected but also to allow comparison of differences and similarities in the implementation and impact of STEPs.

The nursing teams selected for study form part of an NHS Hospitals Trust. This organisation is categorised as a University Teaching Hospital Trust having an annual income of over £400 million and employing 7000+ staff. The Trust employs 3000+ registered / unregistered nursing staff. Approximately one thousand of these are employed in the Critical Care and Surgical Divisions. The Trust occupies two sites and provides a wide range of secondary and tertiary health care services for local and sub-regional populations. One hospital site is situated in the centre of the city and is the main major emergency admission hospital. In addition to general surgical and medical/medical elderly admission wards this site houses the Acute Assessment Unit, Accident and Emergency Department, Critical Care Trauma/Orthopaedic, Neurosurgery, Ear, Nose and Throat, Diabetes and Endocrinology, Ophthalmic, Paediatric and Maternity Units.

Another large site is situated west of the city and is primarily an elective admissions hospital at which orthopaedic, upper gastrointestinal, cardio-thoracic, urological and colo-rectal and breast surgery is conducted. The site also houses general medical and medical elderly wards and outpatient departments, gynaecology, women's outpatient services and a recently completed a £45 million cancer centre development. The Trust has recently undertaken major developments in the Cardio-thoracic and Surgical specialties in order to meet government access targets and to increase overall in-patient capacity.

4.16 The cases - clinical nursing teams

The nursing teams identified as cases for this study were the Neurosurgical Unit, the Urology Unit, and the General High Dependency Unit.

These units were identified for inclusion as cases for the following reasons:

- The Nurse Managers and Matrons for these areas demonstrated an interest in the development of the STEPs programme at an early stage and responded to a request for areas that were interested in participating in the project to identify themselves.
- The range of settings within these departments includes ward, intensive care and high dependency areas.
- As the Divisional Nurse Advisor these areas were accessible to me and I was known to clinical staff.

The description of each clinical team that follows in sections 4.17 - 4.19 includes staffing establishment / available support/ identification and preparation of supervisors / environment / recruitment of study participants. To assist in the portrayal of these cases the dependency and acuity level of patients is described using the Department of Health 'critical care classification' (DoH, 2000). This classification, outlined in table 2, is used to assist in determining the level of care a patient requires based upon the acuity of his/her condition

Table 2 - Critical care classification

Level 0	Patients whose needs can be met through normal ward care in an acute hospital
Level 1	Patients at risk of their condition deteriorating, or those recently relocated from higher levels of care, whose needs can be met on an acute ward with additional advice and

	support from the critical care team.
Level 2	Patients are those requiring more detailed observation or intervention including support for a single failing organ system or post-operative care and those 'stepping down' from higher levels of care.
Level 3	Patients requiring advanced respiratory support alone or basic respiratory support together with support of at least two organ systems. This level includes all complex patients requiring support for multi-organ failure.

Adapted from Department of Health, 2000, Comprehensive Critical Care: A Review Of Adult Critical Care Services, P 8.

4.17 The Urology Unit

The Urology service consists of a purpose built forty bedded ward, the urology out-patient department and a day surgery unit. The Urology Ward provides pre-operative and post-operative care for patients categorised between 0 & 2 on the critical care classification scale. Patients are admitted either electively or as and emergencies with a wide range of urological conditions. The one whole time equivalent (wte) matron (Band 8a, formerly H grade) has overall responsibility for management of the Urology Service but ongoing management of the urology ward is provided by a Charge Nurse (0.8 wte, Band 7, formerly G grade). The Charge Nurse is supported by 2.6 wte, Senior Registered Nurses (Band 6 / formerly F grade); 34 wte, staff nurses (band 5/formerly E grade) nurses 2 Clinical Support Workers (band 3) and 13.6 wte Nursing Auxiliaries (Band 2 formerly A grade)

Five Consultant Urologists and their teams provide medical management of patients on the Urology unit.

4.18 The Neuro-surgical Unit

The Neuro-surgical Unit is a sub–regional specialty unit comprising of a twenty six bedded ward, a four bedded Intensive Care Area and a nine bedded High Dependency Area. The Neuro-surgical Unit is housed at the city centre hospital site.

Patients received on this unit include both elective and emergency admissions with a wide range of conditions including spinal surgery, subarachnoid haemorrhage, major head injuries, spinal injuries and metastatic cerebral tumours. The ward area provides care for patients categorised as Critical

Care Classification levels 0 and 1. The Neuro-surgical High Dependency unit provides care for level 2 patients and the Neuro-surgical Critical Care Unit provides services for level 3 patients. The management of these areas is overseen by the Neuro-surgical Unit Matron.

The neurosurgical intensive care and high dependency areas are managed by 1wte Charge Nurse (band 7) supported by 7 wte senior registered nurses (band 6). The staffing complement for the two units also includes 40 staff nurses (band 5). This group of staff are utilised in a flexible manner between the two areas depending on their level of neurosurgical high dependency / intensive care expertise depending on the number of patients and the dependency levels of the patients in each area.

The ward area is managed on a day-to-day basis by two ward coordinators (band 6). The ward coordinator role combined management of the ward and direct care for a group of five or six patients, communicating with the multidisciplinary team and monitoring the delivery of care by other nurses on the shift. The staffing complement for the ward also included 20 (band 5) 1.64 Clinical Support Workers (band 3) and 8.54 Nursing Auxiliaries (band 2). In addition the Neuro-surgical Unit establishment includes a Teacher / Practitioner post (1 wte, Band 7).

Medical management of patients on the Neuro-surgical unit is provided by five consultant neuro-surgeons and their teams. Ventilatory management on the Neuro-surgical Intensive Care Unit is supported by Consultant Intensivists / Anaesthetists and their teams which are based on the General Intensive Care Unit.

4.19 The General High Dependency Unit

The General High Dependency Unit (GHDU) is a ten beddedunit that alongside a ten bedded General Intensive Care Unit (GICU) comprises the Critical Care Area, which is situated at the city centre hospital site.

The GHDU includes an eight bedded open plan area and two single bedded cubicles providing accommodation for Critical Care Classification (D0H 2002) level 2 patients admitted under the care of medical and surgical medical staff. Medical management on the unit is provided by intensivist / anaesthetic consultant medical staff. The overall nursing management of the GICU and GHDU is the responsibility of the Critical Care Area Matron. The GHDU is managed by a Charge Nurse (1wte, band 7) supported by a Teacher/ Practitioner (1wte, band 7) and 4.8 wte Senior Registered Nurses (band 6 /F Grade). The staffing establishment also includes 21.03 wte Band 5 Nurses, 4.8 wte Nursing Auxiliaries (Band 2/A grade).

The staff on these areas, including the Teacher Practitioner but with the exception of the Charge Nurse, work three x 12.5 hour shifts per week and rotate between the day and night shifts. The Charge Nurse is on duty for five x 7.5 four shifts per week working flexibly between 08:00hours and 20:00 but occasionally works a night shift depending on the needs of the unit. During the period of this project the Charge Nurse was on maternity leave for two periods during which time the Teacher /Practitioner acted into the Charge Nurse role.

4.20 Identification of the Sample Group

There are no well-defined rules for sample size in qualitative research (Patton, 1990) but sampling size is usually restricted to small numbers in order to carry out an in-depth, detailed study (Patton 1990, Miles and Huberman 1994). As I wished to explore the impact of STEPs on individual new registrants and the teams in which they work it was necessary to identify informants that would add to, support or refute my developing understanding in relation to the topic (Crookes and Davis, 1998) I decided to employ purposive sampling using the following predetermined criteria:

1. New entrants to the NMC register working within the clinical areas identified as the cases for the study.

2. Nurses fulfilling the role of practice supervisors

3. Matrons / Charge Nurses overseeing the implementation of STEPs in their clinical area.

Therefore participating new registrants would be recruited serially (Higginbotham et al, 2001) depending on what had previously emerged (Lincoln and Guba, 1985).

4.21 Data collection

In order to acquire a robust data set which would add rigour, breadth and depth to this project, whilst reducing data collection bias I decided to use a combination of data collection methods. The application and combination of various research methods in qualitative research is known as 'triangulation' and is analogous to the same term used in surveying which denotes a method of finding out where something is by getting a 'fix' from a number of places (Robson, 2002). Denzin (1988,) first suggested that this might be done in social research by using multiple and different sources of evidence This is based on the principle that credibility is strengthened if various sources, methods, investigators or theories yield similar findings. It should be noted that no specific method should be privileged over any other any method dismissed out of hand as each of these investigative practices can yield important insights (Denzin and Lincoln, 1998). Triangulation is

viewed as a significant strategy for enhancing the credibility of qualitative research (Lincoln and Guba, 1985) and Yin (2009) maintains:

> *The most important advantage of using multiple sources of evidence is the development of converging lines of enquiry, a process of triangulation and corroboration* (Yin, 2009, p115)

However, research using of triangulation is likely to take longer to complete than single method approaches and requires the researcher to develop expertise in a wide range of techniques. These include, but are not restricted to, interviewing, management of focus groups and transcription and analysis of data (Proctor, 1998).

It is important to realise that all methods can have confounding effects on the researcher's measurement. Therefore it is impossible to know whether an unknown part or aspect of results may have been influenced by any single method. The most important impact of triangulation is the reduction in the likelihood of the researcher experiencing 'inappropriate certainty', which may result from the use of a single method leading to a delusion that they have found the 'right' answer. The use of additional methods may lead to alterative answers, hence removing unwarranted certainty (Robson, 2002). Indeed, the need to triangulate sources of evidence informed my thinking when identifying my sampling strategy.

The prime modes of data collection identified to provide multiple sources of evidence for triangulation during this study are tape recorded unstructured formal interview, informal interviews, focus group interview, literature review and my own reflections as an insider researcher. Winter and Munn-Giddings (2000) state that

> *…data gathering goes beyond simply asking questions and to include processes which encourage all participants to present details of their experience and their conceptions of desirable changes in practice, so that their ideas and perceptions become available for comparison and exploration.* (Munn-Giddings, 2000, p6)

Data collection would continue until no new data emerged that adds to the value of the study, a situation referred to as information redundancy (Lincoln and Guba, 1985) or data saturation (Patton 2002). Lincoln and Guba (1985) advocate that researchers should seek indices of saturation such as repetition of the information obtained and confirmation of previously collected data whilst searching for negative cases to explain variations and diverse patterns and to enrich the emergent model.

4.22 Interviews

Formal interviews would be conducted with new registrants and Matrons/Charge Nurse. As my purpose for conducting interviews is to gain descriptions of situations in the interviewees own words, formal unstructured interviews appeared preferable to formal structured interviews which negate minimal extraneous conversation in order to ensure uniform responses to a pre-set interview schedule for the purpose of quantification (Swanson, 1986). Whilst this approach is termed as being 'unstructured' it should not be assumed that the conversation arising in the interview is totally haphazard as the interviewee is introduced to the area / topics the researcher wishes to discuss. To achieve this an interview guide containing general questions or a topical outline may be used.

Follow up interviews with the initial group of participants would provide me with the opportunity to revisit and check my understanding of the main points during the initial interview. I did consider returning transcripts to participants as it has been suggested that this increases the validity of findings because interviewees are able to confirm that they have meant what they said or not (McNiff, 1988). This approach also provides an opportunity for statements to be withdrawn. However, Kval (1996) warns that some interviewees may experience shock when reading their own verbatim transcribed interview as when transcribed, oral language can appear as incoherent or confused speech and this may lead to participants feeling that they are being characterised as having a lower level of intellectual ability. Further to this Dearnley (2005) reports that in her own experience the use of this approach resulted in participants being upset as they felt that the transcripts made them look silly and unfortunately this had led to withdrawal of a participant from her study. In order to avoid these problems yet maintain a spirit of openness and honesty throughout the project I decided to summarise the main points made by participants for them to verify at follow up interviews.

Informal interview is the use of an everyday conversational style for the purpose of collecting and validating data, and like everyday conversation they have no particular meeting time, place or length (Chenitz, W.C. 1986). The informal interview permits the researcher to get to know the individuals belonging to the group being studied, and to meet them within their own social context. This allows the researcher to get to know them as people and to develop greater understanding of how they perceive their world. Additionally, diary keeping by programme participants with voluntary disclosure of reflections was encouraged as I viewed this as a non–threatening approach to gaining individual insights and views from junior nurses.

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4.23 Focus group interviews

Group interviews used for a variety of purposes are today usually referred to as focus groups although the techniques were originally devised by market researchers to gather consumer opinions. Kreuger (1998) identifies that social scientists in the 1930s believed that focus group interviews rather than traditional information gathering methods enabled producers, manufacturers and sellers to gain greater understanding of the consumer's thinking. Attention to the use of focus group interviews to acquire information for research in the literature is increasing due the growing interest in qualitative research (Patton, 1990. Fontana and Frey, 1994. Kitzinger, 1996.Rabiee, 2004).

Focus group interview is a unique and independent qualitative data collection technique, which is led by the interviewer in a formal or informal manner depending on the purpose of the interview and can add to other qualitative or quantitative methods (Morgan and Spanish, 1984, Fontana and Frey, 1994). Focus groups are also akin to a naturally occurring conversation and therefore provide an opportunity to go beyond stock answers and focus on how participants really feel about a specific topic (Abbott, 2002). Whilst emphasising that opinions vary regarding the optimum size of a group Robson (2002) cites Stewart and Shamdasani's (1990) view that eight to ten participants are usually thought suitable, although smaller numbers are used.

Abbot (2002) identifies a number of advantages and disadvantages to using focus group interviews in comparison to using individual in depth interviews. The factors identified by Abbot to which I believe are most relevant to this study are shown in Table 3 below

Table 3 - Advantages and disadvantages to using focus group interviews

Advantages	Disadvantages
The amount and range of data is increased when collecting from several people at once	The number of issues andquestions raised can be limited due to the number of people present
Group dynamics often enable important topics to be raised and challenged so that the important topics for the group may be uncovered	As with all qualitative methods there can be a problem with generalisability
It can empower some participants to talk as some people prefer more able to talk in a group interview	Conflicts or power struggles may occur which need managing by the interviewer
There are checks and balances and extreme views are weeded out.	It needs to be facilitated in a way that all participants are enabled to contribute

It may be easier to discuss taboo subjects in focus groups- people tend to be less inhibited and researchers less inhibited about raising sensitive issues.	People may be reluctant to express certain views or reveal certain things when other people are there

Adapted from Abbot in McSherry, Simmons and Abbott, 2002 p36

My decision to interview groups of experienced nurses from the participating nursing teams was taken for methodological and practical reasons. I had considered devising a questionnaire for completion by supervising nurses. However, exploration of the literature led me to believe that discussion with groups of senior nurses in a non- threatening situation was more likely to provide new insights or/and greater understanding of themes elicited from individual interviewees (Kreuger, 1988). Furthermore, I believed this method would provide an opportunity to observe participantsreactions and responses to each other during transactions which may reveal patterns underlying attitudes, opinions and behaviour (Byers and Wilcox, 1991, Rabiee, 2004). In addition the focus group approach is seen to be comparable to individual interviews, and is consistent with fundamental qualitative assumptions, as through direct encounter with key individuals it has the potential for full expression of the 'emic' or insider's perspective, (Holloway and Wheeler, 1996), thereby bringing the 'me' closer to the researched phenomena (Clarke, 1999).

On a practical level conducting and transcribing interviews for an additional fifteen staff would have proven difficult due to limited time available to, and the availability of staff due to erratic shift patterns, As my time was increasingly becoming a precious commodity unstructured group interview has the added advantages of being flexible, inexpensive and expedient (Fontana and Frey, 1994, Abbot, 2002).

Fontana and Frey (1994) also advise that group interview is 'recall aiding' due to group interaction and often data rich. However, Kitzinger (1996) is more forceful in advocating overt exploration and exploitation of interactions between focus group participants. Importantly, I decided that group interview would provide me with an opportunity for triangulation of data with data gathered through one to one interview of Staff Nurses and Matrons. However, focus group interviews are not without problems as emerging group culture may interfere with individual expression and the group format makes it difficult to explore sensitive issues, possibly resulting in 'group think' (Fontana and Frey, 1994). Hence, in addition to concern about the questions to ask, the interviewer must to be sensitive to the evolving patterns of group interaction (Merton et al 1956, Fontana and Frey, 1994). The impact of group dynamics and the underlying group culture and power hierarchies requires the interviewer to prevent the group being dominated by one person or a coalition of individuals whilst

encouraging recalcitrant individuals to participate (Merton, 1956, McSherry et al, 2002.). In order to ensure full coverage of the topic it is necessary obtain responses from the entire group, (Merton et al, 1956, Fontana and Frey, 1994) therefore I would need to adopt the role of moderator as well as interviewer when conducting focus group sessions. With these considerations in mind I hoped this approach would increase the potential for elaborating on existing themes and validate or challenge the perspectives and ideas of interviewees.

4.24 Data analysis method

A case study design and the techniques used in this project were chosen to facilitate comparison of the impact of the STEPs model on individual newly employed registered nurses and the nursing teams to which they are appointed and the generation of hypotheses that may be generalised beyond the participating nursing teams was not a prime aim. The intended product of the project is a framework that can be implemented locally and therefore the purpose of analysis in this study is the identification of common themes that are the same in all involved areas and therefore provide direction for refinement of the STEPs

The question of how to analyse qualitative data is a difficult one. In theory verification research, the researchers starting point is a clear hypothesis derived from existing theory which is rigorously tested by the collection and analysis of data, usually quantitative data, using well defined research procedures. Whilst the boundaries between the selection of hypothesis, collection of data and analysis are clearly drawn in theory verification studies, they are not clearly delineated in qualitative research. For this reason an adaptation of constant comparative analysis is used in this study to enable the emergence of themes and ideas addressed in interviews and to link themes and interviews together in to a reasonably robust categorisation system.   Constant comparative analysis is a method most commonly associated with Grounded Theory (Glaser and Strauss,1967), also known as the discovery model (Glaser, 1978) which is a method by which to study fundamental patterns known as basic social - psychological processes which account for variation in interaction around a phenomenon or problem with the object of the developing theory that explains the basic patterns common in social life.(Chenitz and Swanson. 1986. Strauss and Corbin, 1990).

The task of the researcher is to repeatedly read the data line by line and paragraph by paragraph. In order to break down the data into bits and pieces in order to reveal specific incidents or facts (Corbin, 1986). Following identification of specific pieces of information the researcher attempts to identify relationships between these categories or concepts in order to identify themes.. The application of constant comparative analysis in this study is described in chapter 5.

4.25 Ethical issues

At the inception of the action research study two ethical issues relating to the conduct of insider research were apparent. These were the:

1. Appropriateness of conducting research within my home Trust.

2. Relevance and application of the principles of beneficence; utility and respect for autonomy.

4.26 The appropriateness of conducting research within my home trust

The decision to conduct this study in the hospital Trust that I worked was not decided upon lightly and a number of considerations were taken into account. A significant factor in my decision to conduct this study in my home Trust was that I wanted to capitalise on the opportunity to democratise the research process (Fuller and Petch, 1995) by attempting to engage numerous staff in discussion regarding topics, priorities and processes in order to gain wider ownership and commitment to completion of the project. This approach would appear to be supported by several authors who maintain that engaging other practitioners in research helps to facilitate change in the practice environment (McNiff, 2002, Fox, 2007).

As I also wished to gain a greater understanding of change, through action research, I considered it necessary to have access over a long period to a number of nursing teams. As I was in full time employment, a prolonged period of study leave in which time another hospital Trust could be approached for access to refine STEPs and conduct this study, was not an option. But more importantly conducting an action research project in another Trust would not establish ownership by staff in my home Trust nor could transferability of the devised programme to my home Trust be guaranteed.

However, I also needed to consider a range of factors related to undertaking insider research.

4.27 Advantages and disadvantages of insider research

Issues that may positively or negatively affect the insider researcher, sometimes referred to as practitioner researcher include lack of experience and confidence, time management; personal values; preconceptions and potential for bias; maintaining confidentiality and anonymity; role conflict issues; and the researcher's role within the organisation (Fraser, 1997. Robson, 2002. Fox et al, 2007.)

Time management is a particular issue both with action research (Fox,2007) and development of case studies (Yin, 2009) as undertaking systematic research whilst maintaining normal commitments is very difficult (Robson, 2002). Full time work demands energy and time and not all participatory work yields valuable research data. As a full time member of a working group the researcher is somewhat tied by work itself and is not permitted to adopt the free floating role that permits him to follow various avenues of investigation, thereby limiting the scope and depth of the study. In addition the time taken to set up research; gain stakeholder cooperation and requisite approvals before undertaking the study often takes longer than expected. Recruiting appropriate numbers of willing participants; adherence to inclusion / exclusion criteria; agreeing access, arranging to meet and retaining participation throughout the study can also be problematic. (Fox, 2007, Costley et al, 2010).

However full time participation in the organisation may allow access to situations and information that may not be so easily or quickly accessible to an 'outside researcher' as the "inside" researcher is right there where things happen, and where members talk about what has happened (Schatzman, and Strauss, 1973).

Lack of research experience may affect the confidence of practitioners wishing to explore an area of practice, and choosing a research problem through professional and personal experience may appear more hazardous than through literary routes, but novice researchers might take heart from Costley's (2010) succinct statement of advantages provided to the insider researcher:

> *You are in a prime position to investigate and make changes to a practice situation. You can challenge to the status quo from an informed perspective. You have an advantage when dealing with the complexity of work situations because you have in-depth knowledge of many of the complex issues. This is vital when exploring problem or issue in a detailed and thorough way. (*Costley et al. 2010 p3)

Professional experience related to the research being undertaken can be tremendously useful, as during years of working in the swampy lowland of professional practice (Schon, 1983, 1987) the individual acquires an understanding of 'how things work, why and what will happen in certain circumstances (Fox et al, 2007. Costley et al, 2010). Personal experience of a situation, such as loss or change in social circumstances or previous use of the research techniques can also act as a basis for the researcher to consider similarities and differences in various situations and will provide data analysis with some variety. When the researcher takes professional and personal knowledge into the research situation it assists him to understand events and actions being seen and heard

more quickly than if he did not have this background (Fox 2007, Robson, 2002). This can lead to practitioner - researcher synergy, as due to their role practitioners have insights that benefit the identification, design and conduct of appropriate studies.

4.28 Preconceptions, bias and reflexivity

It is however very important that the researcher does not allow this experience to block him from seeing things that have become routine (Strauss, A. Corbin, J. 1990) or allow preconceptions about problems or solutions to influence study design or analysis (Robson, 2002). Gans (1982) warns against conducting a study on a group with which the researcher is very familiar, even if colleagues were able to accept him as a researcher. This warning is based on Gans belief that it would be difficult for anyone to resist the temptation to participate fully, or to shed feelings he had about his colleagues before he started to study them. Contrary to this Northway (2000) asserts:

> *…the positivist emphasis on objectivity has meant that researchers often 'write themselves' out of the 'text' in the belief that to do otherwise would somehow contaminate the data* (Northway, 2000, p18)

A frequently cited concern regarding the validity of qualitative research is the potential for bias. Lincoln and Guba (1985) identify three types of bias; reactivity, respondent bias and researcher bias. Reactivity refers to how, when 'outside' researcher enters the field, he will disturb 'the scene' until participants become used to his presence his observations may not portray the true scene. The 'inside researcher, however is less likely to disturb the scene if his actions and responses are appropriate to his roles as both participant and researcher. Respondent bias can be wide ranging but in brief refers to perceptions, values and actions that lead to participants withholding or obstructing data collection. The third type, researcher bias concerns the assumptions and preconceptions that the researcher possesses that may affect their behaviour whist conducting the research. A growing number of authors are acknowledging that the researcher and the research cannot be meaningfully separated (Ahern, 1999. Polit and Hungler, 1999. Lincoln and Guba, 2000 Finlay, 2003. Hand, 2003.Mantzoukas, 2005, Robson, 2002. Freshwater, 2005, Fox et al, 2007), a notion grounded in the writings of Wittgenstein (1953) in which phenomena are always filtered through the subjective understandings of the researcher.

As researchers both influence and are influenced by the process of engaging in the research process they must go beyond reflection, which may be considered as being a retrospective look at the study and how it was conducted. I was concerned that whilst reflection may inform future projects reflection alone may not impact substantially on my current study. I aspired to recognise my values, assumptions, prejudice and influences (Hand, 2003) and be better placed to make explicit

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how preconceptions and presuppositions have influenced my choice of study design, methodology and the presentation of findings (Mantzoukas, 2005). Exploration of the literature (Crotty, 1998. Wetherell, Taylor and Yates, 2001, Robson 2002, Fox 2007) led me to believe that this may be achieved through taking a reflexive approach. Reflexivity is the way in which the researcher acts on the world and the world upon the researcher and is defined by Robson (2002) as:

> *An awareness of the ways in which the researcher as an individual with a particular social identity and background has an impact on the research process. (Robson, 2002, p172)*

The level of awareness of researcher impact on a study, including the potential for bias, is highly dependent on the researcher's degree of self awareness. Researchers bring differing subjective meaning to a study depending on their past experiences and some of their reactions will be conscious and some unconscious. Therefore it is necessary to understand oneself in order to understand your own research (Fox, 2007).

Some qualitative researchers (Endacott, 1994. Mays and Pope, 2000. Gearing, 2004 Moseley and Mead, 2004) view the need for bias to be identified, eliminated or suspended in order for qualitative studies to achieve the equivalent of validity and credibility of quantitative studies. Mantzoukas' (2005) views reflexive studies only to be valid if bias is fully incorporated and transparent throughout the study. This is challenged by others (Ahern, 1999. Freshwater,2005, Robson, 2002. Fox, 2007) who argue that a subjective bias is never fully known at the outset of the research because what is not known cannot be expressed as only what is conscious and known can be articulated. Therefore at the outset the researcher only possesses a partial view (Freshwater, 2005) and Ahern concludes that:

> *The ability to put aside personal feelings and preconceptions is more a function of how reflexive one is rather than how objective one is because it is not possible to set aside things about which they are not aware.* (Ahern, 1999, p408)

Ahern (1999) attempts to identify areas of potential bias throughout the research process by what she terms 'reflex bracketing' and suggests ways that this may be achieved. Robson (2002) provides an abridged table of Ahern's suggestions (Robson, 2002, p173), and a number of theorists have identified strategies for dealing with bias (Miles and Huberman, 1994. Maxwell,1996. Padgett, 1998. Fox, et al, 2007, Costley et al, 2010). Such strategies include prolonged involvement with the observed group, triangulation, peer debriefing and support, checking of the written account by interviewees, maintenance of a full record of study activities. However, whilst use of such strategies

may be helpful in ruling out threats to validity there is no foolproof way of guaranteeing it (Robson, 2002).

I conclude that providing the researcher possesses the necessary intellectual ability, appropriate skills and the will to view events from a variety of perspectives acceptance of known and unfolding bias can positively influence the manner in the study is conducted. This approach is supported by Finlay (2003) who views that by rejecting the urge to abolish the presence of the researcher subjectivit*y is* transformed from a problem to an opportunity. I believe the potential for gaining valuable insights into how individuals may feel and the profit gained from sharing the failures and triumphs of the group is a risk worth taking.

In order to further consider these perspectives I discussed the advantages and disadvantages of conducting the study in my home Trust with a number of colleagues from both practice and academic backgrounds. The advice received reinforced my belief that if I acted in an open, honest and professional manner whilst establishing some means of reflecting on my own thoughts and feelings, the potential problems of bias could be overcome. To this end I decided to review and record my feelings and attitudes at each interaction with project team members, participants, practice supervisors and the project steering group members. In this way I intended to not only to check for personal bias but to analyse interactions with project participants in order to elicit alternative avenues of enquiry. I also believed a reflexive approach would aid development of my ability to use self in interaction within the dynamic social context to the advantage of the research process.

4.29 The Relevance and Application of the Principles of Beneficence;Utility and Respect for Autonomy

It is acknowledged that insider researchers should understand that the research process is impacted upon by relationships and influence based on expert, resource or position power. They also need to be aware of when power is being used and the need to use personal power effectively in order to avoid detriment to others (Fox, 2007). This concern is valid as in qualitative research studies, particularly those involving interviews the relationship between the researcher and the subject needs to be examined. However, this is rarely done as it is assumed that the researcher will set up the relationship and hold the power (Firby, 1995. Merrell and Williams, 1995). Whilst I believe research should be conducted for the 'greater good', I recognise that this must be balanced with the rights of individual participants. Beneficence and respect for autonomy are highly valued principles in the context of healthcare. They are also key components of researcher and research participant relationships(Merrell & Williams, 1995).

It is acknowledged within medical ethics that beneficence, that is, doing good for others (Gillon, 1992) must be balanced with the autonomy of the patient, including views on liberty rights, privacy and individual choice balanced with the desire to do the best for the patient (Beuchamp and Childress,1989). When a surgeon recommends and fully informs a patient regarding an operation and obtains consent the principles of beneficence and autonomy are not in conflict. However, these principles are often in conflict when applied to the researcher/researched relationship (Merrell and Williams, 1995), particularly when considered in relation to the principle of utility, that is doing something for the greater good (Bentham, 1789). The principle of utility was developed at length by the 18th century philosopher Jeremy Bentham based upon the belief that

> Nature has placed mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what we ought to do, as well as to determine what we shall do. On the one hand the standard of right and wrong, on the other the chain of causes and effects, are fastened to their throne. They govern us in all we do, in all we say, in all we think..(Jeremy Bentham, The Principles of Morals and Legislation,1789, Ch I, p 1).

To Bentham (1789) utility relates to the property in any object, whereby it tends to produce benefit, advantage, good or happiness to prevent mischief pain, evil or unhappiness to the party whose interest is considered. However, Baum (1990) infers that clinical research is compromised when the principle of utility, doing the greatest good for the greatest number is undermined by the principle of beneficence, but acknowledges the difficulties in balancing 'the greater good 'against ideas of beneficence. In doing so Baum appears to draw on the work of Beauchamp and Childress (1989) who subdivided the general principle of beneficence into the provision of benefits and the need to balance harms and benefits, and in doing so incorporate the principle of utility. Utility is usually expressed in regard to the interests of the community and consideration of the individual may be lost. Bentham (1789) considered the community as a fictitious body whose membership is constituted of individuals. Therefore, the interest of the community is the sum of the interests of the members who compose it and according to Bentham (1789) it is in vain to talk of the interest of the community without understanding the interest of the individual. This is particularly important as the principle of non-maleficence applies in research as much as in any other endeavour. A dilemma is posed in qualitative research where a close relationship with the researched is required as it is difficult in these situations to research for the greater good at the expense of an individual participating in the research project (Merrell and Williams, 1995). My proposed approach to addressing this dilemma was to strictly adhere to the principles of beneficence, non-maleficence and to respect the autonomy of the individual by ensuring that participation in the study was preceded by informed decision by the prospective participant. This stance underpins my desire to avoid a

patriarchal approach and reflects John Stuart Mill's (Christians, 2000) interpretation of the utilitarian philosophy, advocating neutrality in the interests of individuals who as free thinking, willing, active beings are responsible for their own choices and actions. The principle of utility, to Mill, and Bentham requires that individuals should be free to do what they will, providing they cause no harm to others.

4.30   Summary of chapter 4

In chapter 4 I reviewed methodological and philosophical considerations and discussed my rationale for adopting a qualitative, constructivist philosophical stance and a phenomenonological approach leading to an action research approach and an intrinsic/collective case study design.

The result of my reflection on the aims and objectives of the project and contemplation on how to achieve them led me realise that a systematic approach that promoted my learning and further exploration of emerging issues would aid thedevelopment of the STEP 1 structure and its content. In brief the emergent project plan would include collaboration with clinical teams to elicit key topic areas; engagement of a small core development team and a number of expert professionals to develop the structure and content of the STEPS model, mapping congruence between the elements of STEP 1 and the dimensions of the NHS KSF and refinement of this model through an action research study. Data would be analysed using a constant comparative methodologyand used to conduct case studies to illustrate the impact of implementation of the model onrecently registered nurses and nursing teams that engaged in this project. The implementation of the project plan is detailed in Chapter 5.

CHAPTER 5 – PROJECT ACTIVITY

5.1 Introduction to chapter 5

In chapter 5 I will detail the activities undertaken during the course of this study.In particular, I will describe my engagement with Trust staff and detail the iterative process that was undertaken with them to determine the structure, content and production of STEP 1. The four stage spiral model action research illustrated in chapter 4 (McNiff, 1996) is used in figure 6 to demonstrate the process of developing professional practice through systematic action and learning throughout this project. The action research cycles detailed in this discussion are:

Cycle 1   Rethinking the STEPs framework

Cycle 2   Organisation and ethical approval process

Cycle 3   Draft framework development

Cycle 4   New registrant Interviews

Cycle 5   Focus group interviews

Cycle 6   2nd round of interviews

Cycle 7   Rollout of STEP 1 across the Trust

In this chapter I will discuss activities undertaken in relation to each of the cycles comprising the action research component of this project (cycles 1-6) and address issues relating to consent, power relationships, access to participants and the conduct of individual and focus group interviews.Transcription and analysis of data, which is a feature of cycles 4, 5 and 6, are also detailed in this chapter. The rollout of STEP 1 across the Trust (Cycle 7) is detailed in chapter 8.

Figure 7- Action Research Cycles

Firm up implementation
plan with implementation
team

Consider future
support and
development of
new registrants

Implement
STEP 1

Initiate roll out
across Trust

Arrange second
round of interviews and
Matron interviews

Consider impact
of STEP 1 on pilot
areas & consider
membership of
implementation
team

Conduct
interviews

Analyse
data

Arrange focus
group interviews

Reflect on
themes
and consider
possible
interventions

Conduct focus
group
interviews

Analyse and
theme data

Arrange new
registrant interviews

Consider themes &
plan focus groups

Conduct
interviews

Analyse and
theme data

Identify pilot areas
in Surgical Division

Reflect on
process and
develop
framework

Engage pilot
areas & identify
relevant topics

Consider relevance
of topics & validate with
medical division

Inform organisation
of STEP development
& plan research programme

Develop thinking on
research approach,
design &
methodology

Gain trust
agreement &
LREC approval

Consider ethical
aspects of plan

PLAN

Consider existing
STEP structure potential for
developing new framework

REFLECT

Assimilate
information
So far

Literature
Search

ACT

Initial thinking on interface
between steps and
NHS KSF

OBSERVE

CHANGE 7
CHANGE 6
CHANGE 5
CHANGE 4
CHANGE 3
CHANGE 2
CHANGE 1

CYCLE 1
RETHINKING THE STEPS
FRAMEWORK

CYCLE 2
ORGANISATION & ETHICAL
APPROVALS PROCESS

CYCLE 3
DRAFT FRAMEWORK
DEVELOPMENT

CYCLE 4
INTERVIEWS

CYCLE 5
FOCUS GROUPS

CYCLE 6
INTERVIEWS

CYCLE 7
ROLLOUT OF STEPS 1 ACROSS THE
TRUST

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5.2   Rethinking the STEPS framework (Cycle 1)

Following publication of the NHS Knowledge and Skills Framework and Development Review – Working Draft (DH, 2003) I reflected on the Department of Health instruction that NHS organisations should not develop new competency frameworks but fully implement the soon to be published NHS KSF. In light of this I briefed the Directors of Nursing and Human Resources regarding the introduction of the NHS KSF and my initial thoughts on progression from this point. Following this I discussedthe impact of the NHS KSF with the Trust Nursing Executive.This groupwhich was chaired by the Director of Nursing,and included Assistant Directors of Nursing and Nurse Managers,decided that preparation for implementation of the existing framework should be discontinued and work should be undertaken to ensure compliance with Department of Health guidance. Following this decision I embarked on a literature search of concepts relevant to developing an incremental approach to professional development, particularly regarding government policy and other concepts relevant to the project. I discussed the reviewed literature at length in chapter 3, however, throughout the project other literature emerged that broadened my awareness of relevant theory and therefore my literature search was not an isolated activity but an on-going endeavour.In addition to exploration of the literature my reflections were aided by discussion with clinical, academic and human resource colleagues consequently a pragmatic strategy emerged in which interaction and joint decision making with practitionerswould be pivotal for redirecting and refining STEP1.

Previous research and development experience had taught me the importance of identifying and engaging with key stakeholdersto develop awareness and ownership of the project within the organisation, thereby increasing the likelihood of success.In cognisance of this I conducted a series of meetings with senior managers and union representatives to seek views on my plan to develop a draft STEPs structure in collaboration with clinical leaders and to pilot and refine it with the input of new registrants and the teams in which they worked. These discussions not only resulted in support for the project but creation of a steering group to fulfil an advisory role in the development and refinement of the STEPs framework.

5.3   Organisation and ethical approval process (Cycle 2)

Prior to initiating my research it was necessary for me to conform withresearch approval procedures in place at the time immediately prior to commencement of the project. This necessitated that I sought ethical approval from the Local Research Ethics Committee and permission to conduct the research in an NHS establishment.

In March 2004 Iapplied to the Local Research Ethics Committee for approval to undertake my proposed project entitled 'An incremental approach to continuing professional development for registered nurses.'

When I attended the Local Research Ethics Committee meetingon 15th March 2004 the ethical principles discussed in chapter 4 were clearly of interest to committee members. In particular their questions explored my plans for recruiting newly qualified staff to the study. I had initially intended to approach newly appointed staff nurses myself in order to explain the research study with a view to their participation in the project. Concern was raised about the potential for junior staff to feel obliged to consent to participate if approached by an Assistant Director or another senior nurse from outside of the clinical area in which they were working. I informed the committee that I was not wishing to coerce staff as this would not be ethical or within my own value set and I would welcome their advice. Following further discussion on this issue it was agreed that potential participants would be provided with verbal and written information relating to the project by the Senior Sister or Matron with whom they were in contact on a regular basis. The Sister or Matron could then extend an invitation to participate in the project. I proposed that in this way it would be possible to distance myself from the recruitment process whilst as far as possible ensuring that new registrants made informed decisions regarding participation. I was also asked to elaborate on the implications for individuals who did not wish to participate in the study. My response was that no one would be excluded from using the materials developed at the outset of the project and access to updated materials would be made available. In this way I sought to ensure that no one was compromised if they wished to be excluded from the study. Committee members were directed to the information leaflet and consent form that I had developed for potential participants. In light of the agreed changes to the recruitment process the committee chairman requested that I submit a revised information leaflet and an informed consent form. The resultant process for gaining consent is detailed in 5.11

Following submission of these documents I was notified in a letter from the committee chairman that my application had been approved (see appendix 5). Subsequently I contacted the Trust Research Governance Manager for formal approval to carry out the project with the Trust. This was granted on production of the letter of approval from the Local Research Ethics Committee.

5.4   Draft framework development (Cycle 3)

A draft framework for supporting new registrants to accumulate evidence of meeting identified NHS KSF criteria as specified in the Trust's role outline for Agenda for Change Band 5 (appendix 15) was

produced with the intention of refining this modelthrough an action research approach. Production of this framework required determination of relevant topics and development of STEP 1 elements.

5.5   Identification of STEPS topics and determination of structure and content

Following the publication of The NHS Knowledge and Skills Framework (NHS KSF) and development review Guidance – Working Draft (2003) the potential structure and content of the STEPs programme was deliberated at length with staff working in the Neurosurgicalunit,Urology Unit and the Critical Care Area which included Intensive Care (ICU) / High Dependency (HDU). As it was intended that the project would assist in the delivery of the NHS KSF, whilst recognising the development needs of clinical nursing teams participating in the project, ward managers and experienced nurses were engaged in an iterative process with the development team to determine particular knowledge and skills that should be demonstrated by newly registered nurses. Each participating clinical area team was invited to identify the knowledge, skills and attitudes they would expect new registrants to possess and exhibit.

In the Critical Care Area this was expedited through series of meetings with a group of senior nurses including the Nurse Consultant for Critical Care, two Teacher/ Practitioners, Charge Nurses & two Matrons. In Neurosurgery and Urology services this was expedited through a series of meetings with the Matron, Charge Nurses and Teacher /Practitioner in the first instance and a list of topics was devised which was shared with F grade / Band 6 nurses for comment and further development.

Critically, members of this group had divergent views regarding the development of junior staff entering the Intensive care area for the first time following registration. One Teacher / Practitioner held the view that the prime responsibility of senior staff with regards to newly registered staff was to enable management of ventilated patients. It was expected that competence in caring for a ventilated patient should be achieved in approximately six weeks. However, when this view was opened up for discussion it became clear that this nurse held views that were not congruent with the other members of the group. An alternative view was raised that brought the historical perspective of recruitment into intensive care / high dependency units into the discussion. It was contended by group members that in the past the numbers of newly qualified nurses was greater than at present and therefore the senior staff in high dependency areas could expect any nurse applying for a post on the unit to have had previous post-registration experience in a general ward. This previous experience was viewed as essential in consolidating knowledge and gaining expertise in the fundamentals of nursing care. However, during recent years the situation had changed and it had

become necessary to encourage recruitment to ICU/HDU immediately upon qualification. To most members of the group this change required the units to provide experiences and support that would encourage application of theory into practice across the range of fundamental nursing practice. This did not negate recognition of the need to develop understanding and ability in technical aspects of intensive care nursing. This combination would in the view of the majority of the group be more likely to result in the development of a well-rounded programme of development for the newly registered nurse entering the intensive care area. Following lengthy debate in which it was identified that complaints made regarding care in the HDU/ICU, though infrequent, usually related to the provision of fundamental needs such as nutrition and hygiene, the views of the majority of the group prevailed.

Following further discussion between the Matron and other senior nursing staff it was decided that the pilot should be conducted in the HDU as recent recruitment of new registrants had recently been higher in this area than in ICU. It was anticipated that following evaluation the ICU could become involved in the project at a later date

Unlike the Critical Care Area there was not a division regarding the content of the programme amongst Neurosurgical Unit staff. The reason for the difference between these units appeared to be because newly qualified neurosurgical nursing staff initially worked in the ward area and rotation to the neurosurgical high dependency / intensive care areas was only considered when the nurse demonstrated their understanding and application of fundamental nursing care to the neuro-surgical patient. However, during the course of the project this practice did change. Due to increased pressure upon the service to meet access targets for elective surgery there was increased use of neurosurgical beds. This resulted in an increase the nursing establishment and subsequently it became necessary to recruit newly registered nurses directly to the high dependency / intensive care areas.

Despite this change in practice the neurosurgical nursing team did not move from the principle that in the first instance efforts should be made to assist newly registered nurses to consolidate the learning that had taken place during their pre- registration programme. In the Urology Unit, new registrants were predominantly ward based and the debate over core versus specialist practice did not arise.

These three groups identified lists of topics that they believed should be included in any work based development for newly qualified staff. Despite the differences in the size and makeup of these reference groups the list of topics produced by each group were surprisingly similar with the exception of topics directly related to their specialty area of practice. The amalgamated topics are shown in Box 3below:

Box 3 - Topics identified for inclusion in work based development of new registrants

Resuscitation	Bereavement & Dying
Drug Administration including Intravenous drug administration	Pain Competencies
Hygiene	Intravenous Drugs
Nutrition	Central Lines
Pain Assessment	Medical Conditions e.g. Diabetes
Tissue Viability	Ward Management
Record Keeping	Pre-operative management
Continence	Immediate post-operative management
Infection Control	Rehabilitation
Cannulation	Preparation for Invasive Procedures
Care of Intravenous Cannulae	

Following discussion with the STEPs development team it was decided that we should engage the nursing teams in the pilot areas in an exercise to identify those topics which may be relevant to all nursing teams regardless of the specialty or the clinical division in which they were located and those that were more likely to be required by nurses in the Division of Critical Care and Surgery. Subsequently it became clear to the development team that a large percentage of these elements were common to all the participating clinical areas with a smaller number being specific to the clinical area. A further outcome that emerged was that in addition to these topics these groups of clinical staff recognised that a number of additional topics were overarching in scope, as they would be integral to the scope of each of the elements as they were developed. These included professional issues including NMC Code of Conduct and Standards of Practice, Clinical Governance, Leadership Skills and Essence of Care Benchmark standards and Information Technology.

In summary, from these collaborations it emerged that a skills escalator approach was appropriate and could be arranged in a fashion that moved from generic nursing care activities to more advanced and specialist activities.

Three 'STEPs' were identified STEP 1 included the majority of what were regarded as common core elements, STEP 2 would comprise elements considered by the groups to be of particular relevance

to the Critical Care and Surgical Divisions and a small group of topics identified as specialty specific elements by each of the areas participating in the action research. These groups of topics were organised into what have been termed STEP One and STEP Two and are demonstrated in Box 4

Box 4 - Topics identified for inclusion in steps 1 & 2

STEP ONE	STEP TWO -
Core Elements:	**Divisional elements**:
Resuscitation.	Pain management
Drug Administration.	Intravenous Drug Administration
Hygiene.	Management of Central Lines
Nutrition.	Selected Medical Conditions e.g. Diabetes, which are encountered by all nurses.
Pain Assessment.	
Tissue Viability.	Pre-operative management
Record Keeping.	Immediate post-operative management
Continence.	Rehabilitation
Infection Control.	Additional speciality specific elements. Examples
Preparation for	include –
Invasive Procedures.	• Management of patients: requiring ventilatory support
Care of Intravenous Cannulae.	• Assessment of neurological status
Bereavement & Dying.	• Bladder irrigation
Management.	
Critical Care Training module.	

However, it was also believed that there may be a need to develop a 3rd STEP which at a later date in the staff nurses development would explicitly deal with the overarching topics again in the context of developing abilities required for leading/coordinating nursing teams in the absence of the Charge Nurse. These topics are identified in Box 3but will be developed to prepare the nurse for team leadership / ward coordination as STEP 3.

Box 5 - Overarching subjects that will be integral to STEPs I & 2

Professional issues

(including NMC Code of Conduct and Standards of Practice)

Clinical Governance (including relevant Trust policies)

Leadership skills>>>>>>>>>>> **STEP 3**

Essence of care

IT skills

At this point, with a view to developing a product that could be transferable across the clinical divisions in the Trust I believed it to be necessary to elicit views from other senior staff regarding the elements identified by the pilot areas. It was my belief that even at this early stage the project should be open to critique and comment and in this way there may be a greater likelihood of gaining ownership of STEPs if it did progress to Trust wide implementation following refinement through the action research approach. In addition I hoped to ascertain whether a concensus on the structure and broad content of the programme could be reached.

An opportunity presented itself to me as a time out day had been planned for Ward Managers employed within the Division of Medicine. The time had been organised by the Practice Development Nurse for the division in order to appraise Charge Nurses of developments within the Trust and to engage them in determining areas for mutual, collaborative projects aimed at improving care standards within the division. I was invited to brief the 28 attendees on the background and development of STEPs. I had also agreed with the Practice Development Nurse that I would conduct an exercise to 'check out' the validity of the identified elements with the Medical Division Charge Nurses. In order to elicit the views of the Medical Division Charge Nurses I gave a power point presentation that included the background to the project, rationale for its development and the perceived linkage the programme would have with the NHS Knowledge and Skills Framework. I then asked the group to consider the abilities that they believed should be demonstrated by newly registered nurses. Finally I presented the group with the list of topics and the initial categorisation as core/divisional or specialty specific that had been identified by the pilot for comparison and invited comment from the group**.**

The discussion that followed revealed that this group believed that topics identified by the pilot areas as core elements in Step One were applicable to the Medical Division. However, the Medical

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Division group believed that several of the topic areas identified by the action research areas as specific to the Division of Critical Care and Surgery were in fact also applicable to their areas. These topics were pain management; intravenous drug administration; management of central Lines; cannulation and selected medical conditions (e.g. Diabetes), which are encountered frequently by most nurses. In addition the Medical Division Charge Nurse group identified discharge planning as an area that was poorly managed but at this stage this topic had not been included in the list compiled by the pilot areas. Subsequent discussion with senior nurses in the pilot areas and project development team members resulted in agreement that discharge planning was an important topic and should be included in the topic list.Further to this the publication of the British Cardiovascular Society Competence Framework Guide for Coronary Artery Disease (Skills for Health, 2003)were discussed and the consensus was that if the STEPs programme was implemented beyond the pilot areas those competencies should be considered in the medical division core and cardiology service as specialty specific elements in STEP 2.

Following this exercise I conducted two further focus group sessions with senior nurses from the Cancer Division and the Children's service to explore whether the identified structure and content of the programme could be used across diverse environments. These focus groups were organised and the composition determined by the Nurse Managers for the areas concerned. The Cancer Division focus group was made up of the divisions Education Coordinator, the Charge Nurses from the haematology Ward, the two oncology inpatient wards and the outpatient department Charge Nurse, a two senior staff nurses and a chemotherapy nurse specialist. The Paediatric focus group included the Nurse Manager, a Paediatric Teacher Practitioner, Charge Nurses from the three paediatric wards.

The proposed introduction of the STEPs programme caused the Cancer Division group some consternation and confusion. The group identified that they had been working for some time on developing their continual professional development programme around the National Cancer Standards and were currently engaged in trying to understand how their work would be affected by the publication of the NHS KSF. However, following a similar discussion to the one held with the Critical Care senior nurses regarding professional development in specialist areas it was accepted that the development of general nursing ability and specialist expertise were not mutually exclusive and advantage could be gained by exploring the newly qualified nurses understanding of the delivery of some core element of practice as these would provide the foundation for further development. The group expressed an interest in reviewing the core elements following

development with a view to implementation and they also express a desire to consider embracing competencies specific to the cancer standards within the specialty specific component of STEP 2.

The paediatric group saw the relevance of the elements previously identified as core elements but recognised a need to ensure that the content of these elements was appropriate to their client group. It was agreed that the paediatric group would review the core elements after they had been developed to further explore their relevance and content in relation to the care of sick children.

5.6 Addressing a dilemma

Throughout this period I was concerned because each of the clinical teams had expressed the abilities that newly qualified nurses should possess as a range of tasks or technical interventions (for example drug administration, tissue viability and pain control) at an acceptable level of competence. I had expected the required abilities of newly qualified registered nurses to be expressed in terms of general attributes or generic competencies that were not situation specific, in a similar manner to those described by Zhang (2002) and Mustard (2002). This caused me to reflect on the direction the project was heading. Contradictory to the existentialist view of development (Benner, 1984, Dreyfus and Dreyfus, 1986), it appeared that senior nurses regarded competence as command of pertinent knowledge and /or skills and was essentially task based or behaviourist. I had also expected some reference to the core dimensions of the NHS Knowledge and Skills Framework (NHS KSF) but with the exception of communication skills these senior nurses did not identify any of the dimensions in their list. I knew that implementation of this aspect of Agenda for Change was in its infancy and activities to raise the profile of the NHS KSF were being undertaken by the Trust's Agenda for Change Team. Nevertheless, I had expected some reference to it to be voiced by these senior nurses.I was concerned that the direction being promoted by senior nurses was unlikely to produce a framework that supported the integration of capabilities required for effective performance or lead to an overall improvement in professionalism or standards of care. In my view the development standards framework set out in the original version of STEPs, which could not be implemented because of the publication of the NHS KSF, were more likely to support the newly registered nurse to move from the marginally acceptable performance of the advanced beginner to a state where practice is efficient, organised and underpinned by conscious deliberation and planning; demonstrating the state described by Benner (1984) as competence. I also believed that the original framework could guide and support development beyond competence, which like Benner I consider to be a staging post in the journey towards expert practice. But it was also clear that to produce a programme that did not clearly link with the NHS KSF would be unacceptable (DH, 2003)

I felt bound by the principle of action research that all participating groups and individuals are co-researchers, and therefore debated this issue with the core development team and the clinical leaders from the three clinical areas. The clinical leaders believed that the elements that had been identified reflected the reality of clinical practice and should not be discarded. The group did however recognise that unlike the original STEPs framework the list of elements did not specify characteristics of expert practice such as those identified by the English National Board(1991). The group did agree that demonstration of competence was not the end of the developmental journey for professionals, and that the principle of working towards competence and eventually expert practice did require something more than what they were proposing at that time. I asked the group to consider how we could use the NHS KSF to clarify the abilities required for effective practice in each of the identified elements. This resulted in a shared view that a method should be devised whereby all nurses could clearly identify the abilities, as described in the NHS KSF, that they were developing in order to deliver a particular aspect of care. For example at what level and which indicators of each of the core dimensions and appropriate specific dimensions of the NHS KSF could be explicitly related to the competences identified in the area of tissue viability or infection control. The outcome of this meeting was an agreement that as the identified elements were developed and populated with 'competences' I should further explore the potential for this approach with the Trust's Agenda for Change team.

Subsequently I met with Agenda for Change project leader and the NHS KSF coordinator to discuss the potential benefits of working together to map the emerging framework against the NHS KSF dimensions, levels and indicators. They were very positive about this approach as it would be possible to use the Trust's broad role outline for Band 5 nurses as a basis for such a mapping exercise as this profile would specify the level and indicators required in each of the core and specific dimensions related to the role .We agreed that upon production of the Band 5 role outline I would lead an exercise to map the STEP 1 elements against the identified NHS KSF dimensions, levels and indicators. I then discussed this proposal with the Nursing Executive Group, the STEPs Steering Group and the Director of Human Resources. This approach was generally accepted as being worthwhile and the mapping exercise was carried out following production of the STEP 1 and the Band 5 role outline. This activity and the final use of the product of the mapping will be further explained in Chapter 6.

5.7 Development of STEP 1 elements

Following identification of the structure required for STEP 1 the major task of developing the competencies which underpinned each element was commenced In collaboration with the two

Practice Development Nurses (PDNs) for the Critical Care and Surgery Division I devised a strategy for this phase of the project whereby a draft of each element could be produced in a timely manner whilst ensuring that each element was underpinned by current best practice. This core development team, including myself, were experienced nurses with proven ability in essential care and each having their own specialist interest and expertise and as part of our daily work champion best practice. However we shared the belief that it was important to involve other practitioners who possessed advanced knowledge relating to specified elements of STEP1. In particular we wished to enrol the help of expert practitioners in developing competencies that supported each element but also to engage them in the development of a supervisor pack, which would identify the level of knowledge and performance expected by staff nurses in relation to each element. The reason for the developing the supervisor pack was twofold. In the first instance the development team and senior nurses in the participating areas believed that it was necessary to illustrate the depth of knowledge and level of performance that the supervising nurse should expect from the newly qualified nurse. In addition, there was a shared belief that many experienced nurses also required development in terms of current best practice and provision of this pack would provide this information without causing them embarrassment.

Discussions were held with a number of key specialist practitioners from a range of disciplines with the aim of recruiting their support for the concept of the programme and for their expertise in specialist aspects of care. Whilst most of these practitioners did not feel able to commit the time to write the elements that required their input it was possible to negotiate an arrangement whereby in consultation with them a broad outline of the content of each element was mapped out. The PDN's then played an essential role at this stage of the project, as with my support and guidance, they produced draft competencies for each of the STEP 1 elements. This work was later aided by input by the Teacher /Practitioner for Neurosurgery. Following its production, the first draft of each element was reviewed by identified specialist practitioners, where appropriate, with a view to ensuring that the content of each element reflected current best practice. The professionals that collaborated in the development of STEP 1 are detailed in the Box 6.

Box 6 - Specialist input into the development of Step 1

Element	Specialist input
Resuscitation	Resuscitation Training Team
Drug Administration	Chief Pharmacist/ Pharmacists

Nutrition	Head of Dietetics/Dieticians
Pain Assessment	Clinical Nurse Specialists - Pain Management Physiotherapists
Continence	Clinical Nurse Specialists - Continence Care
Tissue Viability	Tissue Viability Nurse
Infection Control	Infection Control Nurse Consultant and Specialis Nurse Team
Preparation for Invasive Procedures	Clinical Skills Training Facilitator and Theatre Education Team.
Cannula Care	Clinical Skills Training Facilitator
Bereavement and Dying	Hospital Chaplains
Critical Care Training Module	Nurse Consultant &the Critical Care Outreach Team.

The Critical Care Training Module was formulated by the Nurse Consultant and the Critical care Outreach Team to provide all direct care staff from all professions with the necessary assessment and interventional skills necessary for the safe management of patient's whose condition deteriorates rapidly or is at risk of doing so.

The resulting structure of the practitioners pack included

1. An introduction to the STEPs Framework which included
    • The background, underpinning philosophy and evolution of the framework
    • Roles and responsibilities of participants and supervisors
    • A brief explanation of assessment methodology and guideline for provision of evidence.
    • An example of how the competency statement and competency sign off is presented in the sections relating to each element

5.8 The Use of the Term 'Supervisor'

When STEPs was first developed and implemented the term supervisor was chosen to indicate a nominated individual who would act in a supportive role for more junior staff but also one by which satisfactory professional and clinical performance of less experienced staff would be confirmed. It was intended that the supervisor /supervisee relationship would continue until STEPs 1, 2 and 3 were completed. Naming this relationship between experienced nurses and new registrants undertaking the STEPs programme posed a dilemma as a variety of terms such as mentor, coach, preceptor and teacher have been used to interchangeably (Butterworth, Faugier & Burnard, 1998. Milton, 2004, Bally, 2007). The term mentor has been described as a 'wise councillor and an experienced and trusted advisor (ENB, 1989). In North America the term

> "*Mentoring involves a voluntary, mutually beneficial and usually long term professional relationship, one person is an experienced and knowledgeable leader (mentor) who supports the maturation of a less experienced person with leadership potential* (Canadian Nurses Association, 2004, p24).

This definition mirrors the use of the term in wider society and is similar to the relationship required to support and guide nurses engaged in the STEPs programme. In the UK the mentorship relationship in nursing is a formal one between a registered nurse and a pre-registration student aimed at meeting specified learning outcomes and incorporates teaching, support and assessment during a specified clinical placement and was therefore not thought to be appropriate for use with STEPs.

The term preceptor refers to an intensive but short period of teaching and supervision generally carried out by a staff nurse with the specific purpose of assisting the new registrant during transition into the registered nurse role (Morrow, 1984, O'Malley, Cunliffe, et al (2000). Prior to the introduction of Agenda for Change, preceptorship was an arrangement that varied in duration, often for as little as six weeks with the objective of introducing the new registrant to a clinical specialty. As the relationship in the STEP 1 was envisaged as being over a period of up to two years the term supervisor was deemed to be more appropriate, but should not be considered as clinical supervision, which is defined as

> …*an exchange between practicing professionals to enable the development of professional skills* (Butterworth, Faugier and Burnard, 1998, p12.)

However, following the introduction of the NHS Knowledge and Skills Framework and Review Process (DH 2004) preceptorship became formalised and linked to accelerated pay progression for new registrants in all health professions excluding doctors and dentists. A formalised preceptorship programme, lasting no less than one year, and which specified objectives and standards agreed by the head of profession, was required to be adopted across the organisation. The NMC (2006) followed with a 'strong recommendation' that all new registrants have a period of preceptorship on commencing employment and stressed that preceptorship is about providing support and guidance enabling 'new registrants to make the transition from student to accountable practitioner.   New registrants would be expected to be given protected learning time during their first year and have access to a preceptor with whom regular meetings are held. The Trust's Directors of Nursing and Human Resources accepted STEP 1 as the formal preceptorship programme in September 2006. Therefore the terms supervisor and preceptor both apply during STEP 1, however, the term supervisor is used throughout this report.

5.9   Agenda for Change and Clinical Grading

During the course of this study the NHS was in the process of assimilating staff from the existing clinical grading pay structure to the pay bandings determined by Agenda for Change (DH 1999). Consequently the staff included in the study used either system to define their level of practice. Nurses formerly determined to be F grade became band 6 in Agenda for change terms and are referred to as such throughout this report. The new band 5 incorporated both D and E grade nurses, and therefore spans a range from new registrants to very experienced staff nurses. To avoid confusion the term new registrant refers to the junior nurses participating in this study and band 5 refers to more experienced staff who are remunerated on the same pay banding.

5.10 Identification and preparation of supervisors

The responsibility for identifying the nurses who would act as supervisors was delegated to Sisters, with an overview by the Matrons. The High Dependency and the Neurosurgical Units determined that Band 6 nurses would undertake the supervisory role. The Urology Unit deemed that Band 6 Nurses and very experienced Band 5 Nurses would act as supervisors. This decision was made on the basis that this clinical area possessed a smaller number of Band 6 nurses than the other participating areas.

The initial group of nurses undertaking the supervisor function had attended the Trust 'Preparation for Preceptorship' programme. This programme built on existing skills that nurses acquired through

mentorship of student nurses, whilst stressing skills required for the further development of registered nurses. This included skills in identifying the new registrants abilities, agreeing objectives, providing a supportive environment, coaching, and giving appropriate feedback on performance.During the course of the study views on using nursing grades as the standard for nominating supervisors was challenged and adjustment to nomination criteria adjusted to meet the needs of the new registrants (see section 6.7)

5.11   Staff Participation in the action research project

Between October 2004 and March 2006 a total of 16 new registrant nurses were recruited to the study. In total five nurses participated from the Urology Unit, six from the Neurosurgical Unit and five from the High Dependency Unit (see appendix 8)for demographics of participants) A further five nurses chose not participate in the research but did embark on the STEPs programme. Interviews and data collection from new registrants and concurrent analysis spanned a period of fifteen months. Eight senior registered (Band 6) nurses who acted as supervisors and a further seven registered nurses (Band 5 &6) who worked in the three clinical areas participated in the focus group meetings.

5.12   New registrant interviews (Cycle 4)
Interviewing new registrants required me to manage the consent process, arrange access to research participants and conduct the interviews.

My prime aim in gaining consent was to ensure that junior staff should not feel obliged to consent to participate, that their autonomy was maintained and individualism respected. I was aware that whilst my relatively high status in the organisation could assist me to gain access to senior staff groups, it can be an obstacle to access and ownership of the project at grass roots level due to a perception that the research is too closely associated with management. I decided my aim could be best achieved by requesting Ward Managers to approach potential participants as these staff nurses knew them. In this way I distanced myself from recruitment process whilst as far as possible ensuring that junior staff made informed decisions regarding participation. The STEPs programme and the research project were explained to prospective participants and this was reinforced by the issue of the written subject information sheet (appendix 6)

Following full explanation of the purposes of the project and the purpose of the action research study the nurses would then be invited by the Ward Manager to participate in the research component of the programme. The ward managers were specifically requested to stress that if a

person declined to participate in the study this would not bar them from participation in the STEPs programme or deny them any resultant benefits determined through the action research study. Prior to the new registrants consenting to participate in the study they were made aware that as principal researcher I would act as observer and interviewer for the duration of the project. Written consent was obtained by the Ward Manager using a pre-prepared consent form(appendix 7).

Throughout the study period arranging and conducting interviews at appointed times was problematic. The decision to proceed with an interview was always made by the individual nurse and this resulted in the need to reschedule interviews on numerous occasions, a situation that prolonged the data collection period and delayed the process of constant comparative analysis of data. All new registrants worked 12 hours shifts, were required to rotate to night shifts and frequently work at weekends, thereby reducing the number of opportunities for interviews to be conducted. In addition, I did consider approaching the interviewees during night shifts or at weekends if weekday access was not an option. However, release of staff was difficult at these times due to reduced staffing levels. In order to secure interviews at times that were least likely to interfere with provision of patient care I arranged interviews with Staff Nurses, Charge Nurses/Matrons several weeks in advance. Nevertheless it was not unusual for interviews to be cancelled at short notice, often on my arrival on the ward/unit. Reasons for cancellation included reduced staffing levels due to sickness, intensity of work due to the acuity of the patients and on one occasion a medical emergency. This aspect of the project required me to be both patient and agreeable in demeanour and flexible in managing my time. I conducted the majority of interviews either by foregoing a lunch break or staying into the evenings when activity was less frenetic on the ward/unit.

Following written consent being gained from individuals by ward managers I met with each participating new registrant to explain the purpose of the research, give them the opportunity to withdraw from the study, and if they agreed conduct an initial interview. At this time I stressed that the nature of action research is partnership and that my intention was to work collaboratively with fellow registered nurses to produce a development programme that would be advantageous to nurses throughout the Trust. All interviews took place at a time that was convenient to the participant and this was usually dependent upon the busyness of the workplace, their workload at the agreed interview time and their level of tiredness as most participants worked twelve hour shifts. In addition to confirming consent the use of a tape recorder was discussed with the interviewees and verbal consent for its use was gained. I explained to participants that use of a tape recorder would enhance the flow of conversation that might otherwise be inhibited by constant writing by the interviewer. The use of the tape recorder also facilitated interaction with the interviewee as it allowed me to respond

to verbal and non-verbal cues which might lead to disclosure of new or more detailed information. Tape recording of interviews resulted in an abundance of 'live' data.

In the first instance ten nurses who had been recruited to the three clinical areas were interviewed. Whilst the conduct of repeat interviews was possible with these participants this was not possible with participants that were recruited at a later date (see 5.16). All interviews lasted between forty-eight minutes and one hour and ten minutes. Interviews and data collection from new registrants and concurrent analysis spanned a period of fifteen months.

In order to address my expressed objectives (see section 2.2) my initial interview guide consisted of the following four broad questions.

1. What are your recollections of your first experiences as a registered nurse?
2. How well prepared were you for practice in your new role as a staff nurse?
3. How did you become aware of STEPs and how were you introduced to the programme.
4. What are your initial thoughts regarding STEPs

My rationale for limiting my interview guide to these four broad questions was that I viewed participants as helping me to understand their experience or reality regarding STEPs and I viewed my interviewing role as trying to acquire multiple perspectives.Previous experience had taught me that a flexible approach is preferable to a more formal interview style as it allows interviewees to express their views and to address issues that are of greatest concern to them (Knight, 1998). Unlike structured interviews my intention was to promote interaction and I did not intend to adhere rigidly to a set of questions. Throughout the study formal unstructured interviews followed an agenda largely determined by the interviewees, but I decided that this short interview guide could open discussion and in doing so reveal other topics / issues pertinent to the study. Indeed issues raised in one interview were added to the schedule for discussion in subsequent interviews in order to elicit the importance of the topic to other interviewees. Where necessary I added to the agenda of the interview, but this was not necessary in most instances as the participants in general were very willing to converse and shared their views and ideas freely. As the study progressed the interviews became more focused as I checked out specific points and categories became saturated.

Interviews were conducted in an informal, conversational style allowing interviewees to determine the pace and direction of the conversation and I found that the use of an everyday conversational style of informal interview permitted me to develop rapport, and to meet individuals within their own social context. This allowed me to get to know them as people and to develop greater understanding

of how they perceived their world and enabled maintenance of the participants trust. It was also important to draw on my experience as a clinical nurse and educator in order to use appropriate social skills to demonstrate openness and honesty. I was also cognisant that it was essential that I minimised the risk of making a faux pas or asking the 'wrong' question, at the 'wrong' time, of the 'wrong' person, in the 'wrong' way (Schatzman and Strauss, 1973). To do otherwise could negate the development of rapport with participants and opportunities to focus on important issues or to broaden my general understanding of a situation may have been lost. In order to develop my interviewing skills I reflected on the interviewee's responses and identified cues, such as intonation and body language that would engender greater exploration of a topic by probing for greater detail.

5.13 Concluding interviews (Cycle 6)

Following focus group interviews (see 5.16) I re-interviewed ten new registrants that Iinterviewedearlierin the study. My reasons for second interviews were to check that my understanding of the views elicited previously were accurate, and to provide an opportunity for further views to be voiced, I also interviewed the four nurses that had joined the study later. Interviews with these new registrants were aimed at checking whether or not the assumptions I had made from earlier interviews corresponded with their views and ideas, and establishing whether the saturation of data was adequate. Interviews with this group also allowed me to investigate how, if at all, their experiences differed from their colleagues following introduction of STEP 1. In addition I interviewed the two Matrons and a Charge Nurse as they were well placed to report the reactions of, and views voiced, by staff members, thereby providing insight into the impact of STEP 1.These senior members of staff were also instrumental in facilitating changes in practice, relating to support for new registrants, which resulted from the study

5.14 Transcription of Interviews

Tape recording of interviews resulted in an abundance of 'live' data. Kvale (1996) suggests summarising the main points of the interview and returning these to the participant only for verification or translating the spoken word into an acceptable written format whilst retaining the participant's general style as appropriate alternatives to verbatim transcription of tape recorded interviews. In the first instance I transcribed tape recorded interviews onto a computer using Word 2007 processing programme. The decision not to use clerical assistance for the transcription was made in order to facilitate the on-going analytical process. Transcription was a lengthy process, on average it took six hours to transcribe a one hour interview.

The benefit of this activity became increasingly evident as the analytical process progressed. I found the task of transcribing the interview tapes not only enabled me to 'get closer' to the data, but allowed me to begin to make comparisons and identify further questions to be answered. Listening repeatedly to the words and phrases and incidents in the interviews, often resulted in the emergence of new meaning to what the interviewees were telling me. As I was not only interested in what the interviewees said, but how they said it the documentation of other information such as emphasis of words or phrases, hesitancy or urgency to answer questions, and prosodic sounds were important in determining the importance and meaning of incidents to the interviewees. This exercise not only freed me from potential 'tunnel vision' caused by my professional experience but also enabled the use of that same experience to widen, deepen and generally enrich the study as it sparked off new ideas which resulted in closer study of the data, further exploration of relevant literature and development of my 'theoretical sensitivity'.

Theoretical sensitivity, a term coined by grounded theorists, is the attribute of having insight, awareness of the subtleties of data, the ability to give meaning to data and the capability to separate the relevant from the irrelevant (Glaser,1978, Strauss and Corbin,1990). Theoretical sensitivity comes from a number of sources; the literature, professional experience, personal experience and the analytical process. (Strauss and Corbin.1990) Familiarity with pertinent government publications, articles from magazines, newspaper and professional journals and readings on theory and research assist to' sensitise the researcher as to what is going on with the phenomena being investigated. To this end, in addition to interviewing, all sources of useful information whether printed, oral or visual were used throughout the process of exploration as I sought deeper understanding (Kemp, J 1989).

The development of my understanding from the interviewee's perspective was largely facilitated by the testingand saturation of categories identified from this data in subsequent interviews.

5.15   Data Analysis –Individual interview data

Analysis of data elicited through interviews of individual participants was not an isolated activity, because as the term 'Constant Comparative Analysis' suggests this process was coterminous with data collection throughout cycles 4-6, This activity not only initiated planning activities to be undertaken in subsequent action research cycles but provided a framework for reflection on, and reporting of, the results of this study.

An example of the process I followed to analyse new registrant interviews is provided in appendix 9.The first step in this process was to conceptualise, or deconstruct the raw data. In grounded

theory terminologythis is known as 'open coding'. I accomplished this by reading each interview transcript sentence by sentence and marking each discrete incident, idea, event or phenomenon by underlining with a pencil. I then asked myself "What is this information an example of", and in the manner described by Schatzman and Strauss (1973), I created a label for each underlined segment of text that I believed described the incident, idea, event or phenomenon. In this way I organised the data in a manner that assisted me to compare scripts and identify shared meanings during later phases of the analytical process..

Following initial deconstruction of the interview data I asked myself " Do any relationships exist between any of these codes and can general themes be identified?". To answer this question I reviewed the open codes for similarities and differences in an attempt to find linkages between them. I then clustered codes that I considered to be related together to form higher order categories, a process known in grounded theory terms as axial coding**.**

During the final stage of the analysis process I built on the results of previous coding processes to identify the core categories or themes. I achieved this through integrating related axial codes emerging from the analysis of the transcribed interviews. However, I found that the processes of coding are not linear and totally discrete as saturation of the categories or themes not only required further questioning of interviewees, but also necessitated revisiting transcripts to search for codes that may have been overlooked initially or to verify deductions against data as comparisons between cases were made. Through this final stage I identified the following themes:

- Transition from student to staff nurse role
- Views on the principles of the STEPs approach
- The supervisor/supervisee relationship.
- STEPs Structure, pedagogy and praxis
- Implementation

5.16 Focus Groups interviews (Cycle 5)

Three focus groups were conducted comprising three, four and eight senior registered nurses. The size of the groups being defined by the availability of nominated supervisors and others who may provide a more general perspective on the programme and its impact on the teams in which they work. The arrangements for securing focus group sessions varied between clinical areas. On the Neurosurgical Unit I was able to meet with supervisors and other senior nurses during development

/ supervision days arranged by the unit Matron on a quarterly basis. Access to supervisors on the other pilot areas required me to arrange focus group sessions when adequate numbers of senior staff were on duty in order to allow supervisors to be released without compromising patient safety. Consequently arranging focus group sessions on these units was limited by the same constraints as those that I found with individual interviews.

At the outset of each focus group session I explained that the aim of the session was to explore their views on the STEPs programme and some of the views and ideas provided during interviews with new registrants. In this way I hoped to elicit views on the structure, content and implementation of the programme from different perspectives and to provide opportunities for themes identified during interviews with junior nurses to be supported or refuted whilst maintaining the anonymity of individuals. During the group interviews I found I needed to be vigilant in monitoring group dynamics in order to avoid the identified drawbacks of focus group interviewing (Merton et al, 1956, Robson, 2002, Fontana and Frey, 1994). This required active encouragement of the more reserved group members whilst controlling but not alienating more vocal individuals. In addition, it was important to explore inconsistencies in responses by individuals and promote debate as to why divergent views may exist. Note taking facilitated collection of key information and hence negated the need for time consuming transcription of further taped interviews. These notes comprised individual statements and summaries of discussion and debate with and between focus group members. Whilst I documented relevant, specific statements from individuals verbatim, the majority of my notescaptured areas of consensus or disagreement within the groupin relation to the topics discussed.

5.17 Data Analysis – Focus Groups.

Analysis of the data elicited through focus group interview was conducted in a similar manner to the coding process used to analyse data from interviews of individuals. However open coding of the three focus group interviews was less time consuming as my manner of note taking provided me with the opportunity to highlight key words and phrases during the actual focus group sessions, thereby a enabling speedier open coding phase of analysis.

Subsequently I reviewed the resultant open codes and clustered any that appeared to be related to the axial codes and themes derived from the earlier individual interviews. I found that considerable data revealed during analysis of the focus group data related to the key themes identified during analysis of individual interviews. However, differing views and attitudes to some topics provided useful alternative perspectives and points for discussion during repeat interviews of

initialparticipants and those new registrants that joined the study at a later stage. Extracts of Focus group interview notes with open coding and an example of axial coding relating to the theme 'Transition from student to staff nurse role' are provided in appendix 10

Case comparison enabled me to identify similarities and differences in the impact of implementation of the STEP 1 draft framework had on individuals and teams.

5.18 Summary of Chapter 5

In this chapter I have detailed the processes of engaging clinical teams in determining the structure and content of STEP1; engaging the support and involvement of key specialist practitioners to ensure that the content of each of STEP1 element reflected current best practice; organisation, conduct and transcription of individual and focus group interviews to elicit data and the process of data analysis. The model for implementing STEP 1 throughout the Trust is detailed in chapter 8.

In chapter 6 I will discuss the general themes derived from the interview data and illuminate these findings with the comments of new registrants, focus groups and matrons.

Whilst conducting this study I developed several important insights, not least regarding the role of an insider researcher and these reflections are detailed in chapter 9.

CHAPTER 6 - FINDINGS AND ASSOCIATED ACTIONS

6.1 Introduction - Overview of Themes

Analysis of data derived from interviews and focus group sessions revealed a number of general themes that were common to all three areas. These were:

1. Transition from student to staff nurse role

2. Views on the principles of the STEPs approach

3. The supervisor/supervisee relationship.

4. *STEPs Structure, pedagogy and praxis*

5. Implementation (access to Steps packages; preparation of areas / selection and preparation of supervisors)

In an attempt to provide evidence to support my analysis of the study data I have quoted study participants. All names of study participants quoted in my discussion of these themes are pseudonyms. (See appendix 7 for demographic information)

6.2 Transition from Student to Staff Nurse Role

Without exception new registrants talked at length about the transition from student nurse to registered nurse roles. Topics raised within this overarching theme included stress; accountability; decision making; praxis, knowledge and practical skills, time management, and role identity.

The new registrants that were interviewed early in the study had experienced stress during the first months of clinical practice as Registered Nurses. Because of the timing of the initiation of the study five had been working as registered nurses for approximately three prior to commencing on the STEPs programme. Two interviewees had been qualified for periods in excess of six months and had previously worked in other hospital Trusts and a third had worked in another clinical area within the same hospital. The majority of these nurses had worked as nursing auxiliaries whilst waiting for their registration to be confirmed by the Nursing and Midwifery Council. Several had undertaken student nurse placements in the area that they were currently working. The new registrants claimed that their initial period as a staff nurse was stressful and the words 'terrifying', daunting and scary were frequently used to describe their feelings during the first few months as a Staff Nurse. Overall

the majority felt that at the time of qualification they were unprepared for the responsibilities inherent to the registered nurse role and consequently experienced varying levels of distress.

These factors and their impact on individuals are clearly identifiable in the following exchange with new registrant interviewee Karen, during this transitional phase of her career:

Karen: As a student you don't have any accountability so it is a hard transition to go through. From absolutely nothing (level of responsibility), you go from being told to go home early because it doesn't matter, to doing a full 12 hour shift and it is all on your head and you go home crying at night. To be honest with you that is what I did."

SK: "Have you literally gone home crying"

Karen: "Yes. I have gone home crying and I drank two bottles of wine.

SK: "What caused that?"

Karen: "I had worked three shifts in a row when I was down the sides (cubicles) and they were quite heavy patients butthat was alright because there were two staff nurses down there. But on the last shift it was just me. So I had gone from having three patients, and was tired, to having six patients on my last day. Three patients went down for MRI scans and I had to go down (escort patients). Three patients had to be log rolled. It was quite heavy and I was just … (pause)…it was just that I didn't give my patient suppositories in the end. I was so devastated as I think he hadn't had his bowels open for five days. I was absolutely devastated that I hadn't got time, that I hadn't made time to do it.

This exchange clearly demonstrates this young nurse's desire to provide high quality care, whilst the reality of the situation caused her distress that was heightened further by the recognition of her accountability and limited experience. In her case a coping strategy was adopted that could be harmful and this will be explored further in the next chapter (see 7.2 & 7.3)). Furthermore this nurse has encapsulated the shared concerns of other interviewees who also identified sources of their discomfort recognising identification with the Staff Nurse role and being unprepared for the realities of clinical practice. Specifically interviewees identified workload, time management and the lack of ability to prioritise care as major stress inducing factors.

The most daunting thing for me was at handover to be given six patients; maybe eight patients and you are on your own.   (Janet, New registrant)

I feel like I am chasing my tail all day. Sometimes I will go back to my patient and think 'God I haven't done my obs (observations) for that hour'. My time management I would say is a bit of a problem. My prioritising is absolutely... you know, perhaps I didn't know what was the most important thing   (Paula, New registrant)

My time management skills aren't great anyway but they were all over the shop. So, I would go home at the end of the day and think 'I only just got through the basics washing, medicines & observations.' You finish all of them and then you get round to everything else. (Karen, New registrant)

Additional to these factors, on entering practice as Staff Nurses the responsibilities and accountability inherent in the registered nurse role was brought into sharp focus. Indeed all other identified causal factors appeared to be subsumed within the overriding theme of accountability as most interviewees encountered a personal dilemma in regard to wishing to provide care in an ethical manner whilst struggling with their ability to apply knowledge within environments compromised by economic and human resource constraints. New registrants felt unprepared to manage heavy workloads and at times felt unsupported, this resulted in required aspects of care being overlooked or omitted by new registrants and this produced feelings of guilt when they believed that had not provided an appropriate level of care. These concerns were heightened by the realisation of their accountability as registered nurses.

I was terrified. A relative would ring and they (other staff) would say I will just get the staff Nurse. They would give the phone to me and I would think 'ooh it's me'. I think it was then that I realised that the buck stops here…I don't think you can be prepared for accountability until you are accountable. They can tell you what it is going to be like but until you are accountable it doesn't register. (Cheryl, New registrant)

When asked if the level of accountability ever worried her, Karen replied:

Sometimes…It's when your patient's situation changes. I had a lady who deteriorated quite badly. A subarachnoid (haemorrhage) I think, she didn't get enough fluids in and deteriorated rapidly over the shift. If staff nurse didn't check and get her sent to Intensive care she could have died…. so if you go home with that…. I do not think I could live with that. (Karen, New registrant interviewee)

This nurse believed that without intervention by a more experienced nurse the patient could have died. The stress experienced by this nurse appears to stem from her wish to provide care in an ethical manner, in this instance based upon the principal of non-maleficence. Other interviewees shared a desire to 'do no harm' but also felt compromised by their belief that they lacked knowledge and had harboured misgivings about their fitness for practice. Most new registrants reported lack of confidence at the time of implementation of the STEPs framework.

The pre-registration curriculum was criticised by interviewees who felt their knowledge of nursing fundamentals was pretty good but application in practice was lacking and this led to lack of confidence.

I had done my placements and I enjoyed them and got as much out of them as I could. The academic side teaches you to think and question things in a certain way which is useful. But as regards being on the floor and doing the job I don't think it was very good. (Sharon, New registrant interviewee)

It (the course) did seem to be very much towards the academic side. I think a lot of us that are newly qualified think are not prepared properly for clinical practice ...... you just find yourself asking silly questions. It's about basic things and you think why don't I know this. (Hayley, New registrant interviewee).

The three focus groups were in agreement that many new registrants lack confidence but they all felt this would be overcome as they gained experience and applied their knowledge in clinical settings. The neurosurgical focus group viewed that their new registrants often required reassurance even though they were coping well and their practice was safe.

The most commonly cited area in which new registrants felt ill prepared was the administration of medicines and this reflects the findings related by Charnley (1999). The following quote embodies the views of a majority of the new registrants:

I had not given medicines rounds (alone) anywhere at all...when you go round with somebody (as a student) you haven't got time to look through every single thing and see what it does. They are rushing through it all. Whereas here I need to make sure that what I am giving is what it is meant to be, I need to know why. (Paula, New registrant)

Interviewees also felt that their confidence was affected as their decision making skills, prioritisation and time management needed to be further developed. However there were divergent views among the new registrants as to whether this could have been more adequately addressed during training. This related to identifying potential/real problems and taking appropriate & timely action. Whilst some interviewees believed that decision making skills, prioritisation and time management could not be taught but would develop with experience other believed that these issues could have been addressed more thoroughly by the university during pre-registration education.

You are taught what is normal. You are not taught that this isn't right or that isn't right. …. They didn't challenge us with clinical scenarios to get you to thinking… but I think it would have been useful to be challenged in that way to try and give us a way to develop our clinical judgment. (Chris, New registrant)

Members of both the Neurosurgical and High Dependency focus groups agreed that that these issues resolved naturally as decision making ability develops over time as nurses become more experienced. When asked what is developed with experience that most influences decision making, the consensus in all three focus groups was the improvement of assessment skills, as without accurate assessment decisions were unlikely to meet patient need. These nurses held the belief

thatassessment skills and decision making ability improve through extended clinical experience and this would positively impact on the development of the ability to prioritise. In addition the high dependency nurses felt that sometimes new staff would work on those aspects of care and management that they were comfortable with but not address the aspects of care that stretched/challenged them. These nurses also felt that it was necessary to ensure that junior nurses used such devices as protocols, policies and benchmarks such as Essence of Care to inform decisions. The neurosurgical nurses felt that at one level the juniors had developed decision making skills as they knew when to refer a problem onto more senior nurses or medical staff for advice. They also recognized that improvement of their own documentation would help junior nurses to understand how they arrived at decisions. The Urology focus group however, felt that possibly more could be done during training in regard to developing assessment and decision making skills.

6.3 Role Ambiguity

The lack of confidence experienced by new registrants also appeared to be heightened by being identified as registered nurses by others who were not in the immediate nursing team. Staff nurses on all three clinical areas felt uncomfortable when approached by multidisciplinary staff, particularly doctors, who are unaware of their junior status.

> *It was just so scary. One of the things that seemed really odd was that people saw me and it seemed to be 'oh you are a staff nurse you must know'. They saw me dressed as a staff nurse and doctors just assumed, and I thought please be gentle as I am just getting my head around things* (Susan, New registrant)

This sentiment was implicit throughout numerous interviews and is illustrative of role ambiguity (See chapter 7) Interviews conducted one year after my first contact with new registrants appear to support these findings and seem to indicate that experience and coping abilities gained in the first year in the role can make a difference in dealing with problems in the work environment.

> *I feel tons better than I used to but I am still very much a novice. I accept that & I am happy as long as people remember that. I am happy. I think you need to be pushed and encouraged at times but with support. You cannot be expected to just do it and it can be a bit hit and miss sometimes… It is only now that I feel like a staff nurse. I certainly didn't when I finished uni. (Chris, New registrant)*

Karen, the nurse who confided that she was stressed to the point of binge drinking stated:

> *I don't worry about things as much; my coping mechanisms are better. I still worry but in the year gone by the experience and knowledge that I have gained have meant that I ask people for less (help and advice).* (Karen, New registrant)

6.4 Views on the Principles of the STEPs Approach

From the point of being introduced to the concept and structure of STEPs and throughout the action research period the principles underpinning its introduction was well supported by participating staff at all levels.

At the outset of the programme participating junior registered nurses on all three clinical areas were unanimous in the belief that the STEPs framework provided an overview of the practical skills and knowledge required, and their comments indicated that praxis was important to them.

> *STEPs helps to identify gaps in clinical experience. Whilst knowledge gained in training is good, the university's 'Continuous Assessment of Practice Document' statements are too broad and are not geared to ensure all essential elements of practice are developed to level of competency needed as a staff nurse.* (Susan, New Registrant)

Junior nurses emphasised that the opportunity to consolidate their skills whilst receiving support from experienced nurses was very beneficial. Susan continued:

> *STEPs is a good idea for helping develop experience and skills as it provides direction, sign posting.* (Susan, New registrant)

> *STEPs structure is helpful even in absence of a supervisor as it helps you to identify what you need to learn. (Melanie, New registrant)*

> *I think the structure will help and it gives you an idea of what you should know because obviously you can't know everything at once. It comes with time but STEPs gives you an idea of what you should know.* (Ellie, New registrant)

The Matrons for all three areas recognised the benefits of evidencing the competence for the new registrants, whilst also providing clarity regarding expected performance and one stated

> *"The positives are that I have the confidence of knowing that all my staff are working at a set standard and are competent and practice is evidence based. So for me that is a big plus. For them when they come to their KSF and their PPDR it is their evidence to show that they are competent at this level.* (Natalie, Matron)

This view appeared to be shared by new registrants.

> *KSF and things like STEPs could help with the publics image of the Trust as we would know peoples level of competence and when you get complaints or PALS issues you are in a better position to address the questions raised if the level of care is standardised across the whole ward.* (Ray, New registrant)

When asked if STEP 1 was too basic the consensus of responses on all units was that revisiting aspects of their pre-registration programme curriculum was not problematic as it was a good idea to consolidate existing knowledge and skills

Comments by Cheryl Simms, Paula Lewis, and Ray Parker that demonstrated a view that validation of competence is important were shared by new registrants on all units,

> *I am not always sure that I am doing things right but if I go through the Steps elements and I am assessed I then think I am doing alright.   (Cheryl, New registrant).*

> *It will help sort out where your strengths and weaknesses are as well. You can easily say well I know how to do that. But are you doing it right. It is good to be checked out because then you can think I did that well or I am doing alright. (Paula, New registrant)*

> *There is strength in demonstrating your ability in the clinical setting. Showing what you can do. (Ray, New registrant)*

Support for STEPs persisted despite issues raised later that were viewed as barriers to progressing through the framework. A similar level of support was deduced during the focus group sessions with supervisors as they believed that the content of STEP 1 framework was useful in promoting consistency by detailing the expected standards of care or as one supervising nurse commented:

> *It provides the assessment that should have been carried out during training, assessment of skills and safeguards the profession. (Neurosurgical Focus Group)*

These more experienced nurses also identified that STEPs had a useful purpose for them also, as working through the elements with the junior nurses helped them to renew their awareness of policies and it assisted them to refreshes their knowledge on aspects of law and developments in evidence based care.

6.5 Clarifying the Relationship between the NHS KSF and STEP 1

The importance new registrants attributed to STEPs was primarily related to standards of care and personal and professional development, but as awareness grew regarding the Agenda for Change pay structure, staff required clarification of the relationship between the NHS KSF and STEP 1

> *Some people just don't get STEPs. Some think it is a load of bullshit and we are mugs for doing it. I think their view is that whilst we will have the evidence, which I am perfectly happy about, they will not be discriminated against because they haven't. Do you know what I mean? They think they can demonstrate it in another way. (Hayley, New registrant)*

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It became clear that in its original form the documentation did not clearly demonstrate the relationship between STEP 1 and the accrual of evidence to demonstrate progression against the NHS KSF role outline against which individuals would be appraised

The relationship of STEP 1 to the Agenda for change and pay progression was also raised by junior staff.

> *Say you have two staff nurses on the same grade but one is doing more at least with this (STEP 1) it will identify who is doing the most. Obviously it will reflect on your pay scale. I hope that's what the plan is. (Sharon, New registrant)*

As a result of these types of comment an extensive mapping exercise, was undertaken whereby each every element was assessed to establish which STEP 1 competencies matched the indicators for each NHS KSF dimension that comprised the Band 5 nurse role outline (see appendix11).

Subsequently staff reported confidence in the potential for STEPs to provide evidence of competence against the KSF dimensions, but did question whether STEPs would influence acceleration up the Agenda for Change pay spine. One Matron stated that her staff:

> *Think that STEPs is right in terms of monitoring progression of staff but also see it as another task when they are busy. They accept the values behind the programme and see a link between STEPs, KSF and pay progression (Natalie, Matron)*

General awareness of the STEPs programme evolved over time and there a general consensus emerged through the three focus group interviews that the supervisor pack was informative regarding policies and guidelines as reference was made to existing policies that they were unaware of. As understanding developed a number of experienced nurses on the Urology Unit who were not on the programme demonstrated an interest in gaining access to the STEP1 elements in order to self-assess their current knowledge base in essential care. I was approached by an experienced band 5 nurse with a request to allow other nurses access to the copy of STEP 1. I viewed this as positive support for the project and saw this as an opportunity to spread understanding of the project objectives with the intention of increasing the level of informed support available to junior staff. To this end a compact disc containing a PDF version of STEP1 was made available to the Urology Unit staff and I am aware that individuals made copies of the programme for their own use.

The participating junior registered nurses believed that STEP 1 provided an overview of the practical skills and knowledge required and their comments indicated that praxis was important to them and emphasised that the opportunity to consolidate their skills whilst receiving support from experienced nurses was very beneficial. Two junior nurses identified that whilst support from staff was always available it was not very structured before the introduction of STEPs.

6.6 The Supervisor/Supervisee Relationship

Open coding of the transcribed interviews revealed a number of factors that impacted on the implementation of STEPs including Unexpectedly, issues affecting the development of the supervisor/supervisee relationship were raised more frequently during the early stage of the study than issues relating to the structure and implementation of STEP1.

The essential characteristics of such relationships, have been identified as teaching, counseling, confirmation, accepting, friendship, protection, coaching and sponsorship (Snelson etal, 2002, Hurst & Koplin-Baucum 2003, Bally, 2007) should achieve safe and competent practice through influencing the form, quality and outcome of the career path of both nurses (Greene and Puetzer, 2002. The interactive nature of these essential characteristics leads one to conclude that for the supervisor / supervisee relationship for to be a positive and productive one it is necessary for the nurses occupying these roles to get to know each other (Baltimore, 2004 Fawcett, 2002) Fawcett, (2002) stresses that getting to know 'orienteers' allows them to succeed and Baltimore (2004) emphasises the value of exchanging information regarding personal and professional backgrounds, teaching-learning and communication styles. The importance of this relationship lies in the need for the socialisation of new registrants into the workplace because the most common cause for employees to leave within the first year in a new job is that they feel that they do not 'fit in' (Baltimore, 2004).

During the interviews and focus group sessions the staff nurses and supervisors on all areas identified that finding time to meet together was difficult and consequently progress with the STEPs programme was slow. New registrants and supervisors identified that due the acuity and throughput of patients, the working day was very busy and time for development was at a premium. However on closer scrutiny it became clear that there were other contextual factors were important to address. These inter-related factors were identified as the engagement of an appropriate supervisor, isolation; and the approach taken to 'working through' STEPs. These issues presented to different degrees in each clinical area.

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6.7 Identification of an appropriate supervisor

The appropriateness of the decision regarding who should act in the supervisory role was a raised by new registrants on all clinical areas. On the Urology Ward F grade / Band 6 nurses and band 5/E grade nurses fulfilled the supervisory role. Supervisors were identified initially by the Matron in consultation with the Charge Nurse. But the Matron discussed the appropriateness with the junior nurse and the proposed supervisor following a period of induction in which the new registrant familiarise themselves with their colleagues. The result of this process was that over the research period two participants were supervised by Band 6 nurses and three by Band 5 nurses. The staff nurses who were supervised by Band 5 nurses believed this to be appropriate as "'E grades have quite a lot of experience and were approachable". Supervision by Band 6 nurses was considered to be slightly more difficult but was not considered to be a major disadvantage as they did attempt to spend time with their supervisee when they were not coordinating. One junior nurse said it was advantageous to her to be allocated a Band 6 supervisor as:

> *She is often on the same shift but often as a coordinator. And sometimes it is a bit busy. But that has been good for me as when she is coordinating she has not got her own patients and she is there if I need her. She has her own job to do but she has a bit more time to spend with me than when she has got her own patients.*
> (Sharon, New registrant)

In addition time was periodically allocated to review the supervisee's progress.

On the HDU the decision to allocate the supervisory role to Band 5/E grade nurses was decided by the Charge Nurse in consultation with the Matron. This decision was made on the basis that these nurses had proven their ability to deliver high standards of care and demonstrated extensive knowledge in high dependency nursing.

On the Neurosurgical Unit the decision that the supervision of nurses participating in STEPs should be undertaken by F Grade / Band 6 nurses was made by the Matron, Charge Nurse and Teacher /Practitioner. The rationale provided for this decision was based not only upon the level of experience and knowledge of the specialty possessed this group of nurses, but also because of their proven ability in providing mentorship for pre-registration students and management of the units existing induction programme.

However, the new registrants believed supervision by Band 6 nurses was difficult:

> *You just do not get the time with them (Band 6 nurses) coordinating…. you just do not get the time. It is really difficult.* (Melanie, New registrant

They are always coordinating on the ward. It is very rare that anyone else coordinates…"They don't often do nights. We do two weeks of days and two weeks of nights. So there is two weeks out of the month when we are not going to see our supervisor (Cheryl, New registrant)l)

Due to limited availability, some supervisors appeared remote at a time when getting to know each other is important to the socialisation of new registrants into the workplace (Baltimore, 2004).

New registrants felt that experienced Band 5 nurses would be better suited to the supervisory role, as they seemed to be more accessible.

…. there are so many experienced Band 5s. They run the shifts sometimes but on other days it would be easier for them to do it (supervise). I think I would be more encouraged to talk to a Band 5e. It might work. If you had a band 5, they are more likely to do nights. (Karen, New registrant)

An alternative view, expressed by numerous interviewees, was that the supervisory function could be shared between a Band 6 and Band 5 nurse.

When this issue was raised at the Neurosurgical focus group meeting several Band 6 nurses stated that they felt theirs was the right level to act as supervisor as their level of experience and knowledge led to consistency of support and assessment. Another Band 6 member of the group challenged this view as junior nurses had individually raised concern regarding the accessibility of band 6 nurses; therefore they should stop and listen to what was being said. A discussion followed regarding the potential for input by Band 5 nurses. I asked the group whether they felt that they (Band 6) were the only nurses with the abilities required to assist junior nurses to consolidate their learning from their pre-registration course. The unanimous response was that the majority of experienced registered nurses could provide this support. I then asked them to consider the differing emphasis between STEP 1 & STEP 2. The group recognised that the content of STEP 2, which was being developed on the neurosurgical unit, would be more specific to their speciality and their input and guidance may be more important at that point. It was interesting to note that the discussion did not focus singly upon the ability of Band 6 nurses to fulfil a supervisory role but also how this involvement could be used as a development opportunity for the Band 5 nurses. The group believed that this could be a positive step in assisting experienced Band 5 nurses to meet their own KSF role outlines whilst promoting succession planning within the speciality. One band 6 nurse also suggested that assigning the coordinating role to a Band 5 nurse on a more frequent basis would allow her (Band 6) to work clinically alongside the junior nurse whilst providing a further opportunity for Band 5 nurses to develop their management abilities with support from the Band 6 nurses if required. The final consensus was that more thought should be given to these issues.

Following this focus group session the allocation of supervisors was revisited and I was later informed, by the matron, that experienced Band 5 nurses had been approached regarding expanding andformalising their role in supervising new staff. This group had received this positively. In the first instance a 'coupled' supervisor system was set up where by a band 6 and a band 5 nurses would together oversee the development of a junior staff member. The Band 6 nurses were assigned as the primary supervisors with back up from experienced band 5 nurses. These nurses did do not coordinate on a regular basis and they rotated to night duty with the junior nurses to whom they were assigned. The Band 6 nurses facilitated the overall experience for the junior nurses by collaborating with Band 5 supervisors and the new registrants to assess progress against STEPs and to identify objectives for achievement of STEPs competencies at an appropriate rate of progress. .

Several months later I interviewed the Matron and asked how she felt implementation of STEPs was going on the Neurosurgical Unit. She responded that

> It is working as we are doing it now…we now have Band 6 as the facilitators with backup from senior Band 5 nurses. (Natalie, Neurosurgical Unit Matron)

The senior staff had accepted that there had been a problem due to the availability of Band 6 nurses and the need for "supervision to also be followed through onto night duty". The band 5 nurses had been introduced to the concept and principles underpinning the framework and the content of the STEP 1 by the Practice Development Nurse.

When asked how the Band 5 nurses had responded the Matron stated that:

> The Band 5 nurses have found it a natural progression from preceptorship and like the Band 6 nurses they have also found it enlightening regarding changes in evidence based practice and policy. (Natalie, Neurosurgical Unit Matron)

The matron identified that preceptorship was always strong on the unit but support had previously fallen down after the limited preceptorship period (six weeks) but now support was not only offered for a much longer period, but was also more structured with clear indicators by which to assess progress.

6.8 Isolation

Newly qualified nurses on all units identified availability of supervisors and patient workload as issues that impeded close supervisee /supervisor interaction. New registrants who had commenced in post prior to the implementation of STEP1, indicated that following a short initial supernumerary period, they were allocated a group of patients without close supervision by a senior nurse. In all

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areas the proximity of the area in which the new registrant was working in relation to their supervisor was an issue at times. Unexpectedly, I found that this was viewed as a major problem on the in Urology ward as the ward layout negatively impacted on the ability of new registrants linking with their supervisors.

Patients on this forty beddedward were nursed in a combination of single bed cubicles and bays containing four to six beds, including a High Observation Bay. However, patients could not be observed from the nursing station and therefore nurses were allocated to bays in order to observe their patients. Due to the ward layout and the availability of staff, junior nurses often found themselves working alone in a four or six bedded area without direct support from senior staff and this resulted in them feeling isolated and uncomfortable leaving their patients alone to seek support or advice. Without exception all junior nurses working on the urology ward identified the allocation of individual nurses to bays to be problematic. Comments relating to the ward layout included:

> *People say 'ooh you should come and ask, but there isn't really anybody to ask because they are really busy as well. It has like gone from one extreme to another. Before (in a previous post) I couldn't get any autonomy and now it is like (laughs) "take it away"…. And you work alone here quite a lot because of the way the ward is set out. You have your own patients in a room and if you haven't got heavy patients you can be on your own for the full 12 hour shift.* (Lucy, New registrant)

> *The ward layout is a problem. I could spend 12 hours on shift without much contact with other staff never mind my supervisor …the worst thing is the ward layout as it negates team working. You are isolated as you are working in bays.* (Ellie, New registrant)

> *I have spoken to other nurses who are new starters and they say that the one down side to this job is that you feel quite isolated. You are in a bay and that is it, you know that there are colleagues all around, but you are in there for 12 hours. (Janet, New registrant))*

When this issue was raised with the supervisors at the focus group they proffered that the layout of the ward hindered the ability of staff to work together and junior nurses did become isolated in bays for extended periods. Further to this the Band 6 nurses saw this as a major issue for them in general as it not only inhibited supervision of junior staff but also prohibited team working. It appeared that the approach taken to progressing through STEPs' on this ward might be, at least in part, due to the working practices that had evolved due to the ward layout. When I asked the focus group whether they thought it would be possible for work to be allocated in a way that supervisors and supervisees could partner up to deliver care in two bays they replied this may be possible but allocation of patients would need to change. Unlike most wards night staff undertook patient allocation for day shift nurses. They indicated that this arrangement was counterproductive in terms of continuity of

care, as previous patient allocation did not appear to be taken into account. It emerged that no one, including the matron was clear as to the origin of this arrangement.

The matron, who was in attendance, had not previously been appraised of these concerns. She welcomed the discussion regarding potential solutions to these issues. The group believed that allocating patients to staff should be the responsibility of the nurse in charge for any given shift as they are more also likely to be aware of the experience and capabilities of staff that are working with them. The coordinators for each shift were considered to be in a better position to consider the needs patients and the need for supporting and supervising less experienced nurses. Subsequently, the matron discussed this issue with the Charge Nurse and it was agreed that this change should be adopted. Anecdotal evidence at follow up interviews with the new registrants revealed that the introduction of these changes did increase in the time spent working in closer proximity to more experienced staff. This change was seen to be beneficial for accessing and getting to know the supervisors and improved the observation of their practice by the supervisors.

> *Things have improved as I can get help a little easier now* (Janet, New registrant)

A nurse who was appointed after introduction of the changes said

> *The staff are very good and I am happy with the support I get and I can access my supervisor if I need to.* (Ian, New registrant)

6.9 Approaches to STEPs taken by supervisors and supervisees

As identified earlier it was common to all three areas that finding time to meet together and the pressures of work were considered to be impeding progress through STEP 1. It was clear to me that I needed to understand why nurses on all areas, regardless of staffing levels, spoke about the need to 'meet together'. In order to gain understanding I explored this perception in subsequent follow up interviews, interviews with new recruits to the study and with the focus groups. These discussions, particularly those with Matrons indicated that supervisors appeared to take a pedagogic approach with the supervisee' working through' one element at a time and then meeting with the supervisor who would 'test' knowledge through question and answer sessions. This approach was not congruent with the Matrons' understanding as they believed STEP 1 was developed to improve praxis and therefore the emphasis should be observation of performance supplemented by discussion questioning to explore knowledge and understanding of application to ensure patient and staff safety.

One Matron felt that the approach taken was not in line with her expectations of how progress would be assessed and believed change was needed whereby closer supervision of junior staff would become the norm. In her opinion the key to this change lay in how well acquainted supervising nurses were with the contents of STEP1. She stated:

> *Supervisors need to know it (the content of STEPs) inside out. If they knew it inside out they would not need to take them (new registrants) away from the clinical area to discuss the elements.* (Ursula, Matron Urology Unit)

This comment suggested that supervisors were not fully conversant with the content at the outset and clearly implied that the preparation of supervising nurses was an issue that would need to be addressed.This pedagogic style of the supervisory relationship had led to the new registrants either studying extensively in their own time or not taking any action to progress through STEP1.

On the High Dependency Unit a group of new registrants met as a learning set in their own time. The following excerpt new registrant Susan's interview reveals that whilst forming this group was a reaction to what she terms 'nagging', benefits did accrue from this approach, aligned with observation by senior staff in the clinical area.

> Susan - *I have done a lot of work on STEPs…there are a group of three of us. We have been nagged to get on with it so I said only way to stop them nagging is to do it.*
>
> SK – *What do you mean when you say they have been nagging you to do it.*
>
> Susan - *They say, 'have you done your STEPs yet, have you done it.*
>
> SK – I *would like to know what is meant by doing your   STEPs.*
>
> Susan – *Are you looking at the statements that are made… are you looking at how you fulfil…do you fulfil the statements? Do you need to be asking questions? What do you need to learn?*
>
> SK – *Is anyone observing you at any time and feeding back to you on how they think you are doing.*
>
> Susan - *Oh yeah, yeah…… Sometimes we were told "yes we know you can do that because you do it all the time". But I have actually read through everything (STEP1) and put a written entry for everything.*
>
> SK – *Has that been useful?*
>
> Susan – *Yes it has because although it is very basic. There are things we have been unaware of and just reminding us more than anything. We are ending up with a file full of information that we can draw on at any time.*

On the Urology Ward the way that new staff were managed during the induction period and the way in which they were orientated to the ward impacted on their ability to develop their relationship with their supervisor. This in turn affected the way in which these partnerships functioned and compounded the impact of the ward layout. It became increasingly apparent that induction and orientation to the unit had been inconsistent. All new nurses on the Urology Unit worked for four weeks in a supernumerary state but how this time was utilised was different for individuals. One nurse, compared her induction period with that of a colleague who had commenced work on the unit at around the same time:

> *We had four weeks supernumerary but we both had different experiences. We were quite different really as I spent a lot of time on the ward and in all the clinics to do with urology but she spent most of the with her mentor coordinating (the ward) most of the time, so that was not very helpful (Melanie, New registrant)*

Another junior nurse stated:

> *I spent a week in day surgery and a week with the Clinical Nurse Specialists but as I work 12 hour shifts this actually only left six days to actually get used to the ward before I took my own patients. (Sharon, New registrant)*

These new registrants believed that reorganisation of the supernumerary period could benefit future newly appointed nurses. I asked each one to consider what they felt they needed from the supernumerary period and how the time could be utilised differently to meet those needs. They all related a belief that the supernumerary period should be spent on the ward working with their supervisor and identifying their developmental needs in relation to the elements included in STEP 1.

Subsequently I arranged to interview the matron and had intended to explore with her the issues raised regarding integration of new staff into the team and in particular the concerns raised by staff in relation to induction and 'feelings of isolation'. Following the interviews with junior nurses and focus group discussions, staff on the Urology Ward appeared to have been empowered as it transpired that these issues had been discussed widely within the ward team. The junior nurses had also met with the matron and had voiced their views regarding the induction/orientation of staff onto the ward. They had indicated to her that future new appointees would benefit from a standardised approach to induction/orientation and that this should be structured around the STEPs programme. This resulted in the new registrants being invited to review and redesign the way in which the supernumerary period would be used for future appointees. The outcome was that during a supernumerary period of four weeks all new registrants would provide direct care to patients in tandem with their named supervisor. The opportunities to work in the day surgery unit and the

shadowing of the specialist nurses was postponed until a time mutually agreed by the new registrant, the supervisor and the Charge Nurse as being appropriate to the individuals development. Informal discussions with staff revealed that new registrants are now able to familiarise themselves with the ward routines, patient flow and care pathways, whilst 'getting to know' their supervisors.

The Matron commented to me later that because of these changes supervisors had began to observe practice and explore the knowledge of the new registrants, thereby assisting them to recognise their strengths and their developmental needs relating to the elements in STEP 1. Objectives were now being agreed which ensured that the junior nurse attended to, and are supported in, addressing those developmental needs. The matron added that nurses who identified tiredness due to working 12-hour shifts as a reason for not progressing with STEPs were advised to negotiate shorter shifts. This advice was given to enable their personal development but also as recognition of potential safety hazards to patients and staff

6.10 STEPs Structure

A number of issues relating to the development, layout and implementation of the STEP 1 document arose during the study. These included:

- Introduction of the document whilst it was still being developed

- Development and introduction of specialist components.

- Layout of thedocument andidentification of relationship to the NHS KSF to STEP 1)

- Assessment of performance and sign off by supervisors)

- Accessibility to the documents

- Currency of the programme in academic terms.

6.11 The Layout and Accessibility of STEP1

The development of STEP 1 was slow due to due to the availability of time for the development team to write and consult widely on the content. This resulted in publication of eight elements followed by the remainder as they were produced. The reactions of new registrants to this were

mixed. Initially most interviewees stated a preference to receiving all STEP1 elements together but referring to receiving elements as they were produced a new registrant stated:

> *I think it is an advantage. If you were given the full lot you might wonder how you are going to get through it. I think you could get bogged down really.*

And following distribution of the complete STEP1 package she stated

> *That document could put you off. The first one we were given was thin and you could see yourself completing it*

New registrants were unanimous in identifying difficulty in navigating between the STEP 1 elements, rendering it incompatible with contemporaneous documentation of achievement. The expressed reasons for this were mixed but in general the document was thought to be too bulky in its paper form. For this reason some new registrants chose to leave theirs at home. Additionally, the lack of a clear page index and numbering negated easy use.

6.12 Pedagogy and Praxis

A major concern raised by new registrants and supervisors was that validation of achievement against outcome criteria continued to be time consuming as on the original STEPs documentation supervisors were required to 'sign off' every component of each element (see appendix 11). This combined with difficulty navigating between elements led to them being addressed in sequential fashion and this exacerbated the tendency towards pedagogy.

> *It felt a little like the oral exams you used to have, like French and German, at school. I was getting all hot and flustered. She (the supervisor) didn't expect the answers to be text book but you start panicking and think I should know this.*
> (Susan, New registrant)

Predominantly, the belief of new registrants was that different approaches to signing off the elements should be considered.

> *I feel that by being observed meeting some of the criteria. By setting up and looking after your two patients and writing up some of the elements that you would meet in a day. If I can put down the elements that we have covered and they are happy with the level of observation they can then go on with questioning after that.*
> (Chris, New registrant)

Clearly changes were required as praxis includes deliberate action by which theory or philosophy becomes integrated into the social reality of the practice environment (Bawden, 1989), unfortunately the tendency towards a pedagogic approach negated the promotion of an environment

characterised by adaptation, flexibility and horizontal power but perpetuated feelings of powerlessness. The challenge for the development group was to encourage supervisors to embrace opportunities for empowering junior nurses to identify and address their development needs, and to engage in debate and challenge ritualistic practice. Also, new registrants needed encouragement to reflect on their performance in practice in preparation for a realistic discussion with supervisors regarding their strengths and areas requiring further development.

6.13 Adjustments to Process and Documentation

Reflection on the views of participants led to adjustments being made to the process of validation by the supervisors and the supporting documentation. To encourage reflection and promote ownership of their own development, by the new registrants, the supervisor signature column was removed from the document and a self-assessment form was developed for new registrants to complete (Appendix 11).To promote the integration theory into practice, supervisors agreed to base discussions with their preceptees on observed practice, and not only on verbalized knowledge. In addition a separate sign off sheet was devised for supervisors to verify that the preceptee's performance was satisfactory and underpinned by sound knowledge and appropriate attitudes (Appendix 12)

When STEP 1 was first implemented the NHS KSF was also being introduced into the Trust and consequently most new registrants demonstrated a lack of understanding of the NHS KSF and how STEPs could assist in providing evidence of progression against role outlines as the initial documentation did not explicitly identify the relationship between STEP1 and the NHS KSF. Individuals were concerned that they would have to complete STEP1 and then provide separate evidence to meet NHS KSF requirements.

New registrant Karen admitted to being:

> … *a bit confused about the different levels and relating it to quality and the KSF*.

To address the issues raised I engaged study participants in dialogue to identify how the NHS KSF interface could be made explicit. It was agreed that this could be aided by inserting the dimensions and levels to which STEPs criteria related to the NHS KSF. Appendices 13 and 14 demonstrate a revised STEP1 Element including amended layout; NHS KSF mapping, and an example of an element in the STEP 1 Supervisor Pack). This was possible as earlier in the development of STEP1 a mapping exercise was undertaken to ensure that the content of the program correlated with the requirements of the NHS KSF as identified in the Trust's Band 5 Broad role outline (appendix 14).

These issues were also raised with the implementation group and subsequently the relationship between STEP 1 and the KSF was reinforced with the clinical teams.

6.14 Improving accessibility

To improve access and usage of STEP1, alternatives to hard copy presentation were explored. The introduction of rewritable compact discs was explored and initially proved favourable to the paper version not only enabled easier document navigation but also allowed evidence collation, self assessment and supervisor sign off directly to disc. When asked her view about loading the programme in word format on rewritable disc one junior nurse stated:

> *To work with the actual document isn't so easy as it is so bulky. You can't always carry it around with you. A disc and self appraisal will work nicely together as you will be able to see where you are up to. I would be more likely to go home from work and type into straight in to the programme. I would think 'oh I did that today' and quickly go and do it.* (Melanie, New registrant)

The use of rewritable compact discs was popular with staff but following introduction, updating and adding content proved difficult as this required recalling discs and reissuing new discs. This proved to be time consuming, logistically difficult and costly. In addition, to allow staff to type directly onto the document, rewritable CDs were used. Unfortunately it became apparent that this could lead to unauthorized alteration of content. There was also concern that the use of CDs could result in result in acquisition and use of the programme by unauthorized individuals/organizations in violation of the Trust copyright.

These problems were overcome by withdrawing the use of CDs and loading the programme onto the 'Managed Learning Environment' (MLE) that had recently been developed under the sponsorship of the Strategic Health Authority. This approach had the same advantages as using CDs but also allowed easy amendment of the document on line. In addition, staff could access their personal documentation via the internet and as the MLE and the electronic version of the NHS KSF were to be linked, evidence of progression could be downloaded from STEP 1 therefore aiding the appraisal process.

6.15 Reaction to the changes

Following the introduction of these changes new registrants demonstrated greater awareness of how they could use STEP 1 to provide evidence for appraisal against NHS KSF dimensions and help to shape future learning:

*I like the clear linkage with the KSF as, along with the self-assessment sheet, I can identify what I need and take some control over my development (*Sharon, New registrant)

A junior nurse who, commenced in employment following amendment of the documents, found:

the layout is easy to follow and with support from my supervisor, it gave me direction for my development. This has helped me to settle into the staff nurse role. (Eve, New registrant)

6.16 Currency of the programme in academic terms

As stated the content of STEP1 was generally viewed to be pertinent to the needs of new registrants and the support of an appropriate supervisor invaluable. However, new registrants believed that STEP1 would be more valuable to staff if it had the currency of academic credits, which could be used towards a validated academic award.

6.17 Summary of Chapter 6

In chapter 6 I have discussed the major themes derived from interview data and illuminated these findings with the comments of new registrants, focus groups and matrons. These themes include identification of strengths and areas for development relating to the STEP1 programme structure, content, accessibility and documentation. In addition, a number of issues where raised relating to organisational and management support for new registrants during transition from student to staff nurse. The lessons learnt through the action research used to develop and test STEP 1 influenced decisions regarding the roll out of STEP 1 across the Trust (for implementation of STEP1 across the Trust see chapter 8).

CHAPTER 7 - DISCUSSION of RESULTS and CRITICAL REFLECTIONS

7.1 Introduction to Chapter 7

In this chapter I reflect on and discuss the results of my study, and relate this to relevant literature. Utilising Hart and Bond's 'Action Research Typology I will critically reflect on this project and explore my role, its impact on the outcome of the action research project and attempt to elucidate strengths and weaknesses of this work.

7.2 Stress, accountability and preparation for practice

International nursing literature is scattered with anecdotal evidence (Bashford, 2002, West, 2007) and findings of studies that indicate that it is not uncommon for newly registered nurses to experience stress (Kramer, 1974; Chang, 1993; Madjar et al, 1997; Allen, 1998, Charnley, 1999; Chang & Hancock, 2003; Macintosh, 2003 Hautman, 2003; Lotmark et al, 2006; O'Shea & Kelly; 2007; Chang & Daly, 2008, Duchscher, 2009). The knowledge that high levels of stress are experienced during the transition from student to staff nurse is not new as Kramer (1974) indicated that new registrants experience 'reality shock' due to a variance between the real and the ideal world. This discrepancy between their understanding of nursing from their education and their experiences in the 'real' world of hospital practice leaves new registrants with a sense of groundlessness (Mohr, 1995), a state described by Duchscher (2009) as 'transition shock'.

Through studies conducted in Canada over a ten year period Duchscher (2007, 2009) builds upon the work of Kramer (1974) to provide a conceptual framework of 'transition shock. Duchscher (2009) identifies that the contrasting experience of roles, relationships, responsibilities and knowledge in clinical practice and the familiar student experience can result in doubt, confusion, disorientation and a sense of loss resulting from a broad range and scope of physical, intellectual, emotional, developmental and sociocultural factors. Duchscher emphasises that these factors are both an expression of and mitigation within the experience of transition and that:

> *These factors may be further aggravated by antecedents related to unfamiliar and changing personal and professional roles and relationships, unexpected and enhanced levels of responsibility and accountability that are unable to be afforded to the graduates during their student experience, and expectations that they will apply to their everyday practice situations clinical knowledge that has often been untried, is contextually unrecognizable or is simply unknown. (Duchsher, 2009, p1110)*

A common conclusion in the nursing literature is that students emerge from pre-registration education with a lack of practical, organisational and managerial skills (Gerrish, 1990, 2000.

Watkins, 2000.Bick, 2000. O'Shea and Kelly, 2007). It appears little had changed since Gerrish's initial study, as in my study coping with workload, time management, lack of ability to prioritise care and role conflict were identified as major stress inducing factors. Additional to these factors the responsibilities and accountability inherent in the registered nurse role was brought into sharp focus, in particular being responsible for managing the care of a number of patients simultaneously (Chang & Daly, 2008). Indeed all other identified causal factors appeared to be subsumed within the overriding theme of accountability as most interviewees encountered a personal dilemma in regard to wishing to provide care in an ethical manner whilst struggling with their ability to apply knowledge within environments compromised by economic and human resource constraints. Charnley (1999) also identified that new registrants find themselves in a situation for which they have spent several years training and for which they were going to be prepared, but suddenly find that they are not.

Similar to the findings of Charnley (1999) these new registrants felt the student nurse uniform had shielded them from the full breadth of the role and associated responsibility. Specifically the new registrants felt that as students they had been protected in terms of task allocation and the timescale for their completion. Subsequently, the volume of work and time constraints resulted in aspects of care being forgotten or omitted. The disparity between expectations of their Staff Nurse role and the reality had led to role conflict resulting in feelings of guilt, as new registrants believed that had not provided the appropriate level of care.

Bick (2000) views the problems that new registrants experience regarding time management and prioritising their workload are difficult to teach in college and can be learned better in clinical practice; it has been concluded that this has implications for the pre-registration curriculum (Gerrish, 2000; O'Shea and Kelly 2007). Whilst, this is likely, as my study progressed it emerged that amelioration of these factors emerged over time and may be dependent, to a degree, on the effectiveness of the supervisory relationship (see section 7.4). However, my research indicates that that support for registrants is often poorly managed and that senior nurses often expect new registrants to manage a workload comparable to experienced staff. It also demonstrated that programmes such as STEP1 can assist in relieving the stress caused by role ambiguity by providing clarity regarding care standards and the expression of outcomes expected of new registrants during their preceptorship period. But it also highlighted the need to address issues relating to the organisation of support for new registrants through satisfactory preceptorship relationships, thereby easing the role socialisation process. This relationship should be based upon a tacit knowledge transfer model rather than on workload division.

7.3 Role ambiguity and organisational sabotage

In Chapter 6 extracts of numerous interviews illustrated role conflict or role ambiguity experienced by new registrants. Role ambiguity has been generally defined as:

> lack of clear, consistent information about the behaviour expected in a role. (Kahn, Wolfe & Quinn, 1964).

Chang and Daly (2003) identify two types; objective and subjective ambiguity. The former arises from lack of guidance on role definition and expected performance and the latter, which is related to psycho-sociological aspects of performance, occurs when individuals are concerned about how others view them in relation to achievement of personal goals. Chang & Hancock (1998), following factor analysis of two surveys of new graduates, reported that role overload and ambiguity were negatively correlated to job satisfaction in the first few months of employment. The data in the present study reveals that as in other studies (Hewison & Wildman, 1996.Madjar, McMillan, et al. Maben, Latter, and McLeod–Clark, 2006. Duchscher 2010) new registrants commenced in employment with a robust set of nursing values and wished to deliver evidence based care in an ethical manner but were unable to practice as they wished due to a theory-practice gap that resulted in heightened stress levels due to role conflict. It is contended that this is due to a contrast between the values of nurse education and a new managerialism in the NHS whereby new registrants experience a shift from the idealised practice adopted during their educational process to a productivity, efficiency and achievement oriented environment (Duchscher 2010). Hewison and Wildman (1996) maintain that:

> …the reality of the environment in which nurses are expected to practice is one oriented to throughput, numerical targets and financial constraint, whilst as a learner they are exhorted to treat patients as individuals, implement nursing theory and advance their own learning. (Hewison and Wildman, 1996, p754)

This may be exacerbated by professional and organizational factors that effectively sabotage the new registrant's ability to practice in line with their value set. To Maben et.al (2006) professional sabotage includes adherence to covert rules, lack of support and poor nursing role models; whilst organizational sabotage includes time pressures, role constraints, staff shortages and work overload.

In my study, one example of professional sabotage by adherence to covert rules was illustrated by the accepted practice on the urology ward of day shift allocation of workload by night nurses who did not have a clear overview of the experience or abilities of staff, particularly new registrants (see 6.8) This resulted in new registrants working in areas geographically removed from those colleagues who were most able to provide guidance and support, and this caused them to feel isolated. This

practice had been the norm for so long that no one, including the Matron, was able to identify when or why this practice had been adopted.

In chapter 6 I related the experience of Karen, who being exposed to an excessive workload with minimal support, resorted to binge drinking in a misguided effort to cope with the stress this had caused. Karen had experienced feelings of guilt and inadequacy when she had forgotten to administer suppositories, but I believe she was a victim of organisational sabotage. Reduced staffing levels had led to inappropriate patient and workload allocation resulting in time pressures that were outside of her previous experience.Enhanced ward staff awareness of transition issues may have enabled proactive planning, appropriate patient allocation, reduced workload or clear identification of support arrangements for Karen. In addition, if potential problems during transition had been discussed and positive coping strategies explored prior to registration and reinforced during the transition period over indulgence in alcohol may not have occurred.

7.4 The role of STEP 1 in the creation of psychological contracts and relief of stress

The new registrants interviewed in my study revealed that they felt unprepared for the changes that accompany embarkation on post registration professional practice for the first time as they were confronted with a broad range and scope of physical, intellectual, emotional, developmental and sociocultural changes. This research indicates that participation in STEP1 can assist in relieving the stress experienced by new registrants. The experiences related by participants indicated that stress induced by role ambiguity was reduced as STEP1 provided a vehicle for reflection upon their current level of knowledge, its application in practice and a guide to future learning as it provided clarity regarding care standards, expression of the Trust's expectations and the outcomes that new registrants must achieve. In addition, this study indicates that the clarity of standards provided by STEP 1 also assists in the development of apsychological contract and reduction of role ambiguity

As discussed in chapter 3 the relationship between the employee and their employer assists in the formation of a mental schema of mutual obligations. The employee weighs his or her obligations towards an organisation against the organisation's obligations towards them as an employee and adjusts behaviour on the basis of critical outcomes (Anderson and Schalk, 1998), thereby developing an unwritten (tacit) agreement, or psychological contract, which contributes to a mutually beneficial relationship (Shore and Shore (1995). Indications that participation in STEP1 influences the development of the psychological contract are found in the comments of new registrants, supervisors and matrons. There is evidence in the study that staff at all levels in the nursing teams viewed STEP1 as providing clarity regarding expected standards. New registrants, in general, held a

belief that that STEP 1 assisted their understanding of what is expected of them and signposted them to what they needed to achieve. As identified in chapter 3 there are difficulties demonstrating that espoused organisational expectations are representative as individuals inhabit them, each with their own views and expectations. (Rousseau, 1990. Schalk and Freese, 1993). However, due to the extensive consultation with large numbers of staff, at all levels during the planning, development and implementation of STEP1 it might be assumed that the expected standards expressed in STEP1 are representative of the nursing profession in this Trust.

In addition, as demonstrated in chapter 6, the implementation of STEP 1 encouraged a milieu that empowered new registrants to verbalise their views and for senior staff to gain further insight into the impact of working life on new registrants. This resulted in agreed changes in the organisation of induction, supernumerary activities and direct supervision. Through such opportunities, and their ability to communicate effectively, new registrants contributed to the development of a psychological contract and possibly those of other new registrants. This study provides evidence that identification of appropriate supervisory nurses, who were accessible and able to assist new registrants to use STEP 1 to reflect upon their practice, identify areas for development and to set achievable developmental goals had a positive effect on reducing stress levels. The comments of new registrants who were employed following changes made as a result of this action research demonstrated that they were experiencing a relatively stress free initial post registration period as the clinical environment met their expectations in providing clarity regarding the standards to which they should aspire, and support in attaining them.

In the study by Chang and Hancock (2003) role ambiguity emerged as the most salient feature of role stress and lack of job satisfaction as there was still a significant negative correlation between role ambiguity and job satisfaction, but no significant correlation between role overload and job satisfaction after 11 – 12 months in the role. This may imply that during this period sufficient experience and coping skills are gained to enable new registrants to manage the workplace problems that they are confronted with daily (Chang & Daly, 2008). These results are supported by the present study,as after 12 months the new registrants were more comfortable managing their time and workload. They were also less perturbed by the acuity of their patient's conditions as they felt more comfortable asking for help/advise from senior colleagues. However, support and supervision remained important to them throughout this period.

These findings also support the Dreyfus model and the findings of Benner (1984) that the movement towards competency is the climax of rule guided learning, featuring a growing ability to recognize

and discriminate between features of practical situations. Thus enabling coping in pressurised situations and increasing ability to plan ahead (Eraut, 1994)

7.5 Provision of structured support and supervision

During the course of this study it became clear that the provision of an effective supervisory relationship was seen by new registrants to be essential in easing transition into the staff nurse role. Indeed the comments of the new registrants reflect the views of various authors (Allen, 1996, Wolfensperger-Bashford, 2002; West, 2007; Cowin and Duchsher, 2008) and researchers (Charnley, 1999; Chang & Hancock, 1998; O'Shea & Kelly 2007; Clark and Holmes, 2007) that during the period of transition between student and staff nurse roles new registrants benefit and are comforted by the provision of structured support and supervision. The new registrants in the current study clearly indicated the need for structured and accessible support irrespective of the time of day or night. This became explicit particularly in the neurosurgical unit regarding who should undertake the supervisory role, and the impact of ward geography on supervision on the Urology Ward.

Duchsher (2009) identifies that some of the difficulty in making the switch from partial to full responsibility is the pairing of new registrants with more experienced nurses to complete a designated workload and as a result the new registrant is unlikely to reach out to their senior counter parts whose work load is as great as their own and therefore negating a preceptor - based tacit knowledge transfer model. In a study of how professionals learn in practice, Cheetham and Chivers (2001) discovered that many interviewees reported that working with experienced professionals resulted in almost unconscious learning through a form of osmosis that happened without close observation of colleagues and without conscious effort. This phenomenon of learning by osmosis appears to be particularly effective in the acquisition of tacit knowledge or 'know how' that is not easily articulated, for instance, how to act as a professional (Eraut et al, 1997. Cheetham and Chivers, 2001). This situation appears to relate to Vigotsky's (1979) theoretical framework in which it is claimed that the mechanisms of higher mental functioning emit from internalization of social relationships. Vygotsky's ideas are nicely summarized by Forrester (1999):

> *Learning takes place in the zone of proximal development, defined as the distance between learners existing knowledge as determined through problem solving independently, and the level of potential development as determined through problem solving under adult assistance / guidance, or in collaboration with more experienced peers. It is this idea which underlies subsequent research, focusing on the strategies shown by a more competent dyad member and how these are eventually taken over by a less competent participant in order to regulate and monitor his or her own behaviour. (Forrester, 1999, p87)*

Forrester maintains that despite growing literature relating to the outcomes of learning through this dynamic; the processes implicit within this 'interactional zone' remain largely unknown. He goes on to claim that a unique way of understanding these processes may be to focus on how individuals notice something, display recognition of relevant information, provide justifiable evidence of on-going learning, and other associated practices for improving learning in context. Forrester continues by referring to Gibson's (1979) 'affordance' theory of perception and action by which it is argued that organism and environment are coupled together resulting in a resonance which affords or provides for some sets of actions and events that result in particular perceptions of the world. Recognition of these affordance structures are an immediate (non-cognitive) phenomenon inherently part and parcel of on-going dynamics of events and actions (Forrester, 1979). It appears to me that the notions put forward by Vygotsky and Gibson may have relevance to Lave and Wenger's (1991) concept of Peripheral Situational learning as these theories of learning are all context related.

The results of my study also suggest that this process may be related to Lave and Wenger's (1991) notion that learning is enhanced through being embraced within a community of practice instead of attempting to apply formally acquired principles and skills which operate independent of the social context. Further to this as the issues of appropriate and accessible support were addressed participants in my study indicated that they were less stressed as they knew where to go for support and in most cases saw their supervisor as a role model. This appeared most notably in the Urology Ward following reorganisation of work allocation that resulted in new registrants working in tandem with senior partners across a larger clinical area, rather than dividing up the workload geographically.

During the course of this study it also emerged that if supervisors are capable of providing appropriate support and direction the grade of the supervisor is less important to the junior nurse. The new registrants felt it was important for the supervisor to be available and approachable when support/advice was needed, but also found comfort when the entire nursing team was viewed as being generally supportive. As a number of the new registrants were employed prior to the initiation of STEP 1 it was possible to compare views regarding the support offered to them before and after implementation. The general view was that prior to implementation supervision was often ad hoc and unstructured with little time together. Time to sit and work through STEP 1 together remained problematic at times, but once participants recognise the role of the supervisor in observing and verifying the new registrants self-assessment and agreeing a development plan this became less of an issue. Whilst it was anticipated that Band 6 nurses should undertake this role due to their

experience and expertise, the new registrants stressed the need to work with a supervisor frequently in order to establish a working relationship.

The essential characteristics of supervisory relationships that have been identified as teaching, counseling, confirmation, accepting, friendship, protection, coaching and sponsorship (Snelson et.al 2002, Hurst& Koplin-Baucum 2003, Bally, 2007), promote safe and competent practice through influencing the form, quality and outcome of the career path of both nurses (Greene and Puetzer, 2002). The interactive nature of these essential characteristics leads one to conclude that for the supervisor / supervisee relationship to be positive and productive it is necessary for the nurses occupying these roles to get to know each other (Baltimore, 2004 Fawcett, 2002) Fawcett, (2002) stresses that getting to know 'orientees' allows them to succeed and Baltimore (2004) emphasises the value of exchanging information regarding personal and professional backgrounds, teaching-learning and communication styles. Goleman (2006) would term such supervisory behaviour as affiliative leadership, which is concerned with:

> *promoting harmony and fostering friendly interactions nurturing personal relationships that expand the connective tissue with the people they lead.* (Goleman, 2006, p 64)

The importance of this relationship appears to lay in the recognition that the one of the strongest indicators of satisfaction is the percentage of time a person feels positive emotions at work. (Fisher, 2000. Goleman et.al, 2006). Emotions are recognised as sources of information to make sense of and navigate the social environment (Salovey and Grewal, 2005) through verbal and non-verbal assessment and expression of emotions, control of emotions and the use of emotions in solving problems (Mayer and Salovey 1993).

7.6 Emotional Intelligence – implications for practice

The development of successful relationships has been linked to 'emotional intelligence' (Salovey and Mayer, 1990. Goleman; 1996, 2002; Salovey and Grewal, 2005) and has been defined by Goleman(1998) as:

> *The capacity for recognising our own feelings and those of others, for motivating ourselves, and managing our emotions and those of others* (Goleman, 1998, p317)

This requires self-awareness, well-developed social skills and adeptness in motivating and regulating oneself and others.(Freshman and Rubino, 2002). It is claimed that emotional intelligence positively influences performance through harnessing emotions to facilitate cognitive abilities, (Salovey and Meyer 1990. Goleman, 1995, 2002. Lam and Kirby, 2002) and this has an effect on forming satisfying relationships and success at work (Salovey and Grewal (2005). Further to this it

has been postulated that the possession of high emotional intelligence increased the individuals ability to pay attention to use, understand and manage emotions, and these skills serve adaptive functions that potentially benefit themselves and others."(Mayer, Salovey and Caruso, 2004).

This is relevant to the results of my study and it has heightened my awareness regarding the relevance of emotional intelligence to the selection and preparation of nurses who are charged with supervising / preceptoring new registrants or with mentoring pre-registration nursing students. The findings of my study in relation to the management of new registrants in what can be both physically and emotionally demanding work emphasises the importance of senior nurses recognising signs of stress in new registrants and helping them to cope with feelings of inadequacy and guilt. Supervisors need to appreciate the need for developing and utilising their E I capabilities to enhance the supervisory relationship but also the need to foster these capabilities in new registrants as they are relevant to provision of patient centred care and multidisciplinary teamwork. To Mayer and Salovey (1993) emotional intelligence can be described as involving verbal and non-verbal assessment and expression of emotions, control of emotions and the use of emotions in solving problems. This applies to nursing work, as sensitivity to the patient's emotions during assessment and identification of need followed by interpretation of emotional expression and appropriate responses using professional skills such as communication skills, empathy and counseling skills can result in modification of emotional states and anxiety reduction (McQueen, 2004).

McQueen (2004) professes that there is relationship between emotional intelligence and emotional labour and cites Hocschchild's (1983) definition of the latter as

> *"induction or suppression of feeling to sustain the outer appearance that results in others feeling cared for in a safe place."* (Hocshschild 1983 cited in McQueen, 2004 p103)

Nowadays it is generally considered acceptable for nurses to show their emotions and demonstrate their humanity by empathising with patients. But they also need to manage their own emotions if they are to be successful in offering help and support. However, this emotional labour is not without personal costs. Monitoring of the emotions of others in addition to one's own emotions, to ensure that verbal and non – verbal actions and responses are appropriate' can lead to the nurse feeling emotionally drained or exhausted.

The comments of new registrants in this study lead me to believe that consideration should be given to including the management of emotions in pre-registration curricula in the interest of patient care and the potential for reducing the stress invoked through emotional work.

7.7 Preparation for transition

My action research did however illuminate the fact that support for registrants is often poorly managed because of failure to develop the supervisor / supervisee relationship. Due to the demands placed upon nurses occupying a coordinating role, or because senior nurses preferred a work division model new registrants were expected to manage a workload comparable to experienced staff rather than developing a working partnership that would support a tacit knowledge transfer model of preceptor management. Through the action research process, the need to address issues relating to the organisation of support for new registrants through satisfactory supervisory relationships became evident to senior nurses, and their subsequent actions assisted in easing the role socialisation process.

The element of surprise is an important contributing factor in the experience of transition shock and inclusion of theory relating to transition in pre-registration preparation (Duchsher, 2009) or post-registration transition programmes may assist new registrants to make necessary adjustments. It appears that experienced staff may also benefit from theoretical input relating to transition as an understanding of the factors affecting new registrants may produce proactive planning, promote empathetic relationships and enable targeted support during transition. Whilst literature advising on personal management of role change is helpful, reports of inclusion of formal transition theory in the content, structure or process of programmes is not apparent in existing UK literature, despite increased developments in Australia and North America (Evans, J. 2005, Chang. E, Daly, J. 2008. Cowin, L. Duchser J. 2008. Duchsher, J. 2009). Duchsher (2009) contends that 'Transition Theory ' suggests that

> educational institutions and industry employers should focus on providing preparatory theory about role transition for senior nursing students, facilitating educational clinical placements that more appropriately prepare graduates for the dynamic, highly intense and conflict-laden context of professional practice …
> Duchsher, 2008, p9

It has been postulated that structured support programmes allow new registrants to ease into their new role through a gradual introduction to the responsibility and workload (Cowin and Duchsher, 2008) and an Australian study (Evans, 2005) concluded that participation resulted in new registrants feeling accepted and valued, and less likely to leave employment. Transition programmes were viewed to give time to allow individuals to adapt to the full role responsibilities of the Registered Nurse role from the protected student position. The role of preceptor, when implemented in the

intended manner, was also considered a strength. However, Evans (2005) also identifies that universities need to explore ways to provide students with opportunities to take more responsibility for patient care and gain a realistic understanding of the registered nurse role. Greater communication between the education and healthcare providers was also encouraged regarding their perceptions of undergraduate courses. Contrary to Evan's findings following a review of transition programmes in Australia, Levitt-Jones and Fitzgerald (2004) conclude:

> …*there is enough doubt in the efficacy of formal transition programmes to at least investigate potential alternatives such as concentration on the development of a supportive practice culture conducive to learning*
>
> *Levitt – Jones, T. Fitzgerald, M. 2005, p 45*

UK researchers have depicted the challenges facing new registrants (Gerrish, 1990, 2000. Charnley, 1999, Ross and Clifford, 2002) and proposed strategies to address them. However it appears that introduction of structured transition programmes in the UK incorporating transition theory would be innovative. Ross and Clifford (2002) promote the need for careful planning to meet individual transition needs in the final pre-registration year and the need to address inconsistencies in preceptorship arrangements for new registrants. They suggest that discussion should be held between service and university regarding final placement in terms of specific learning outcomes; ability to request preferred final placement, and mentor support on final placement. They do however stop short of advocating structured support in the form of transitional programmes or inclusion of transition theory in pre or post registration programmes.

My research and experience of implementation leads me to contend that a transitional support programme created in partnership between educators and healthcare providers may be more likely to support seamless transition into professional practice, negating some of the problems experienced following registration. Such programmes could draw on the particular expertise and experiences of academic and clinical nurses to address practice standards and preceptorship arrangements through approaches such as STEP 1, whilst addressing the advice of Duchsher (2009) that transition programmes might include*:*

- *Contextually based learning scenarios related to the stages of transition and practitioners experiences of 'transition shock'*
- *Intergenerational and inter/intraprofessional communication (e.g. work ethic and style differences as well as role distinctions)*

- *Workload delegation(e.g. delegating to older and more experienced staff and prioritizing competing demands of a full workload)*
- *Lifestyle adjustment(e.g. adjustment to working alternating shifts)*
- *Change and conflict management (e.g. dealing with loss and change and navigating evolving relationships with family, friends and colleagues.*
  (Duchsher, J, 2009, p8)

This content could be delivered in partnership using a variety of methods which could include theoretical sessions, learning sets,preceptorship, clinical supervision, e-learning, simulation, graduated increase of workload, reflective practice and portfolio development. There is also the potential for developing greater understanding of interprofessional working through short placements (for example shadowing in key departments such as pharmacy /dietetics / catering and medical records). I would envisage such programmes being initiated within the university setting with academic input supplemented from experienced practitioners and continued with contributions by academic and clinical staff in the hospital or community practice setting.

7.8 Critical reflection on the strengths and weaknesses of the study utilising Hart and Bonds Action Research Typology

In chapter 4 I detailed my rationale for adopting an action research approach to further develop STEP 1 and in doing so I outlined the Hart and Bond's Typology of Action Research. As I became more conversant with Hart and Bond's typology it appeared to me that viewing my project within this multidimensional framework would encourage acknowledgement of the setting and political context in which the project was conducted.This project was aimed at developing and refining the STEPs programme across a variety of clinical settings with input required from a large number of participants including staff nurses, clinical managers, trade union/professional organisation representatives and senior managers. It therefore seemed to me that ongoing review using this multidimensional framework would assist me to clearly depict the reality of the setting including the impact of various individuals and groups on the trajectory of the evolving project. I also believed that these considerations and reflection of the political context of the project would assist me to reflect on and articulate my philosophical values as they relate to the development and implementations of STEPs.

As stated in chapter 4, Hart and Bond (1995) describe four types of action research that are organised around two alternative models of society, ranging between a consensus, rational social management model and a conflict/structural change model. During the course of a project, action

research could shift along this continuum, for example from being outcome led to process led and from being focused on research to being focused towards action. The position of a project along this continuum may reflect the stance taken by the action researcher, however, as in the case of this study, shifts may occur in response to the context in which the study took place and as part of the political nature of action research (Hart and Bond, 1995). Hart and Bond's (1995) action research typology (see appendix 4) proved to be a useful tool for clarifying the processes used for implementing and refining STEP 1. Reflection on my findings using Hart and Bond's criteria assisted in identifying which of the four action research types, and how the related values attributed to each, dominated at various stages of the study. The typology also provides a useful framework for carrying out a personal critique of my decisions and actions whilst undertaking this project, thereby eliciting a number of strengths and weaknesses in my approach.

7.9 Educative base, research relationships and degrees of collaboration

At first glance the action research type illuminated in this study appeared to be professionalising because STEP 1 elements were identified by nurses, and used in the development of nurses. But on closer scrutiny the project resembled a mixed experimental / organisational/ type. The research problem and change intervention were identified by the researcher and expanded upon by senior colleagues (experimental). In addition, the elements detailing expected outcomes for STEP 1 were derived through an iterative process with a selected group of senior staff (organisational) to arrive at a consensus on how new registrants could demonstrate capability (experimental). The need for this approach arose out of a perception by these senior nurses that new registrants needed help to transfer theoretical knowledge into the practice within very busy clinical environments (organisational).

As the outcomes were designed without cognisance to the needs of new registrants, as they might see them, the change intervention process was initially top down, and the educative base could be viewed as enhancing managerial control as changes in behaviour of junior staff would result in movement toward the consensus arrived at by the senior group. The project was aimed at assisting new registrants to identify and meet their learning needs, but it could be argued that at the outset this was subordinated to the desire of senior staff to promote their consensus view of what is important.

The role of the researcher and participants were clearly differentiated and whilst senior nurses may be viewed as co – researchers there is a risk that the involvement of new registrants may be seen to be an instrumental technique rather than central to an underlying collaborative philosophy. Indeed

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Hart and Bond (1995) stress that one of the challenges for the action researcher, particularly when working within a dominant organisational type, is how to involve a range of groups with different degrees of formal and informal power within an organisation as participants in the process. It is not possible to mandate in advance that the action research process will be fully participatory as the level of participation is influenced by the character of the problem, the conditions under study, and the intent and capability of the researcher (Greenwood,et al. 1993). Greenwood stresses that

> *To view participation as something that can be imposed is both naïve and morally suspect(*Greenwood et al. 1993 p175)

To overcome this dilemma new registrants were invited to join in the project and the elements were provided for them to use and evaluate. In this regard new registrants became co – researchers and as was illustrated in chapter 6, new registrants identified that the components of STEP1 assisted them to clarify their learning and development needs with a focus on assisting integration of knowledge acquired during pre-registration education into clinical practice. New registrants viewed their development to be important in improving patient care and advocacy and the educative base characterised the professionalising type, but at times exhibited values representative of the empowering type.

7.10 Individuals in groups

This dimension relates to group interactions and factors that impact on these (Lyon, 1998). The action research approach and methods adopted for this project were decided by me (experimental). However, new registrants had complete autonomy in regard to participation or non-participation in the research without compromising their engagement in STEP1 (empowering).

The individuals in groups aspect of the typology caused me to review my own interactions with participants in the research and this influenced my resultant actions. Acting in a reflexive manner required me to become what Hunter (1993) termed as an 'interface manager. That is someone who occupies a position at the interface of a number of interconnected individuals, groups or organisations. Writing on the function of such 'interface managers' Hart and Bond (1995) state:

> *Such individuals need to establish networks on the basis of shared interests rather than organisational hierarchy…and with individuals at different levels in an organisation or community* (Hart and Bond, 1995. p52)

It occurs to me that the action research approach to this study had led me into a more reflexive investigative style whereby revelations by research participants influenced the actions I took and this led to potentially different outcomes than if I had not allowed myself to diverge from my original

approach. This is exemplified by the comparison between my interactions with the neuro-surgical group and the approach I took on the Urology Unit. At the outset new registrants and their supervisors, on both clinical areas, occupied follower and leader roles respectively but as the study progressed the new registrants in each area exerted their influence over organisation of supervision and ward management. I had been concerned that my position in the organisation may be an obstacle to gaining a true picture of how implementation was going but It became clear to me that through my discussion with the neurosurgical nurses focus group I had in fact become a voice for the new registrants by raising their concern regarding their relationship with and access to Band 6 supervisory nurses. This led to renegotiation of team boundaries resulting in the inclusion of experienced Band 5 nurses as supervisors for new registrants. I had inadvertently facilitated movement from the organisational type to the professionalising type, as the revised arrangements were perceived to improve access to advise and support by more experienced nurses. Despite the positive outcome I did come to realise that my challenges had the potential for inciting conflict between the new registrants and their supervisors. Similarly my interaction with the urology team promoted discussion that resulted in junior nurses being empowered to influence change in the organisation of nursing teams and initial induction on the unit.

Due to my concern regarding the potential for conflict in the Neurosurgical unit due to my intervention, I handled the disclosures of the Urological staff differently. I ensured they had the opportunity to raise their concerns with their Matron. My discussions with the new registrants revealed inconsistencies of opportunities to work with their supervisors due to a lack of a standardised approach to induction. They had also felt isolated due to the ward layout and patient allocation by night staff rather than the nurse in charge on the day shift. These nurses, unlike their neurosurgical counterparts felt empowered to directly address their concerns with the Matron, and their subsequent involvement in revising the induction programme, allocation of patients and accessing help and support within the clinical care. My approach to assisting urological nurses to make transparent the management of their identified concerns was influenced by my experiences with the neurosurgical nursing group. As a result of acting in a reflexive manner the action research with the urology group moved towards the empowering type. It also became clear to me that there was a significant shift in the problem focus of the action research.

7.11 Problem Focus

Hart and Bond (1995) emphasise that one of the distinguishing features of action research is the solving of problems in an immediate situation and within a particular setting with the intention of creating a future state in which the 'real' comes closer to the 'ideal' and policy emerges from the gap

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between the ideal and the actual However, they defer to Cunningham (1993) for clarification of the word problem in relation to action research:

> *a problem is a definition of a need for change and describes how certain issues can be addressed.* (Cunningham, 1993 p 75)

The decision on the type of action research undertaken is normally determined by whoever identifies the problem (Lyon, 1998). In this study the problem was the further development and the implementation of STEP 1 (experimental /organisational). However, whilst the initial problem was not negated, as issues including access to appropriate supervision, induction and ward layout emerged the focus moved towards the professionalising / empowering end of the spectrum as it necessitated new registrants to recognise the structural and organisational obstacles to their development, illuminate their views to senior colleagues and engage in determining a future that more closely resembled the ideal state as they perceived it to be.

It is in this aspect of the typology that I feel my lack of experience in action research is most apparent. I believe I acted in a reflexive manner to enable professionalising / empowering activities that were not directly related to the structure, content or implementation of STEP1 following emergence of issues that were that were important to the new registrants. However, in hindsight the problem focus may have been different if initially I had explicitly sought the views of nurses who had been registered for between one and two years as to what they now perceived as developmental needs of nurses during the transition period. Reflection on the statements of new registrants leads me to surmise that if the problem focus had been derived in this way it may have been defined as identifying and providing appropriate support and development during the transitional period. Identification of a different problem focus in the first instance may have resulted in a very different programme for new registrants. However, due to the publication of the NHS KSF, discussions with senior nurses resulted in identification of the performance criteria that collectively incorporated content that required demonstration of behaviours reflective of the levels and indicators identified in the Band 5 role outline.

7.12 Change Intervention, improvement and involvement and cyclic changes

It has been said that action research:

> *..is about taking action in the real world and a close examination of the effects of the action taken, thus it always involves intervention.* (Lathlean, 1994, p 45)

Further to this it has been said that how a change is implemented determines the action research approach (Lyon, 1999). However, it appears to me that the converse is also true as researchers with more experience than Lyon or I may well choose action based upon the objective of the project. That is to say a researcher seeking to empower an individual or group may knowingly employ different methods than if the objective was an organisational or professionalising one. In addition my experience of conducting this study has led me to recognise that whilst an intervention may be identified at the outset of the action research project additional interventions may be employed due to the context of the situation or possibly more importantly to the changing problem focus. As discussed earlier the issues of appropriate supervision in neurosurgery and the design of induction in urology actions that were not necessarily seen as directly related to STEP1. Nevertheless they did in fact empower staff to bring about change that was essential to the implementation and examination of the impact of STEP1. Consequently the impact of these interventions also required exploration. Interventions in the experimental type of intervention are more discrete than in the empowering type, which may include the building of alliances, opening up lines of communication and reframing issues. Hart and Bond (1995) suggest that:

> *It may be that the intervention is about changing the ways in which problems are discussed, which has the effect of initiating other changes. The first may not be the sole, direct cause of the second, although it may be a contributory factor.* (Hart and Bond 1995, p63)

In addition the criteria of 'improvement and involvement' and 'cyclic changes' are demonstrated in that through my reflections on the interview data as it emerged I acted in ways that enabled new registrants to influence change in their work areas. These changes resulted in reports of improved experience and experiential learning and therefore resembled characteristics of the professionalising type.

7.13 Summary of Chapter 7

Chapter 7 has not only afforded me the opportunity to reflect on the study data but it also opened up rich sources of literature that were particularly beneficial in the development of my understanding of the initial experiences of new registrants. In particular this has heightened my understanding of influencing factors that may positively or negatively affect their learning and socialisation in the immediate post registration period. In additionutilisation of Hart and Bond's 'Action Research Typology assisted me to reflect on this work and identify its strengths and weaknesses. This approach also required me to explore my role and its impact on the outcome of the action research and thereby enhanced my capacity for reflexivity. This in turn had implications for planning a campaign to enthuse staff to implement STEP 1.

CHAPTER 8 - ROLLOUT AND FURTHER DEVELOPMENT OF STEP 1 (Cycle 7)

8.1 Introduction to chapter 8 – Values and beliefs underpinning the rollout and further development of STEPS

In chapter 8 I detail the planning and conduct of this campaign and outline further developments that have occurred since conclusion of the action research.

As the implementation and action research in the pilot areas was drawing to a close in June 2006, the findings to date were presented to the STEPs Steering Group. The group was updated on the action research process, the initial findings and briefed on the structure of STEP1. In light of the generally positive response, which was exemplified by requests for more information from areas that were not involved in the action research, and a desire to capture the momentum for change the decision was made to initiate implementation of STEP 1 throughout the Trust.

My personal philosophy regarding the spreading of STEP1 was built upon a recognition of the need to engage staff in actively embracing the implementation of STEP1 and is synonymous with Bevan's (2009) view that:

> …connecting with peoples' core values and motivations to affect change can
> deliver improvement at previously unseen depths (Bevan etal, 2009, p4)

It follows that achieving results in an environment that is increasingly complex and uncertain necessitates commitment building, particularly where traditional management levers such as hierarchy and structure are diminishing (Bevan 2010). A product of the action research project was a recognition that a deeply held, and often voiced belief was that successful preceptorship of new registrants has a positive impact on the standard of care delivery, resulting in safe care and a positive experience for patients. However it seemed that planning to implement STEPs through traditional 'top down' approaches ' may not tap into this passion or gain the widespread 'buy in' and momentum that would be needed for rapid implementation. In essence it was necessary to organise a movement or campaign that would result in STEPs having significant impact across the organisation. Bibby et al (2009) state:

> …the approach to organisation in movements comes from a very different perspective
> to traditional approaches. Nonetheless movements have to be organised; it is this
> organisation that, firstly translates energy and passion into purposeful effective action,

and secondly, enables the movement to stay in existence through necessary coordination and resourcing.(Bibby etal, 2009, p101)

8.2 The STEP 1 Implementation Model

I realised that transforming this belief into action would need leadership input by individuals who were willing and able to engage with staff at all levels in order to gain the commitment required to successfully implement STEP1.

Bibby et al (2009) advocate that organising for impact requires a leadership approach that does not rest with one individual but is tiered through a series of individuals or groups. This approach is termed distributed or collective leadership (Gregory, 1996. Denis, Lamothe and Langley, 2001, Huffington, James & Armstrong, 2003 Bibby etal, 2009)). The model identified by the STEPs development team and adopted for implementation of STEP1 comprised of a core implementation team, an extended core team and local champions or 'bridge builders'. The steering group continued to maintain oversight of the entire STEPs development and required periodic reports on the progress of the implementation process. See figure 8 for an overview of this model.

Figure 8 - STEP 1 Implementation Model
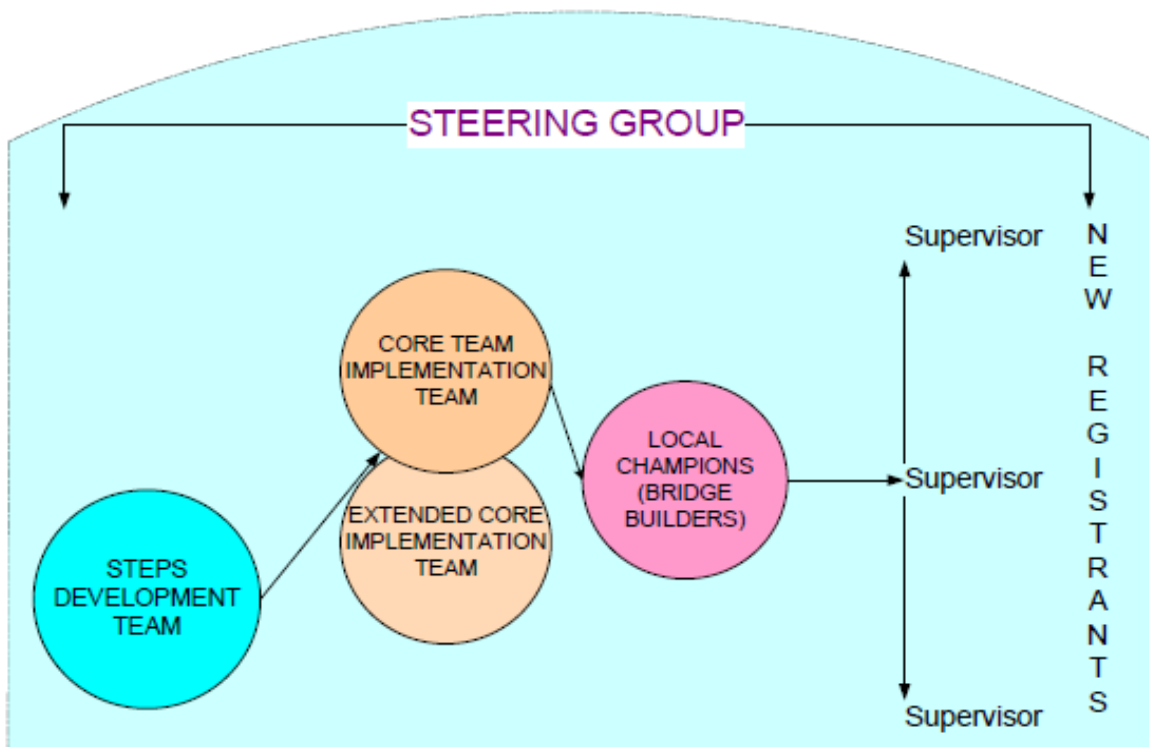
8.3 STEP1 Core Implementation Team

Nurse Managers assisted in recruiting appropriately experienced, skilled and enthusiastic volunteers to join the core implementation group, The substantive roles of group members are identified in Box 7 The names of individuals have been erased to preserve confidentiality.

Box 7 – STEP 1 Core Implementation Team Membership

Name	Role	Representing
	Education and Development Co-ordinator	Cancer and Diagnostics
	Practice Development Nurse	Women's services
	Teacher Practitioner	Paediatrics
	Practice Development Nurse	Surgery 1 & 2
	Assistant Director of Nursing	Nursing Directorate
	Clinical Skills Co-ordinator	Nursing Directorate
	Teacher Practitioner	Critical Care
	Nurse Manager	Medicine
	Charge Nurse	Medicine
	Training Advisor	Theatres

Recruitment of this core group of enthusiasts was important for several reasons. Coming from diverse backgrounds they brought a wealth of clinical experience, various experiences of change management and deep understanding of the environments in which they would be influencing change. They also held shared values regarding engagement and empowerment of clinical teams. Furthermore, the homiphilly principle, the notion that most human communication will occur between a source and a receiver who have a common frame of reference, is important when trying to build critical mass for change. Attempts to depart from the homiphily principal will often result in ineffective communication due to mistakes in meaning, caused, not only due to lack of common ground, but differences in technical competence, social status, beliefs and language (Bibby etal 2010). Despite their relatively senior positions these individuals were closer to staff on a daily basis than me and were able to engage in peer-to-peer communication with potential supporters and champions of the programme in the clinical areas.

In essence, the roles of the core implementation team, collectively was to act as 'bridge builders', raising awareness of STEPs at grass roots level across the organization and foster commitment and initiate the building of a community of practice. Individually, they would orchestrate, facilitate and enable action within their respective business units (Bibby etal, 2010) and identify champions in each clinical area who would drive implementation within individual clinical areas.

8.4 Extended Implementation Team

In addition to the core team, implementation was aided by input from the Trust's Knowledge Management, Web Services and Education and Development Teams.

The Knowledge Management Team were instrumental in the loading of STEP1 onto the computer based Managed Learning Environment thereby enabling easier access to STEP1, both within the Trust and from remote locations. Additionally, periodic electronic updating of content removed the need to recall and replace hard copies or compact discs. It also enabled hyper-linking to a wide range of e-learning materials to aid further learning. This team developed secure electronic registration and user guides for accessing STEPs online thereby protecting the integrity of the programme.

The Web Services Team contributed to the implementation of STEPs through the development of 'STEPs' website on the Trust intranet. This provided a vehicle for communicating a wide range of information about STEPs including the way in which it had been developed, key messages from the action research, and contact details of members of the STEPs development team and the core implementation team.

8.5 Implementation Activities

The implementation group met initially on June 22nd, 2006 and monthly thereafter until Spring 2008 when the implementation group was integrated into the existing Nursing and Midwifery Education Forum, as by this time implementation was viewed as core activity instead of a project. In the first instance the Implementation Group identified the terms of reference represented in Box 8.

Box 8 - Implementation Group Terms of Reference

The Systematic Training and Education for Practice Implementation Group will:

1. Devise a plan and proposed timetable for implementing the STEP 1 of the Systematic Training and Education for Practice framework in the Nursing and Midwifery professions across the Trust.

2. Gain approval of the identified implementation plan by the Executive Director of Nursing

3. Lead the implementation of STEP 1 in each division

4. Agree responsibilities and process for developing the core and specific elements of STEP 2

5. Agree a communication strategy for disseminating information regarding the rollout of STEP 1 and the development of Step 2 within each division.
6. Collaborate with the Knowledge Management Manager (ERMEC) facilitate access to STEPs on the Managed Learning Environment.

7. Provide quarterly progress reports to the Executive Director of Nursing, Nursing Executive and the STEPs Steering Group

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This group decided that STEP 1 should be implemented simultaneously as a high profile had resulted due to on-going communication during the action research stage of STEP1 development. This had resulted in an espoused will at senior clinical levels to embrace a standardised approach to supporting and developing new registrants. Due to the perceived size and complexity of this exercise the task group recognised the need to identify action plans for rolling out STEP 1. Key actions were identified and an implementation action plan was developed (see Appendix 16).

Over a four week period the implementation leads met with groups of staff in their divisions to discuss the approach to implementing STEPs and invited staff tonominate themselves as ward champions who would take the lead in identifying and developing staff who would act as STEPs supervisors. Self-nominated champions would provide a point of contact for the division's

implementation lead. They would also identify suitable staff to assume the role of supervisors, and enrol new registrants onto the STEPs programme.

Meetings to explain the purpose and content of STEPs to new registrants were also arranged by the divisional implementation leads. Verbal information to clinical teams was reinforced through the distribution of an information booklet that was developed by a member of the implementation team (see appendix 17).The core group also devised a standardised 'Activity Information Log' in which to record strategy related activities conducted in each division. Access to these logs enabled the core group to communicate Trust wide progress to all staff. The planned date for the first new registrants to commence STEP 1 was September 30th, 2006.

8.6 Rapid Spread Methodology

By the methods outlined above STEP1 implementation was initiated throughout the Trust within a three month period. The approach used to roll out STEP1 across the Trust displays similarities to the Rapid Spread Method (Stevens, 2010) which was promoted by the Department of Health for introducing clinical care bundles, despite pre-empting its creation by several years. Whilst the Rapid Spread action model has been tested in two Trusts it has not yet been fully researched. Despite this Janice Stevens maintains that it:

> …gives clinicians a step by step tool for implementing evidence –based practice across an entire organisation quickly, no single ward or small scale pilots , no chance for silos to develop while momentum fizzles out elsewhere…….we found that people can do things fast if there is a will. (Stevens, 2010, p1)

On reflection it is recognised that the principles underlying 'Rapid Spread' are synonymous with those underpinning the rollout of STEP1 as identified by Stevens (2010) as a triumvirate of *belief, behaviour, be sure*. (Steven 2010,p2). She emphasises that kick starting large scale change requires the will to change. To find this will you need to promote the belief in staff to believe that change is possible and that they can personally make a difference.

This belief will enable behaviour change, but in addition to belief and the will to change behaviour it is necessary to ensure that policies, procedures and things you want to happen occur consistently. Bevan (2010) reinforces this message:

> One of our greatest leadership priorities looking forward is to build a quality and productivity strategy that is based on commitment to change rather than compliance with change… By connecting to our deeper purpose and collaborating around our collective mission, we increase the chances of unleashing the energy

and creativity of our workforce and making more profound, wide ranging changes more quickly and more sustainably. (Bevan, 2010, p5)

Stevens describe the Rapid Spread approach as a six week preparation period. This stage is aimed at creating the case for change, setting up the implementation team, setting up data capture mechanisms, gaining executive support and ensuring staff are have knowledge relevant to the change .This is followed by the 30 days 'doing it. A workbook is provided for each stage identifying actions to be taken and by whom and each action is ticked off when they are achieved.

Whilst implementation STEP1 did not result in the use of single care bundles within a specified time, it did result in the rapid introduction of an organisation-wide mechanism for supporting and developing new registrants. This was achieved through carefully preparing clinical areas for change by creating an implementation team that owned an action plan and were able to communicate this to the clinical areas with which they had an established working relationship.

8.7 Evaluation of STEPs Implementation

One year after its introduction as the preceptorship programme for nursing across the Trust, an evaluation was carried out to determine whether STEP1 met the needs for all participating staff and if improvements could be made either to the content or implementation process. Questions in the survey were elicited from comments made and issues raised during the action research project. These related to the role of STEPs in aiding role transition; explanation of STEPs prior to implementation; the appropriateness of STEP1 content and expected level of performance and level of support provided to supervisees. Sisters and Matrons who had participated in the action research project reviewed these questions. This feedback reinforced the need to ask questions specifically enquiring if STEP1 assists preceptors to support new registrants, and whether STEP 1 provides Sisters / Charge Nurses with assurance that the required standards of care were understood by new registrants.

Nurse Managers distributed evaluation forms to the Sisters / Charge Nurses in which new registrants were undertaking STEP1. Boxes 9 & 10 display the questions Sisters/Charge Nurses and new registrants were asked and the distribution of responses as actual numbers. A total of 16 Sisters / Charge Nurses and 62 new registrants returned completed questionnaires.

Box 9 - Sister / Charge Nurse Responses

Sister /Charge Nurse Responses	Agree
The STEP 1 assists the transition from student to registered nurse	15 out of 16
The content of STEP 1 is appropriate to the needs of new registrants	15 out of 16
The level of performance required is appropriate	14 out of 16
Mapping of STEP 1 against the Band 5 role outline has improved understanding of the KSF	14 out of 16
Completion of STEP 1 assures me that new staff are aware the standards of care they are expected to provide	13 out of 16

Box 10 - New Registrant Responses

New Registrant responses	Agree
The purpose of STEP 1 was clearly explained	35 out of 59
STEP 1 assists the transition from student to Registered Nurse	47out of 62
The content of STEP 1 is appropriate to the needs of new registrants	48 out of 61
The level of performance required is appropriate	53 out of 62
STEP 1 helped me identify and address gaps in my skills and knowledge	48 out of 60

I have been adequately supported in my use of STEP 1	33 out of 59
The documentation overview has been helpful.	35 out of 62
The documentation of competency has been helpful.	30 out of 38
The KSF Mapping has been helpful.	28 out of 37
The Self-Assessment documentation has been Helpful	25 out of 38
The Mandatory Training Record documentation has been helpful.	44 out of 49

As the numbers participating in this survey were small statistical analysis was not applied however the responses do demonstrate trends.

The majority of respondents in both groups were in general agreement that STEP1 aided transition into the registered nurse role and that the required level of performance was appropriate to new registrants. The majority of new registrants felt that the documentation of competency was helpful and most Sister / Charge Nurse respondents thought that STEP 1 increased awareness of the expected standards of care. Further to this a number of Sisters / Charge Nurses reflected the views of Matrons, interviewed during the action research project, that STEP 1 was also of benefit to more experienced staff. Comments by respondents included

> *I did find Steps very useful for new starters, but it also sets the minimum standard for existing staff and have used it to ensure all staff are up to date, especially with the Drug Policy*

> and

> *It makes it easier to preceptor as you have a framework to work against. It makes tackling poor practice simpler and less subjective*

Whilst the survey indicated that the Trust-wide rollout of STEP1 was generally received positively by most Sisters/Charge Nurses and new registrants some results required closer consideration of the implementation process.

Fortyeight new registrants stated that STEP 1 helped them to identify and address gaps in their skills and knowledge. However, it should not be overlooked that twelve new registrants did not think Step 1 helped them to identify and address gaps in their knowledge and skills. This equates to a

quarter of the total responses to this question, but there may be several explanations for this. In hindsight this question may not have been constructed satisfactorily as some new registrants may have felt that the programme aided them in identifying gaps in their skills and knowledge but did not assist them to address these issues, and therefore gave a negative response. Greater clarity regarding new registrants' views relating to identifying and addressing gaps in skills and knowledge may have been gained if these two issues had been addressed as separate questions.Another explanation may be that whilst STEP 1 was developed to ensure that knowledge and skills regarding the fundamentals of care were embedded in practice, some new registrants may have expected that immediately following their employment greater emphasis would have been given to assisting them to develop skills and knowledge pertaining to the speciality in which they were working. This explanation may also be the reason that thirteen out of sixty one new registrants disagreed that the content of STEP 1 was appropriate, whereas Sisters/Charge Nurses almost unanimously believed that the content of STEP 1 was appropriate.

It is also worth noting that the levels of negative new registrant responses in regarding receipt of a clear explanation of the purpose and the adequacy of support in the use of STEP1 could indicate a divergence of expectations of new registrants and senior nurses. When asked regarding the level of explanation and support in the use of STEP 1 the number of negative responses by new registrants would appear to indicate that some clinical areas prepared supervisors and supervisees well but others did not structure the introduction of STEP 1 in a satisfactory manner. Lack of explanation and supportin some clinical areas may also be the reason for a perception by thirteen of thirty eight respondents that the self assessment document was not helpful. Furthermore, feedback from both groups of respondents indicated that the identification, preparation and information for supervisors required to be revisited.

This overall situation was unlike that recorded at the end of the action research project where the high level of satisfaction regarding the purpose of STEP 1 was probably a result of the time taken to explain the purpose of the action research. In addition the action research provided opportunities for new registrants to input into the modification of the content in STEP 1 and influence the implementation process in their clinical area. These factors probably increased their sense of ownership. It could be concluded that some areas included in the organisational roll out would have benefited frommore detailed explanation, and discussion with both new registrants and other team members regarding the purpose of STEP 1

In order to address these issues I decided to integrate the STEP 1 Implementation group into the Nursing and Midwifery Education Forum, which is comprised of all Trust Teacher/Practitioners; representation from the Trust Education and Development Department and the Faculty of Health and Social Care at the local University. The latter group met bimonthly to share information on local developments and educational initiatives. The purpose of this integration was to promote discussion on how to improve the introduction of STEP 1 and subsequent support for new registrants by those individuals best placed to facilitate change. This discussion resulted in Teacher / Practitioners accepting responsibility for developing supervisors and supporting implementation of STEPs within their clinical areas. They also now ensure that at the outset new registrants understand the STEPs framework and the need to assess their ability to integrate theory and practice. Progress on implementation of STEP1 and development of STEP 2 are now standing agenda items at these meetings. In addition, a STEPs website has been developed on the Trust intranet in order to provide easy access by all staff to current information regarding STEPs

8.8 STEP 2 Development

As identified initially in chapter 1, and detailed in chapter five, a further stage of development, known as STEP2 was identified for development to assist staff to develop knowledge and skills beyond those demonstrated during their progression through STEP1. A number of elements would be core to all clinical areas, however this stage gave clinical teams the freedom to identify and develop additional STEPs elements particular to their area of practice. Whilst being initiated during the implementation of STEP 1, it is during STEP 2 development that distributed leadership flourished.

To initiate the development of STEP 2 a debate regarding the purpose and content of STEP 2 was opened with members of the Nursing and Midwifery Education Forum. It emerged that some wards / departments had already developed teaching packages for aspects of care relevant to the speciality. However many areas had not developed such packages and until then there had not been a mechanism for ensuring the quality of the existing teaching packages. In addition, how evidence from these teaching packages could be captured and used to demonstrate progress against an individual's role outline was unclear, as they had not been mapped against the NHS KSF dimensions.

A second outcome of consultation with the Nursing and Midwifery Education Forum was the identification of additional aspects of care that would be considered as core elements but were seen to assist the registrant to advance their knowledge and expertise beyond the content of STEP 1.

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8.9 Academic recognition of personal and professional development achieved through completion of STEP1

As identified in chapter 6, new registrants revealed that they felt the ability to accrue academic credit related to STEP1 would be beneficial to future academic development and would ultimately be career enhancing. Subsequently I discussed this perspective with academic colleagues at the local University and with the Education Commissioning Manager at the Regional Strategic Health Authority. This resulted in an agreement to develop a work based module that would provide a means of gaining academic credit learning for experiential learning gained whilst completing the component parts of STEP 1 (see Appendix 14 –module poster).

Undertaking STEP 1 was determined as the prerequisite for accessing the module. Each student was required to produce a portfolio of evidence (3000 words plus completion of STEPS 1) to demonstrate achievement of the module learning outcomes and a personal learning contract as agreed with the academic supervisor. The objectives of the programme, which was validated with a currency of 40 credits at level 6, were to:

1. *critically reflect on learning gained from practice and analyse the link between theory and practice*

2. *critically apply experiential learning to recommendations for practice and a personal action plan*

3. *demonstrate personal, professional development as a result of experiential learning and reflection*

The assessment criteria identified in the module specification demonstrated in Box 11

Box 11 - Assessment Specification (Extract from the, University Module specification)

Assessment Specification:	
The student will provide evidence of	Relates to learning outcome number
Personal learning contract that has been agreed by the academic supervisor and completion of STEPS Phase 1	1 – 3
Critical reflection on the cumulative learning from practice based experience	1
Critical discussion of the links between experiential learning and theory	1

Recommendations for practice and a personal action plan	2
Reflection on personal, professional development as a result of experiential learning	3
Reference to current literature and research	1 – 3

8.10 The impact of the changing context of health care and nursing on the STEPs programme and its future development

Whilst healthcare has developed over time the characteristics of nursing are fundamentally unchanged and as Cummings and Bennett, (2012) point out in the joint NHS Commissioning Board and Department of Health Vision for Nurses, Midwives and Care givers:

> *As our NHS helps people to live longer, care needs are changing, and our health and care services are evolving to meet them. What has not changed is the fundamental human need to be looked after with care and compassion, by a professional who is competent and communicates well. To be looked after by someone with the courage to make changes to improve people's health and care, with the commitment to deliver this all day, every day.* (Cummings and Bennett, 2012, p4)

The values expressed in this vision (i.e. care, compassion, competence, communication, courage and commitment) reflect the central tenets of the nursing and midwifery professional code (NMC, 2010). The vision also embraces the components of nursing expressed by Packard and Ferrara (1988) cited by LaSala and Bjarnason (2012) as taking the right actions to effect health promotion and quality of life; possessing the knowledge and skills to discern when and not to respond; knowing what the appropriate actions should be and demonstrating a willingness to act, thus supporting the ethical principal of beneficence.

Whilst these fundamental values and purpose are enduring the context of nursing is changing. A more informed and educated society with access to information through new technologies has led to raised expectations and a decline in deference (Kendal and Lissaurer, 2003) leading to NHS staff being questioned, scrutinised and challenged by patients, relatives, carers and the media.

The cultures, attitudes and working practices of staff play a critical role in determining the quality of healthcare being provided and the image portrayed to the public. However the image of the healthcare professions has been sullied by repetitive reports of negligent or incompetent care and has led to intensified inspection and regulatory frameworks. This, in conjunction with an increasing emphasis on financial management, productivity and efficiency, has resulted in calls for changes in practice (DH, 2010. Meulenbergs et al, 2004) and development of a new professionalism in the NHS (Kendal and Lissauer, 2003) A significant strand of this new professionalism emphasises that the practitioners role and identity should be based on a desire to teach, facilitate and share control with patients rather than to maintain their exclusive mastery of a specific body of knowledge (Davies, 1996) Thischange requires multidisciplinary working that promotes greater interdependence, accountability and recognition of the contribution of all team members to the process of care (Salvage, 2002. Kendal and Lissauer, 2003). This assertion is echoed in the Willis Commission on Nursing Education report (2012) in which it is advocated that interprofessional learning must play a key role in continuing professional development.

The impact of this on the STEPs development to date has been the intention and subsequent positive action to engage other professions in the creation of specific programme elements. This has been mutually beneficial to nurses and other professionals by encouraging reflection on each other's roles, their contribution to patient care and their interdependence. In addition a single STEPs programme for nurses and Operation Department Practitioners is an established feature of the development of new registrants in operating theatres. Also I have been approached by the recently appointed Head of the Therapy professions in the Trust to discuss the development STEPs and advise on the creation of a programme for new registrant therapists. It is envisioned that this could lead to opportunities for multidisciplinary learning and a more consistent multi-professional approach to new registrant support across the Trust.

Currently a transition programme for new registrants that I am leading on is in the early stages of development and provides a major opportunity for multidisciplinary learning in the Trust, particularly in relation to professional values and the areas of partnership working, multidisciplinary team building and leadership. It is envisioned that this will require a review of STEP 1, exploration of ways to facilitate uptake of the learning resources provided in 'Flying Start England', and development of a simulation programme to assist in development of associated key competences.

8.11 Summary of Chapter 8

Chapter 8 has been concerned with the challenges faced in raising the profile of STEP1 and the overall vision for STEPs. This was achieved through the engagement of a core implementation team with the aid of an extended team, which together led a campaign to win the hearts and minds of staff across the nursing and midwifery workforce. The result of this campaign was widespread engagement of staff and rapid embedding of STEP 1. All of this has been achieved, in the absence of dedicated financial or human resource support.

In Chapter 9 I will elaborate on some of the factors that contributed to this success and I will reflect on my contribution to the programme and the learning I have gained as a result of engagement in this project.

CHAPTER 9 – CONCLUSIONS, RECOMMENDATIONS AND PERSONAL REFLECTIONS

9.1 Compliance with the Terms of Reference

The primary aim of this project was to develop, refine and implement STEP1 as a preceptorship programmefor new registrants that promoted lifelong learning and provided evidence of performance in the workplace. This project report demonstrates how I have addressed the three objectives that would aid me to address the research questions stated in Chapter 2.

The three objectives were to:

- collaborate with new registrants and the clinical teams in which they work, to produce, implement and evaluate a preceptorship programme that meets the requirements of the NMC and the NHS KSF.

- elicit how the approach to competency development illustrated by this framework is viewed by programme participants and wider nursing teams in which they work.

- conduct an initial qualitative assessment of the effectiveness of the STEP1 in assisting entrants on the NMC's professional register to achieve specified practice requirements.

Initially to widen my understanding of concepts related to an incremental approach to continuing development for registered nurses I undertook a critical review of related literature. Through this process I gained greater understanding of the concepts of lifelong and work based learning, competency and performance. I also explored the impact of changes in NHS policy towards continuing professional development brought about by the ideological perspectives of successive governments. Engaging in discussion and debate with individuals and groups from the wider NHS and Higher Education Institutions also deepened my appreciation of the relevant issues. Crucially, I have collaborated with new registrants and the clinical teams in which they work, to produce, implement and evaluate a preceptorship programme that meets the requirements of the NMC and the NHS Knowledge and Skills Framework. In addition I engaged directly with senior nurses in all clinical divisions to achieve successful implementation of STEP 1. I firmly believe that clinical engagement at all stages of this initiative democratised the overall process, and this resulted in extensive ownership of the project, commitment to its completion and action upon the findings.

 Throughout this project I have sought to act in a reflexive manner taking account of emerging views and ideas that have strengthened the programme and aided the embedding of STEP 1 into the

culture of nursing within the Trust. Importantly this has also led me to recognise and act upon opportunities to move along the action research continuum from an experimental / organisational approach to a professionalising and in some instances empowering model.

I conclude that I have met the three stated objectives, but more importantly in doing so I have am able to summarise how I have addressed the overarching and supplementary research questions identified in chapter 2 (section 2.3)

9.2 Summary of how the research questions have been answered

The overarching research question was 'What impact and meaning would implementation of the STEPs framework have for newly registered nurses and teams in which they work?'I have identified two major differences made by the introduction of STEP 1, (1) Its introduction assisted in alleviating role ambiguity and improved role clarity by informing new registrant's of the care standards expected by the Trust and the expression of the outcomes they were expected to achieve during their preceptorship period. (2) Implementation also highlighted shortcomings in the organisation and delivery of support for new registrants. This resulted in clinical teams reviewing and addressing the management of new registrants, thereby improving their experience during the transition period. These points are elaborated upon through evidence cited in answer to the supplementary research questions.

Supplementary questions that are fundamental to this study were:

1. What are the perceptions of new registrants and their managers regarding STEP 1 as a vehicle for assisting to integrate knowledge acquired during pre-registration education into clinical practice?

2. Does the STEPs model assist new registrants to identify and address their learning needs?

3. Is STEP1 a useful tool for supervising and assessing the performance of new registrants?

4. What is the impact of the implementation of STEP 1 on the provision of support for new registrants?

In chapter 6, I quoted numerous responses gained during interactions with new registrants, Matrons and three focus group members relating to the first two supplementary questions.Comments by new

registrants signify that praxis and opportunities, with support, to consolidate their knowledge and skills were important to them. It is also apparent that the documentation and STEP 1 content prompted new registrants to reflect on their practice. In particular STEP 1 was viewed to present expected standards of care, thereby providing a template for planning future knowledge and skills development. In addition, access to STEP 1 documentation proved to be a useful tool for more experienced nurses to revisit aspects of care and update their knowledge, particularly about current policies and protocols. These findings demonstrate a general belief that STEP1 assisted in identifying gaps in clinical experience and provided 'sign posting' for acquisition of competence and improved performance.   Prior to conducting interviews and analysing the data I had expected there to be numerous comments regarding the content of STEP1, but the outcome was somewhat different as new registrants and supervisors generally found the content to be appropriate. However, the new registrants placed greater emphasis on the context of their work rather than on the content of the programme. New registrants believed performance and competency should be assessed but felt that the environments in which they worked were not always geared to supporting their transition from student to registered nurse roles.

In relation to question 3, comments from all levels of staff regarding the usefulness of STEP1 for supervising and assessing the performance indicated that the STEP1 practitioner and supervisor packs provided the expected standards upon which a supervisees' progress could be measured. However, the pedagogic approach adopted by a number of supervisors clearly impeded the assessment of performance because questioning of new registrants was their prime mode of assessment. However, following discussions in the focus group sessions supervisors were encouraged to engage with their supervisees in different ways. In an effort to improve documentation of progress through STEP1 the supervisee self-assessment document and a supervisor sign off sheet were devised. These documents were viewed as aids to discussing the new registrant's transition from both supervisee and supervisor perspectives. But more importantly, in my view, the requirement for supervisors to verify the supervisee's satisfactory performance resulted in supervisors agreeing to base their discussions on observed practice in addition to the verbal exploration of the new registrants' knowledge. I conclude that the way in which skills, knowledge and attitude were assessed, was influenced by the STEP 1 content and development of self-assessment and supervisor documentation. Nevertheless I believe the action research process, which allowed the views of new registrants to be vocalised, was pivotal in influencing experienced staff to rethink how they monitored the development of new registrants during their transition from student to staff nurse roles.

The final supplementary question required me to assess the impact of the implementation of STEP 1 on the provision of support for new registrants. In general new registrants viewed STEPs as a positive initiative that helped to improve knowledge and addressed gaps in clinical skills. However, in Chapter 6, I demonstrated that this was tempered by concern that prior to the introduction of STEP 1 support was available but not well structured. This was most evident regarding the allocation of work and how supervisory relationships were established and developed. These factors caused anxiety for new registrants and in the absence of solutions to these issues the primary aim of STEP 1 would not be met. In addition it became clear that where pedagogic approaches to supervision existed, promotion of praxis by empowering junior nurses to engage in dialogue that challenged existing practice was negated. However, by providing opportunities for all participating staff groups to expose their concerns a milieu was promoted that aided junior staff to challenge existing supervisory and induction arrangements. Chapter 6, section 6.9 provides evidence of how changes in the urology nursing team's supervisory practice positively influenced the new registrants' experience.

I have demonstrated that partnership with key stakeholders to initiate, evaluate and sustain change has provided benefits for new registrants and the clinical teams in which they work. In particular the development of structures and processes have resulted in a general assertion that STEP 1 is a vehicle for assisting to integrate knowledge acquired during pre-registration education into clinical practice as it aids identification of learning need and objective setting. In addition, the introduction of assessment documentation and revised supervisory arrangements enhanced the experiences of new registrants and aided demonstration of a supportive management culture. Five years have passed since the introduction of STEP1 across the Trust and its continued use is testament to its sustainability. At the time of completing this project report Teacher/Practitioners attached to clinical areas regularly discuss the uptake of STEP1 at the Nursing and Midwifery Education and Training Forum. Nursing teams across the Trust report that STEP1 continues to be beneficial to new registrants and production of STEP 2 elements provide further opportunities for learning and development. I believe this situation isdue to three major factors. The first is that since implementation, demonstration of achievement and progress has been measured against STEP1 and has been linked to gaining the first financial increment after six months. However, more importantly Teacher / Practitioners oversee the preceptorship arrangements in wards/departments, ensuring that new registrants commence and proceed through STEP 1. Their relationship with new registrants acts as a conduit for valuable feedback regarding its structure and content, hence STEP1 is continually under review and is now being reviewed for a second time since implementation in order to maintain its currency. This is done by ensuring that best practice in the form of

recommendations from research findings; clinical incident reviews and reports from agencies such as the National Patient Safety Agency are integrated into or replace existing information. Changes to STEPs documentation is achieved universally in the Trust via the Managed Learning Environment and this is communicated through the STEPs website and by teacher practitioners within their clinical areas.

I conclude that the research questions identified in chapter 2 have been addressed.

9.3 Recommendations for future development and research

The future quality of nursing care will rest in the hands of this generation of new registrants, and those that follow them. It is crucial that the culture of any nursing team supports reflection on practice thereby enabling sense making, understanding and moving towards a state of conscious competence or in the least conscious incompetence (Hannabuss, 2000). These two concepts; that of knowing what you know and being aware of shortfalls in your knowledge are fundamental to ensuring patient safety and planning for future development.

In this project I have demonstrated the importance of providing structure and direction through supportive structures that encourage new registrants to reflect on how their existing knowledge relates to the reality of practice. I have also illustrated benefits that new registrants gain from dialogue that results in greater understanding of their needs by more experienced staff and sharing of explicit and tacit knowledge, thus aiding transition. Therefore the recommendations from this research are that:

- The transferability of the framework to other organisations should be tested.

- Educational institutions and employers should consider developing transitional programmes collaboratively to address issues relating to 'Transition Theory' and aid seamless movement from student to Registered Nurse roles.

- Educational institutions and employers should consider the initiation of evaluative research of 'Transition Programmes' developed in the UK and also engage in opportunities to engage in multinational comparative studies of approaches to supporting nurses during the initial post registration period.

- Further research is needed to explore the benefits and opportunity costs of running programmes such as STEP1 in tandem with other transitional models, such as, Flying Start England in an attempt to tailor programmes to meet individual development needs.

- Employers should promote the development of communities of practice whereby a safe environment is created for individuals to engage in learning through observation and interaction, and to support community activities to help individuals make sense of new knowledge.

- Consideration should be given to the exploration of nursing teams as communities of practice and the degree to which they create social structures that facilitate learning through interactions and relationships with others.

9.4 Personal reflections

This project has enabled me to focus on moving forward work that has been a major factor and motivator for the greater part of my career. That is, to build capacity and capability for professional support during role transition across the career spectrum. In this regard this project has been a small but not inconsequential step. The project has also given me great satisfaction and has enabled me to develop my appreciation of the potential to enhance reflection and engender change by individuals and teams. Changes generated through this action research, particularly pertaining to the organisation of support structures and staff deployment, were not being envisioned at the outset of the project but this has given me greater insight into the nature of empowerment.

For me, the most inspiring aspect of this project, and therefore its greatest strength, has been the large numbers of staff within the Trust who intuitively believed that STEPs would ultimately be of benefit to the public they serve. This belief has been demonstrated by the many staff members who gave their time either to assist in the identification and development of STEPs elements; participated in the action research or facilitated the implementation stages following refinement of the model. It is through their efforts that STEP1, which was afforded no other resource, is now recognised as a core component in the development for newly registered nurses in the Trust. I am grateful and humbled by the trust and support afforded to me by all participants**.**

As leader from its inception I have found this project challenging, at times demoralising and at others uplifting. Consequently, I have experienced several areas of critical learning. The most significant of these relate to:

- my role as insider researcher
- distributed leadership, responsibility and accountability

9.5 My role as insider researcher

From the outset of this project I explored the potential benefits and drawbacks of conducting a study in one's own place of work (see Chapter 4). During the course of the study I became acutely aware of these issues, not least that insider-researchers have different dynamics to external action researchers, because the insider-researcher has intimate knowledge of the process under study and wishes to maintain a relationship with the organisation, as an employee, when the research is complete (Coghlan, 2001).As the literature suggested my knowledge of the organisation did facilitate access to a wide range of professionals whose various contributions assisted progression at all stages of the project. But I had to remain aware that any preconceptions I possessed could lead to wrong assumptions and premature conclusions and thereby negate in depth enquiry. As the project progressed I became increasingly aware that my roles as researcher and senior manager were at times indistinguishable.

I have previous experience of insider research. However, my previous study was of a fairly homogenous group (Knight, 1998), whereas this project included nurses of varying levels of experience and backgrounds. Therefore I was very well known to some staff members, acquainted with others, but a stranger who held a senior position, to most new registrants. I became acutely aware that each individual's perception of me as an insider or outsider depended largely on our previous history and this led me to consider whether I was an insider or outsider researcher. As the project progressed I came to realise that the insider- outsider perspectives are not mutually exclusive frames of reference but two conceptual rather than real ends of a continuum (Christenson and Dahl, 1997). Subject to differing situations, contexts and values the researcher's status moves forwards and backward along this continuum (Merton, 1972).

Mercer (2007) views the researcher's identity as multi-dimensional with some features being innate but unchanging, such as gender and ethnicity and others such as age, which is innate but evolving. Other dimensions include time and place of the research, power relationships and personalities of the researcher and the research participants. It might be concluded that people possess a status set rather than a status and:

… the researcher who shares a particular characteristic, for example gender, ethnicity or culture, with the researched is an insider, and everyone else, not sharing that particular characteristic, is an outsider. Mercer, 2007, p5

Throughout the data collection process I had to remain aware that a participants perception of me as a senior manager could influence levels of participation and lead the respondent to become constrained or overly casual. Conversely, previous knowledge of my career could lead interviewees to assume that detailed explanation was unnecessary. This would be likely to result in diminished opportunities for me to learn about their situation. I became aware that it was essential to remain cognisant of these factors in order to establish a milieu that encouraged the respondent to disclose pertinent information. Hence as a researcher I moved to and thro between these two conceptual boundaries, adapting my style to enhance rapport with each interviewee or focus group therefore I was both an insider and outsider**.** The need to be aware of and fulfil responsibilities attached to each role was ever present. The most noticeable example of this was new registrant Karen's disclosure regarding binge drinking. This provided an ethical dilemma because as a researcher I had been privileged to sensitive information and as such should treat it as confidential. However, as a senior nurse I have a duty to act in the best interests of the nurse and her patients. Her disclosure did cause me concern both for her wellbeing and for patients who may be at risk from errors she may have made if suffering from the effects of alcohol. However, Karen did not reveal any illegal activities to which I would have immediately acted upon, as the requirement to report unlawful conduct over-rides any confidentiality agreements. I had to decide what, if any, action I should take. I did not pursue this issue at the time but afterwards I reflected on our conversation. My options, as I saw them were to either raise the situation with the Ward Sister, in order for Karen's workload to be monitored and her behaviour observed, or to personally explore the situation further with Karen. As I wished to promote a trusting relationship with this junior nurse I chose the latter. On a subsequent visit to the ward an opportunity presented for me to speak with Karen about the disclosed event. It transpired that the event she had related to me took place 2-3 months before the interview. She told me she had not over indulged in alcohol before and she had not experienced events again that had led her to binge drink. Furthermore she had realised that this was inappropriate and she did not enjoy the effect alcohol had on her. I emphasised to her that she should not be afraid to discuss her concerns with her supervisor/preceptor or the nurse in charge if she thought acceptance of a workload or the complexity of patients were beyond her experience. At my final interview with Karen (see 6.3) she related that over the preceding year she had learnt to cope more responsibly with pressure despite still feeling stressed at times.

The need to remain vigilant to insider researcher issues was constant throughout the project however this also enhanced my confidence as researcher as I became overtly aware that expertise gained through long experience in educational and managerial positions had significantly enhanced my ability to put people at ease whilst maintaining a focus on gaining appropriate information. However, despite this wealth of experience, the revelations related new registrants requiring intervention demonstrated the ethical dilemma resulting from the dual roles of researcher and senior manager.

9.6 Leadership, responsibility and accountability

As previously indicated a major difference between this project and previous initiatives that I have led has been its heterogeneous nature.Whilst the action research focused primarily on the views of both newly registered and experienced nurses to determine topics and refine the structure of STEP1, I also engaged and collaborated with a large number and range of practitioners to develop the content of the individual elements of the programme. This included specialist nurses pharmacists, dieticians and the therapists. In doing so it was necessary for me to adopt what may be termed a distributed or collective leadership approach. Distributed leadership has been identified as a consequence of movement to new, flatter organisational structures including networks, and cross functional teams that form strategic alliances (Gregory, 1996. Denis, Lamothe and Langley (2001). Whilst organising a campaign, as discussed in the last chapter, to establish STEPs in the 'hearts and minds' of practitioners I developed an understanding of protainment. Protainment is defined as accepting that distributed leadership requires a clear understanding at all levels of the organisation of how it is defining itself in relation to the context in which it exists and what is needed for success to be achieved (Huffington, James and Armstrong, 2003). In other words, protainment is the management of an organisation's ecology in relation to the project. Achieving protainment required that I ensured that a clear understanding and shared acceptance of accountability for the overall direction and functioning of the project existed at all levels of the organisation. I attempted this by actively promoting the role of practitioners in the development of the vision, values, and objectives at all stages of the project. The enactment of these principles were central to the development of STEP 1 elements, the implementation model for the roll out of STEP 1 and the proliferation of STEP 2 elements by a large number of individuals and clinical teams.

Learning achieved through the D. Prof programme's expert seminar series and by undertaking 'Insights Discovery 3.5', resulted in awareness of areas that I needed to address if I was to successfully lead this project. The Insights system (copyright 1992-2010, Insights Dundee,

Scotland), which is based upon the Jung's (1921) model of personality and preferences, offers a framework for self-understanding and development. One aspect of my 'Insights Discovery' profile that directly related to protainment was my desire to allow individuals the freedom to be innovative in their work without undue interference. Reflection on this finding led me to accept that I initially lacked a focus on developing shared accountability for the success of the project. In particular I came to recognise that I had at times failed to ensure that the career aspirations of staff reporting to me did not outweigh the importance of effectively contributing to the success of the organisation in meeting expressed objectives. I also came to realize I had an inadequate focus on the accountability of others for achieving delegated tasks and that this not only requires clear communication of goals and objectives but also how those objectives contribute to effectiveness and the performance of the organisation. I recognised that in the past I have not always been clear regarding individual responsibilities, or consistently ensured that individuals understand that whilst they have the authority to make decisions they remain accountable to the organisation. I have found that providing this clarity of expectation has also been beneficial in recruiting staff that I do not manage directly, but whose input into the development and implementation of the programme was crucial.

A further finding in my 'Insights Discovery' profile was that whilst tenacious persistence and dedication to a cause are hallmarks of my character, I have had a tendency to be a back-office expert rather than forcefully express my ideas or feelings. In order to maintain the momentum in developing and implementing STEP1 and gaining support for my vision for this incremental model of development I have had to overcome my reticence to push myself and my views forward. I achieved this, after initial reluctance, by actively engaging individuals and groups within and out with the Trust. I have presented this vision to numerous staff groups and at a number of conferences. I have also engaged with and gained support from executive directors at Trust and Strategic Health Authority levels. For my on-going personal development it is important to continue to overcome my reticence to speak out and share my views and not view this as self-promotion,

These changes in my approach are also proving to be beneficial in ensuring that the outcomes of aspects of my work and that of my staff are seen to be pertinent and important to the success of the Trust. Since gaining these insights I have continued to promote freedom to act but I have taken greater account of the degree to which individuals require supervision, support and regular but not over-frequent monitoring of achievement. I believe that acting on these insights has enhanced my ability to secure demonstrable sustained change.

9.7 Contribution to practice - ending the doctoral programme

This concluding element of my doctoral programme has provided the opportunity to integrate learning and experience that has led to a deeper understanding of leading professional and practice development. It has also offered an opportunity to influence learning and development in clinical practice based upon knowledge of issues that concern new registrants whilst complying with NHS Knowledge and Skills Framework requirements (DH 2004a). As a result it has contributed to practice through provision of a tool that is appropriate to the experience of new registrants and therefore assists in eliciting strengths and areas for development. Implementation of STEP 1 for nurses and operation department practitioners, and collaboration with therapy professions, demonstrates the potential for adapting the framework for use by other professions. The STEPs approach aids new registrants to self-assess against a set of expected standards and aids supervisors/preceptors to assess a new registrant's level of praxis and performance. This dual approach to assessment provides a basis for discussion regarding progress, but also aspects of fundamental and speciality related care and critical events. Through such communication a milieu is developed that enables access to tacit knowledge held by more experienced practitioners. Another major contribution to the promotion of overt and tacit knowledge transfer is that this project highlights how careful implementation of any preceptorship programme, which takes into account the views of preceptors and preceptees, will identify where and how existing arrangements for support and supervision may be improved.

However, as stated in chapter 1 this project has been the initial stage in the delivery of a vision for a programme of incremental development of nurses from the time of registration through to advanced practice and I am increasingly aware that my work is not finished. I am left to reflect what has been achieved, what I have learnt and to contemplate if and how my overall vision for creation of an incremental development framework spanning a professional career can be realised. Currently STEP 2 is an on-going initiative and a more comprehensive approach to addressing transition issues is in its formative stages.

In addition to the developments outlined in chapter 8 I have shared my conclusions and recommendations with the Faculty of Health and Social Care (FASC), University of Hull, and this resulted in a recent decision to develop a transition module in the final semester of the undergraduate nursing programme. I have also recently been approached to join the curriculum development group for this module. It is envisioned that this module will assist in preparing students for the 'real world' of nursing and act as a primer for new registrants entering transition / preceptorship programmes in Trusts, thereby aiding a seamless transition from student to registered practitioner. In recognition of my on-going commitment to professional development I was awarded

an Honorary Fellowship in the Faculty of Health and Social Care, University of Hull. I am also currently engaged in developing a development programme tailored to enhance the capability of Ward Sisters to proactively lead their teams during a period of economic and human resource retrenchment. In addition I will be working with the Trust Education and Development Team to create a programme for Band 6 nurses who aspire to a Band 7 ward / department manager position. These should provide opportunities to develop awareness by senior staff regarding transitional issues and associated supportive techniques.

I feel that overall the D.Prof programme has enhanced my ability to spread understanding of and support for projects. It has also demonstrated to me that I have the staying power to see major initiatives through to conclusion. Despite my years of experience at a senior level I believe the journey I have undertaken through this doctoral programme has reinvigorated my desire to learn, whilst positively influencing patient care through professional development initiatives, and to recognise and act upon opportunities to do so.

References

Abbot, P. (2002) implementing evidence-informed nursing: Research awareness. In McSherry, R. Simmons, M. Abbott, P. (2002) Evidence informed nursing: a guide for clinical nurses. London: Routledge

Adelman, C (1993).Kurt Lewin and the origins of action research.Educational Action Research.p1 (1), 7-24

Ahern, J.K.(1999). Ten tips for reflexive bracketing. Qualitative Health Research 9, (3), p (1998)407 – 411.

Allen, R. Allen, J. Kraft, C. Certner, B.(1982) The organizational unconscious. How to create the corporate culture you want and need. Prentice –Hall, Englewood Cliffs, New Jersey

Allen, K (1998) The transition from student to professional nurse. The Florida Nurse, 46, (6) p14

Anderson, N. Schalk, R.(1998) The psychological contract inretrospect and prospect. Journal of Organizational Behaviour,19, p637 -647.

Appleton, J.V. (1995) Analysing qualitative data: addressing issues of validity and reliability. Journal of Advanced Nursing.22, p993-999

Argyris, C. (1960) Understanding organisational behaviour. Homewood, Illinois :Dorsey.

Argyris, C. Schon, D (1974).Theory in Practice: Increasing professional effectiveness.Jossey Bass,San Francisco, CA

Armitage, P. Champney-Smith, J. Andrews, K. (1991) Primary nursing and the role of nurse preceptor in changing long term mental health care: an evaluation. Journal of Advanced Nursing.16, p413-422

Ayer, S. Knight, S. Joyce, L. Nightingale, V(1997).Practice Led education and development project: styles in clinical supervision. Nurse Education Today, 17 (5) p347 - 358

Bally, J.M.G. (2007) The role of nursing leadership in creating a mentoring culture in acute care environments. Nursing Economics.25 (3), p143 -148.

Baltimore, J.J. (2004). The hospital clinical preceptor: essential preparation for success. Continuing Education in Nursing.35 (3) p133- 140.

Baum, M. (1990) The ethics of clinical research.In Byrne.P (Ed).Ethics and Law in Healthcare and research.Chichester, John Wiley

Bawden, R. (1989) Praxis: the essence of systems for being. In Viskovic(ed) Research and development in higher education.p1-7. Campbelltown, NSW. Herdsa.

Beasley, C. Bassett, S. Travis. (2005) Changing Times. Nursing management. 11, (10) p12-14

Beauchamp,T.L. Childress, J.F. (1989) Principles of biomedical ethics. London, Routledge Kegan Paul

Beinart, S. Smith, P (1998) <u>National Adult Learning Survey</u>. 1997. Sheffield Department for Education and Employment,

Bentham, Jeremy (1789) <u>Introduction to the Principles of Morals and Legislation</u>.www..la.edu/research/poltheory/bentham/ipm 1ipm 1.c01.html. Accessed 29 July, 2007

Benne, K.D. Bennis, W (1959) <u>Role of the Professional Nurse.</u> American Journal of Nursing 59, p196 -198

Benner, P. (1984) <u>From Novice to Expert: excellence and power in clinical nursing practice</u>. Reading, Addison – Wesley

Benner, P. Tanner, C.A.. Chesla, C.A. (1996) <u>Expertise in Nursing Practice: Caring, clinical judgement, and ethics.</u> New York, Springer.

Benton, D. (2003) Agenda for Change: job evaluation. <u>Nursing Standard,</u> 17, (36):39 – 42

Bibby, J. Bevan, H. Carter, C. Bate, P. Robert, G. (2009) <u>The Power of One, The Power of Many.</u> NHS Institute for Innovation and Improvement.

Bick, C. (2000) Please help me I'm newly qualified. <u>Nursing Standard</u>, 14, p44-47.

Blake, W (1797/1992) <u>Annotations to Sir Joshua Reynolds discourses</u>. Penguin Classics

Bevan. H (2010) The NHS needs to build its own social movement. In The Clock is Ticking. <u>Health Service Journal Supplement,</u> 9 December 2010.

Boud, D. Garrick, J. (1999) Understandings of Work based Learning, in Boud, D. Garrick, J. (eds) <u>Understanding Learning at Work.</u> Routledge: London and New York.

Bourdreau, P. 2005. <u>The Logic of Practice.</u> Cambridge: Polity Press

Boyatzis, R.E. (1982) <u>The Competent Manager: a model for effective performance.</u> John Wiley & Sons, New York

Bradshaw, A. (1997) Defining competency in nursing (Part 1): a policy review. <u>Journal of Advanced Nursing.</u> 6: 347 – 354

Bradshaw, A. (1998) Defining competency in nursing (Part 2): an analytical review. <u>Journal of Advanced Nursing.</u> 7: 103 – 111

Bromley, D.B. (1986) <u>The Case Study Method in Psychology and related disciplines</u>. Chichester: Wiley

Brophy, P. Craven, J. Fisher, S. (1998) <u>The Development of UK Academic Library Services in the Context of Lifelong Learning</u>. Manchester University.

Bryar, R (1999) An examination of case study research. Vol 7, No 2, Winter 1999/2000

Briar, R. Closs. S. et al. (2003) The Yorkshire Barriers Project: diagnostic analysis of barriers to research utilisation. <u>International Journal of Nursing Studies,</u> 40, p73 - 84

Burnard, P. (1995) Nurse educators' perceptions of reflection and reflective practice: A report of a descriptive study. Journal of Advanced Nursing, 21,1167 – 1174.

Butterworth, T. Faugier, J. Burnard, P (1998)Clinical Supervision and mentorship in nursing. 2nd edition. Cheltenham: Stanley Thornes Ltd.

Burns, N. Groves, S.K. (1997) The Practice of Nursing Research: Conduct, Critique and Utilization. 3rd edition. Philadelphia PA. WB Saunders Company.

Burton, J. Jackson, N (eds) (2003) Work Based Learning in Primary Care. Radcliffe Medical Press.

Care Quality Commission,(2009) Investigation into Mid-Staffordshire NHS Foundation Trust. Commission for Healthcare Audit and Inspection.

Canadian Nurses Association (2004).Achieving excellence in clinical practice a guide to preceptorship and mentoring. Ottawa, Ontario.

Carr, W. Kemmis, S (1986) Becoming Critical: Education, Knowledge and Action Research. London, Falmer Press

Casey, K. Fink, R. Krugman, M. Propst, J. (2004) The graduate nurse experience .Journal of Nursing Administration, 34 (6) , 303 – 390.

Chang, E. (1993) The Socialization of Tertiary Graduates into the Workforce. PhD dissertation. School of Education Administration, University of New South Wales.

Chang, E. Daly, J (2008) Managing Transition from Student to Graduate Nurse. In Chang , E. Daly, J. (2008). Transitions in Nursing: Preparing for professional practice. Elsevier, Australia. pp I – 15.

Chang, E. Hancock, K. (2003) Role Stress and role ambiguity in new nursing graduates in Australia. Nursing and Health Sciences 2003, 5:155 -63

Charnley, E. (1999) Occupational stress in the newly qualified staff nurse.Nursing Standard, Vol. 13, (29) 33-37.

Cheetham, G. Chivers, G. (2001) How professionals learn in practice: an investigation of informal learning amongst people working in professions. Journal of European Industrial Learning, Volume, 25, Number 5.

Chein, I. Cook, S. Harding, J. (1948)The field of action research. American Psychologist, 3: 43-50

Chenitz, W.C.(1986) The Informal Interview in Chenitz, W.C and Swanson,J.M. (editors) From Practice To Grounded Theory: qualitative research in nursing. Addison Wesley. California, pp 79 - 90

Chenitz, W.C. Swanson, J.M. (1986) Qualitative Research using Grounded Theory. In Chenitz, W.C and Swanson,J.M. (editors) From Practice To Grounded Theory: qualitative research in nursing Addison Wesley. California. pp3 -15.

Chin, R. Benne, K.D (1976) General Strategies for Effecting Change in Human Systems in Bennis, W .G. Chin, R. Benne, K (1985) The Planning of Change. Holt, Rhinehart & Winston.

Cherryholmes, C.C.(1992) Notes on pragmatism and scientific realism. <u>Educational Researcher</u>, 11, p13-17

Christensen, D. H. and Dahl, C. M. (1997) Rethinking research dichotomies, <u>Family and Consumer Sciences Research Journal,</u>25(3), 269-85.

Clarke, A. (1999) Focus Group Interviews in health care research.<u>Professional Nurse,</u> 14, (6), 395

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. Vol 44(7) pp 1210 - 1217

Closs, S.J. Baum, G. Bryar, R et al (2000) Barriers to research implementation in two Yorkshire hospitals. <u>Clinical Effectiveness in Nursing</u>Vol 4 (1) 3-10

Coffield, F. (1999) Introduction: Lifelong Learning as a new form of social control. In Coffield, F. <u>Why's the beer always stronger up north? Studies of lifelong learning in Europe.</u>Policy Press, Bristol.

Coghlan and Brannick (2000) <u>Doing Action Research in your Own Organization</u> , London : Sage

Coghlan, D., (2001). <u>Insider Action Research Projects: Implications for Practicing Managers'. Management Learning.</u> 32 (1), 49-60.

Coit Butler, F. (1978) The concept of competence: an operational definition. <u>Educational Technology</u> 18, 7 – 16.

Collier, J. (1945) United States Indian Administration as a laboratory of ethnic relations.<u>Social Research,</u> 12, 275 – 6.

Corey, S. (1953) <u>Action Research to improve School Practice.</u> New York, Columbia University.

Costley, C. Elliott, G. Gibbs, P. (2010).<u>Doing Work Based Research: Approaches to enquiry for insider-researchers</u>. Sage

Cowin, L. Duchsher, J. Transitional programs. In Chang, E. Daly, J (2008) Managing Transition from Student to Graduate Nurse. In <u>Transitions in Nursing: Preparing for professional practice.</u> Elsevier, Australia. Pp323 - 340

Cummings, J. Bennett, V. (2012) <u>Developing the culture of compassionate care: creating a new vision for nurses, midwives and care-givers.</u> NHS England

Davidson, P. Elliot, D. (2008) Managing approaches to nursing care delivery. In Chang, E. Daly, J.(2008)<u>Transitions in Nursing 2nd edition</u>. Churchill Livingstone.

Dearnley, C. (2005) A reflection on the use of semi-structured interviews.<u>Nurse Researcher</u>13, 1 p 19 - 28

Denis, J-L, Lamothe, L. Langley, M. The dynamics of collective leadership and strategic change in pleuralisticorganisations.<u>Academy of Management Journal</u>, August 2001, Vol 44, -no 4, p809 - 837

Denzin, N. K. (1988). <u>The Research Act: a theoretical introduction to sociological methods</u>. Englewood Cliffs, NJ: Prentice –Hall.

Denzin, N.K. Lincoln, Yvonna.S (2000) Handbook of Qualitative Research (2nd edition). Sage Publications.

Department of Health (1991) New Deal for Junior Doctors. The Stationary Office

Department of Health (1998)   A First Class Service. London, The Stationary Office

Department of Health (1999a) Agenda for Change: Modernising the New NHS. The Stationary Office

Department of Health (1999b) Continuing Professional Development in the New NHS. London, The Stationary Office

Department of Health (2000) The NHS Plan: a plan for investment, a plan for reform. London, The Stationary Office

Department of Health (2000).Comprehensive Critical Care. London, The Stationary Office

Department of Health (2001) Working Together – Learning Together. London, The Stationary Office

Department of Health (2002) A Guide to NHS Foundation Trusts. London, The Stationary Office

Department of Health (2002) A Modernised NHS Pay System. London, The Stationary Office

Department of Health (2003) The Job Evaluation Handbook. London, The Stationary Office

Department of Health, (2003b)Agenda for Change Proposed Agreement. The Stationary Office

Department of Health (2003) The NHS Knowledge and Skills Framework (NHS KSF) and Development Guidance – Working Draft. Department of Health Publications.

Department of Health (2004a) The NHS Knowledge and Skills Framework and Development Process (NHS KSF). Department of Health Publications.

Department of Health (2004b) Standards for Better Health. Department of Health Publications.

Department of Health (2010) Quality, Information ,Productivity and Prevention Assurance Process: embeddinghealth workforce information. Department of Health Publications.

Department of Health (2010) Equity and Excellence: Liberating the NHS.Department of Health Publications.

Department of Health (2010) Preceptorship Framework for Nurses, Midwives and Allied Health Professionals. Department of Health Publications.

Department of Health (2012) Liberating the NHS: Developing the Healthcare Workforce From Design to Delivery.Department of Health Publications.

Dilthey, W. (1910). Introduction to the Human Sciences. Princeton University Press.

Drucker, P.F. (1991) The New Productivity Challenge.Harvard Business Review, Nov – Dec: 69-79.

Duchsher, J.E.B. (2009) Transition Shock : the initial stage of role adaptation for newly graduated nurses. Journal of Advanced Nursing 65(5), 1103-1113

Elkin, G. (1990) Competency-based human resource development. Industrial and Commercial training, 22, 4pp 20 - 25

Endacott, R. (1994) Objectivity in observation. Nurse Researcher 2:2, p30 -40.

English National Board for Nursing, Midwifery and Health Visiting (1991) The ENB Framework for Continuing Professional Education for Nursing, Midwifery and Health Visiting: Guide to Implementation. London, ENB Publications

Ermarth, M.(1978) Wilhelm Dilthey: The Critique of Historical Reason. Chicago: University of Chicago Press

Eraut, M (1994) Developing Professional Knowledge and Competence. London,Falmer Press,

Eraut, M. (1995) Knowledge creation and knowledge use in professional contexts. Studies in Higher Education (2): 117 -133

Eraut, M. Alderton, J. Cole, G. Senker, P(1998) Development of knowledge and skills in employment. Unpublished research paper, Economic and Social Research Council, Swindon.

Eraut, M (1998) Concepts of competence. Journal of Interprofessional Care. 12: 127-139

Eraut, M. (2004). Informal Learning in the workplace. Studies in Continuing Education, Vol. 26,No 2, July 2004.

Evans, J (2005) The value of transition support programmes for newly registered nurses and the hospitals offering the programmes in New South Wales. http://dlibrary.acu.edu.au/digitaltheses/ public /adtacuvp94.29052006. Last accessed 8 May 2012.

Firby, P (1995) Critiquing the ethical aspects of a study. Nurse Researcher, Vol 3, No 1. September, 1995

Faure, E (1972) Learning to be. Paris: Unesco

Fawcett, D.L. (2002) Mentoring: What is it and how to make it work. AORN Journal. 75, 950 – 954.

Field, J. (2000) Lifelong learning and the new educational order. London: Trentham Books.

Field, J. (2004) Lifelong Learning and cultural change: a European perspective. Conference on Lifelong Learning and new learning culture, National Cheung – Cheng University, Chia-Yi, Taiwan, 1-2 October, 2004

Field, J. (2006) Lifelong learning and the new educational order (fully revised 2nd edition). London:Trentham Books:

Field, P. Morse, J.(1985) Nursing Research: the application of qualitative approaches. London:Croom Helm.

Finlay, L. (2003) The Reflexive Journey: mapping multiple routes. In Finlay, L., Gough, B. (eds) A Practical Guide for Researchers in Health and Social Sciences.Chapter 1:Oxford, Blackwell Science

Fisher, C.D. (2000) Mood and Emotion whilst Working: Missing pieces of job satisfaction. Journal of Organisational Behaviour (21) 185 -202

Fontana, A. Frey, J (!994) Interviewing; the art of science. In Denzin, N. Lincoln, N. Handbook of Qualitative Research p 361 - 376. Sage Publications

Fox, M. Martin, P. Green, G. (2007) Doing Practitioner Research. Sage Publications.

Forrester, M. (1999) Conversation and instruction within apprenticeship: affordances for learning. In Ainley, P. Rainbird, H (editors) Apprenticeship: Towards a New Paradigm for Learning p 86 – 98. London: Kogan Page

Francis, R (2010) The Mid Staffordshire NHS Foundation Trust Inquiry. Department of Health

Fraser, D.M. (1997) Ethical dilemmas and practical problems for the practitioner researcher, Educational Action Research, 5 (1):161-171.

Freshman B. Robino, L (2002) Emotional intelligence; a core competency for health care administrators. Health and Care management. 20(4) 1-9.

Freshwater, D (2005) Writing, rigour and reflexivity in nursing research, Journal of Research in Nursing 10 (3) 311 - 315

Fullan, M. (1982) The new meaning of educational change. New York, Columbia University Press 435, 442, 443. P 91

Gans,H.J. (1982)The Urban Villagers: Group and Class in the Life of Italian-Americans.New York:The Free Press.

Garrick, J. (1999) The dominant discourses of learning at work. In Boud, D. Garrick, J. (eds) Understanding Learning at Work. London and New York:Routledge.

Garrick,J, Usher, R (1999) Flexible learning, contemporary work and enterprising selves .Proceedings of the '1st International Researching Work and Learning Conference, Trinity and All Saints College, 10-12 September, 1999. University of Leeds: 61 – 69

Gear, J. McIntosh, A. Squires, G (1994) Informal Learning in the Professions. The University of Hull.

Gearing, E.R. (2004) Bracketing in Research: a typology. Qualitative Health Research.14: 10, 1429 – 1452.

Geertz, C (1973)Thick Description: toward an interpretive theory of culture. In Geertz. C (ed), The Interpretation of Cultures. New York: Basic Books.

Gerrish, C (1990) Fumbling along. Nursing Times 86, 35-37

Gerrish, C (2000) Still fumbling along: a comparative study of the transition from student to staff nurse. Journal of Advanced Nursing 32, 473-480.

Gibbs, T. Brigdon, D. Hellenberg, D. (2004) The education versus training and the skills versus competency debate. <u>SAFam Pract</u>: 45 (10)

Gibson, J.J. (1979) <u>The Ecological Approach to Visual Perception</u>. Harvard, MA: MIT Press.

Giddens, A. (1991) <u>Modernity and Self Identity: self and society in the new modern age</u>Cambridge:Polity,

Gilham, B. (2000) <u>Case Study Research Methods. Real World Research</u>. London: Continuum.

Gill, J. Johnson, P. (1991) <u>Research Methods for Managers</u>.London, Paul Chapman.

Gillon, R(1992) <u>Philosophical Medical Ethics.</u> Chichester, John Wiley

Girot, E. A. (1993) Assessment of Competence in Clinical Practice – a review of the literature. <u>Nurse Education Today </u>13, 83 -90

Glaser, B. (1978) <u>Theoretical Sensitivity.</u> Mill Valley, CA: Sociology Press.

Glaser, B. Straus, A. <u>The Discovery of Grounded Theory: Strategies For Qualitative Research.</u> Aldine, Chicago.

Glass, A, Higgins, K. McGregor, A. Delivering Work Based Learning. <u>The Scottish Executive</u> (2002)

Goleman, D. (1995) <u>Emotional Intelligence.</u> Bantam Books

Goleman, D. (1996) <u>Emotional Intelligence: Why It Can Matter More Than IQ.</u> Bantam Books.

Goleman, D (1998) <u>Working with emotional</u> intelligence.London: Bloomsbury.

Goleman, D. Boyartzis, R. McKee. (2006) <u>The New Leaders: transforming the art of leadership into the science of results. London: </u>Little, Brown

Gomm, R. Hammersley,M. Foster, P.(2000) <u>Case Study Method</u>. Sage Publications.

Gonczi, A, Hager, P. Athanasou. J (1993) <u>The Development of Competency Based Assessment in the Professions. </u>National Office of Overseas Skills Recognition Research Paper No 8, Canberra, Australian Government Publishing Service.

Gopee, N (2001) Lifelong learning in nursing: perceptions and realities. <u>Nurse Education Today</u>, 21 (8) p607-615

Gopee, N (2002) Human and Social Capital as facilitators of lifelong learning in nursing. <u>Nurse Education Today</u>, 22, p608 – 616.

Gray, D. (2001) <u>A Briefing on Work-based Learning</u>. Assessment Series 11, Learning and Teaching Support Network.

Gray, D, Cundell, S, Hay, D O'Neill, J. (2004) <u>Learning through the workplace: a guide to work-based learning</u>. Cheltenham:Nelson Thomas,

Greene, M. T & Puetzer, M. The value of mentoring: A strategic approach to retention and recruitment. <u>Journal of Nursing Care Quality</u>. 17(1), 63 – 70.

Greenwood, J. (1994) Action research: a few details, a caution and something new. <u>Journal of Advanced Nursing,</u> 20, 13 -18

Greer, S. (1990) On the selection of problems, In Bynner, J. and Stribley. K. (eds) <u>Social Research: Principles and Procedures.</u> Harlow: Longman

Guba, E.G. LincolnY.S. (1989) Fourth Generation Evaluation. NewburyPark, CA:Sage.

Hamilton, D(1994) Traditions, Preferences and Postures in Applied Qualitative Research in Denzinn & Lincoln,<u>Handbook of Qualitative Research</u>. Ca: Sage

Hand, H. The mentors tale: a reflexive account of semi – structured interviews. <u>Nurse Researcher</u> Volume 10, 3, p 15 – 27.

Haffer, A. (1986) Facillitating Change. <u>Journal of Business Administration</u>.16 (4) 18 -22

Hakim, C (1987) Case Studies. In Bulmer, M. <u>Contemporary Social Research13. Research Design Strategies and Choice in the Design of Social Research</u>. London, Allen & Unwin.

Hart, G. Rotem, A. (1994) The best and the worst: student's experiences of clinical education.<u>Australian Journal of Advanced Nursing.</u> 1994 Mar-May;11(3):26-33.

Hart, E. Bond, M. (1995) <u>Action Research for Health and Social Care: a guide to practice</u>. Open University Press.

Harrington, H.A. Theis, E.C. Institutional factors perceived by baccalaureate graduates as influencing their performance as staff nurses. <u>Nursing Research</u> 17, 228- 235

Health Care Commission (2005) <u>National Staff Survey.</u> Health Care Commission

Hewison, J. Dowswell,,T. Millar, B (2000) Changing patterns in training provision in the National Health Service: an overview, in Coffield F. (ed) <u>Differing Visions of a Learning Society</u>, Vol 1: Policy Press. 167 - 197

Higginbotham, N. Albrecht, G. Connor, L. (2001) Health Social Science: <u>A Transdisciplinary and Complexity Perspective.</u> Oxford, Oxford University Press.

Hinds, PS. et al (1990) Further assessment of a method to estimate reliability and validity of qualitative research.<u>Journal of Advanced Nursing</u> 15, 430 – 435.

Hodgkinson, H.L (1957) Action Research: a critique. In Kemmis et al (eds) <u>The Action research Reader, 2nd edition</u> (1982) Australia, Deacon University Press.

Hofstede, G. (1980) <u>Culture's Consequences: International differences in work-related values,</u>Beverley Hills: Sage,.

Hofestede, G. (1998) Attitudes, Values and Organizational Culture,: disentangling the concepts, <u>Organizational Studies</u>, 19, 3, 497-493.

Holloway, I. Wheeler, S. (1996) <u>Qualitative Research for Nurses</u>. Oxford, Blackwell.

Holter, I.M. Schwartz–Barcott (1993) Action Research: what is it? How has it been used and how can it be used in nursing? <u>Journal of Advanced Nursing</u>. 18, 298 – 304

Howe, K.R. (1988) Against the quantitative- qualitative incompatability theory: or dogmas die hard. <u>Educational Researcher</u>, 19, 10 -16

Huffington, James & Armstrong, (2003) What is the emotional cost of distributed leadership. In Huffington, C. Armstrong, D (2003<u>) Working below the surface: The emotional life of organizations</u>. Tavistock Clinic Series

Hull and East Yorkshire Hospitals NHS Trust. (2003) <u>The Nursing and Midwifery Strategy</u>. unpublished

Hunter C, K Spence, K McKenna, R Iedema (2008) Learning how we learn: an ethnographic study of neonatal intensive care. Journal of Advanced Nursing<u>.</u> 62, 6:657-664.

Hurst , S. Koplin –Baucum, S (2003) Role acquisition, socialisation and retention. Unique aspects of a mentoring program. <u>Journal for Nurses in Staff development</u>. 19(4), 176 -180.

Imison, C. Buchan, J. Xavier, S (2009) NHS <u>Workforce Planning: Limitations and possibilities</u>. Kings Fund.

James. W(1907).Pragmatism: <u>A new name for some old ways of thinking</u>**.** New York: Longman Green and Co

Jarvis, P. (2007) <u>Globalisation, Lifelong Learning and the Learning Society: Sociological perspectives</u>. Routledge.

Jones, M, (1997) Thinking nursing. In Thorne, S.E. Hayes, V.E.<u>Nursing Praxis: knowledge and action, chapter 8. Thousand Oaks California: Sage</u>

Jung, C.G. ([1921] 1971). <u>*Psychological Types*, Collected Works</u>, Volume 6, Princeton, N.J.: Princeton University Press.

Kahn. R.L. Wolfe, D.M, Quinn, R.P. et al. (1964) <u>Organisational Stress, studies in role conflict and ambiguity.</u> New York, Wiley.

Kant.,I (1999) <u>Critique of pure reason. (The Cambridge Edition of the Works of Immanuel Kant in Translation)</u> Guyer, P, Wood A. (editors). Cambridge University Press

Kemmis, S. (1982) <u>The Action Research Reader, 2nd edition</u>. Australia, Deacon University Press.

Kemp, J. (1989) <u>Nursing at Night.</u> Unpublished M.Phil. thesis. University of Hull.

Kendal, E. Lissauer, R. (2003) <u>The Future Health Worker</u>. The Institute for Public Policy Research.

Kennedy, I (2001) <u>The report of the public Enquiry into Children's Heart Surgery at the Bristol Royal Infirmary 1984 -1995. Department of Health</u>

Kikkala, I . Munnukka, T. (1994) Nursing Research: on what basis. Journal of Advanced Nursing 19, 320 - 327.

Kitzinger, J. (1994) Introducing Focus groups. In Mays, N. Pope, C. Qualitative Research in Health Care. London, British Medical Journal Publishing Group.

Knight, S. (1998) A study of the 'lived, experience of change during a period of curriculum and organisational reform in a department of nurse education. Journal of Advanced Nursing, 27, 1287 – 1295

Knight, S. Ayer, S, Joyce, L. Nightingale, V. (1996) Defining a Model for Team Leader Development. Nurse Education Today 16, 309-315

Koskinen, K., Pihlanto, P. and Vanharanta, H. (2003), Tacit knowledge acquisition and sharing in a project work context, International Journal of Project Management, 21, 281-290.

Kramer, M. (1974) Reality shock – why nurses leave nursing. St Louis, MO, C.V.Mosby,

Kreuger, R.A. (2008) Focus Groups: A practical guide for applied research. Sage, Newbury Park, California.

Kvale, (1996) Interview: an introduction to qualitative research. London, Sage.

Lam, L. Kirby, S.(2002) Is emotional intelligence an advantage? An exploration of emotional and general intelligence on individual performance. Journal of Social Psychology 142 (1) 133-143.

Lauri, S. (1982) Development of nursing process through action research. Journal of Advanced Nursing. 7, 301- 307.

Lathlean, J. (1994) Choosing an appropriate methodology in Buckeldee, J and McMahon, R. (eds) The Research experience in nursing. London, Chapman and Hall, pp31 – 46.

LaSala, C; Bjarnason, D. (2012) Creating workplace environments that support moral courage. The Online Journal of Issues in Nursing Vol. 15, No 3, Manuscript 4.

La Valle, I. Finch, S. (1999) Pathways in Adult Learning; summary.Sheffield: Department for Education and Employment.

Lave, J. Wenger, E. (1991) Situated Learning: Legitimate Peripheral Participation. Cambridge University Press.

Levitt – Jones, T. Fitzgerald, M. (2005)   A Review of Graduate Nurse Transition programmes in Australia. Australian Journal of Advanced Nursing. Vol 25, no 2, p40 – 45

Levinson, H (1962) Men, management and mental health, Cambridge MA; Harvard University press.

Lewin, K (1946) Action Research and Minority Problems in G.W. Lewin (ed) Resolving Social Conflicts: Selected Papers on Group Dynamics by Kurt Lewin. New York, Harper and Brothers.

Lesser, E.L. Storck, J. (2001) Communities of Practice and organisational performance.

Lincoln, Y. Guba, E. (1985) Naturalistic Enquiry. London, Sage.

Lincoln, Y. Guba, E. (2000) The only generalization is: there is no generalization. In Gomm, Hammersley and Foster (2000) Case Study Method; key issues, key texts. Sage publications

Lindeman, E. C. (1926) *The Meaning of Adult Education*, New York: New Republic. Republished in a new edition in 1989 by The Oklahoma Research Center for Continuing Professional and Higher Education.

Logue, A.W. Smith, E. Rachlin, H. (1988) Research on self control: an integrating framework. Behavioural and Brain Sciences.Cambridge University Press

Lotmark, A. Smide, B. Wikblad, K.(2006) Competence of newly graduated nurses – a comparison of the perceptions of qualified nurses and students.Journal of Advanced Nursing, Vol 53 isue6 pg 721-789

Lyon, J. (1999) Applying Hart and Bond's typology: implementing clinical supervision in an acute setting.Nurse Researcher, Vol 6, No 2, p39-53

Maatsch, J.L. (1990) Linking competency to assessment tests in Willis, S.L. and Dubin, S.S. (eds) The Experience of Learning. San Francisco, Jossey Bass

Macintosh, J. Hautman, M.A.. (2003) Reworking professional nursing identity/ Commentaries and Responses. Western Journal of Nursing Research, Vol25, issue 6p725.

Madjar, I. McMillan, M. Sharke, R, et al. (1997) Report of the Project to Review and Examine Operations of Beginning Registered Nurses in the Workforce. Sydney: Nurses Registration Board of New South Wales.

Mantzoukas, S. The inclusion of bias in reflective and reflexive practice. Journal of Research in Nursing (2005). Vol 10 (3) 279 -295.

Marsick, V. Watkins, K. (1990) Informal and Incidental Learning in the Workplace. Routledge, London.

Marrow, C (1998) Keeping above the surface in an action research study. Nurse Researcher Vol 6, no 2, p 57-70

Marton, F. Ramsden, P. What does it take to improve learning?, in P. Ramsden (ed.) Improving learning: New Perspectives. London: Kogan Page.

Mathers, N. Huang, Y.C. (1998) Evaluating methods for collecting data in published research. In Crookes, P. Davies, S. (eds) Research into Practice. Bailierre Tindall

Matthews, J.H. Candy, P.C. New dimensions in the dynamics of learning and knowledge. In Boud, D. Garrick, J. (1999) Understanding Learning at Work. London and New York:Routledge.

Maxwell, J.A, (1996) Qualitative Research Design: An Interactive Approach. Thousand Oaks, California.

Mays, N. Pope, C (2000) Qualitative research in health care : assessing quality in qualitative research. British Journal of Medicine 320: 50 – 52

McCaugherty, D. (1991) The theory – practice gap in nursing education: its causes and possible solutions: Findings from an action research study. Journal of Advanced Nursing,16: 1055 – 1061.

McQueen, A. (2004) Emotional intelligence in nursing work. Journal of Advanced Nursing, 47 (1): 101-108

McNiff, J. (1988) Action research: Principles and Practice.Basingstoke, Hampshire, Macmillan,.

McNiff, J.(1996) You and your Action Research Project. London, Hyde

McNiff, J.(2002) You and your Action Research Project 3rd edition. www.jeanmcniff.com/booklet.asp . Last accessed 4/4/2013.

Melia, K.M. (1987) Learning and Working: the occupational socialisation of nurses.London,Tavistock.

McSherry, R. Pearce, P. Tingle, J. (2002) Clinical Governance: a guide for health professionals Oxford: Blackwell

Menzies, I.E.P.(1960) A case study in the functioning of social systems as a defence against anxiety: a report on a study of the nursing service in a general hospital. Human Relations, 13, 95 – 121

Mercer, J (2007) The challenges of insider research in educational institutions: wielding a double-edged sword and resolving delicate dilemmas. Oxford Review of Education, 2007, 33 (1) p 1-17

Merrell, J. Williams, A. (1995) Beneficence, respect for autonomy and justice: principles in practice. Nurse Researcher Vol 3, No 1, September, 1995

Merton.K, Fiske, M, Kendall, P.L. (1956) The focused interview. Glencoe IL. Free Press.

Merton, R. (1972) Insiders and outsiders; a chapter in the sociology of knowledge. *American Journal of Sociology,* 78(July), 9-47.

Messick, S. (1984) The psychology of educational assessment. Journal of Educational Measurement. 21, 215-238

Meyer, J.E. (1993) New paradigm research in practice: the trails and tribulations of Action Research. Journal of Advanced Nursing. 18, 1066 – 1072.

Meulenbergs, T. Verpeet,E. Schotsmann, P. Gastmans, C. (2004) Professional codes in a changing nursing context: literature review. Journal of Advanced Nursing, 2004 May: 46(3): 331-6

Miles, M.B. Huberman, A.M. (1994) Qualitative Data Analysis: An Expanded Sourcebook. California, Sage.

Miller, D. Hogan, J. Pringle, S. West, G. (1998) Credit where credit's due. The report of the accreditation of work-based learning project. SCOTVEC

Milligan, F.J.(1998) Defining and assessing competence: the distraction of outcomes and the importance of the educational process. Nurse Education Today 187 - 342, 25

Milton, C.L. (2004) The ethics of personal integrity in leadership and mentorship: a nursing theoretical perspective. <u>Nursing Science Quarterly</u>, 17 (2) 116 – 120.

Mitchell, J (2000) Case and situation analysis. In<u>Case study method: key issues, key texts</u> (eds Gomm, R, Hammersley, M , Foster, P) Sage, London 165 - 186

Mohr, W.K. (1995)Values, ideologies and dilemmas: professional and occupational contradictions. <u>Journal of Psychosocial Medicine</u>. 33(1), 29 -34

Morgan, G. <u>Images of Organisation.</u> Thousand Oaks, CA. Sage.

Morgan D.L. and Spanish M.T. (1984) 'Focus groups: a new tool for qualitative research', <u>Qualitative Sociology</u>, 7: 253-70

Montgomery, A. (1997) Recruiting – the ever present problem. <u>British Journal of Theatre Nursing</u> 7(9):1418.

Moseley, G.L. Mead, M.D. (2004) <u>Some considerations on biases in sampling</u>. Nurse Researcher, 12:1, 20 -34

Munhill & Boyd (1995) <u>Nursing Research: qualitative perspective.</u>New York,National League for Nursing Press.

Mustard, L. (2002) Caring and Competency. <u>JONA's Healthcare, Law, Ethics and Regulation</u> Volume 4(2) 36 – 43

National Audit Office (2009) <u>NHS Pay Modernisation in England: Agenda for Change.</u> The Stationary Office. London.

Nonaka, I. (1991) The Knowledge Creating Company<u>. Harvard Business Review</u>. July / August 1997 (reprint)

Nonaka, I. and Takeuchi, H. (1995), The Knowledge Creating Company. *:* How Japanese Companies Create the Dynamics of Innovation Oxford University Press, New York.

Northway, R. (2000) Disability nursing research and the importance of reflexivity. Journal of Advanced Nursing 32, 2391 – 397.

Norrie, P (2004) Expanding the case study: the narrative thread. <u>NT Research</u>, vol 9 no 4

Nursing and Midwifery Council (2010) <u>The Code: Standards of conduct, performance and ethics for nurses and midwives. London, NMC</u>

Nursing and Midwifery Council (2010)   Standards for pre-registration nursing education, London, NMC

Nursing and Midwifery Council (2006) NMC Circular 21/2006. Preceptorship Guidelines. London, NMC

Ogier, M. (1982) Ward Sisters and their influence upon learners. <u>Nursing Times Occasional papers</u> 77 (11): 41 – 43

Orton, D (1981) Ward learning Climate and the Student Nurse Response. Nursing Times (17) 65-68

O'Malley, C. Cunliffe, E. Hunter S. Breeze, J (2000) Preceptorship in Practice. Nursing Standard, 14, 28 p45 -49.

O'Shea, M. Kelly, B. (2007) The lived experience of newly qualified nurses on clinical placement during the first six months following registration in the Republic of Ireland. Journal of Clinical Nursing, Vol 16 p 1554

Otter, S. (1989) Student potential in Britain. Leicester, Unit for the Development of Adult Education.

Oxford Dictionary: 10th revised edition. Oxford University Press. 1999

Packard, J.S. Ferrara, M. In search of the moral foundation of nursing. Advances in Nursing Science, 10 (4), 60-71.

Padgett, D.K. (1998) Qualitative Research Methods in Social Work Research: Challenges and Rewards. Thousand Oaks, California.

Patton, M. (1987) How to use qualitative methods in evaluation. Sage Publications.

Patton, M (1990) Qualitative Evaluation and Research Methods. London, Sage

Paul, R.W. Heaslip, P. (1995) Critical Thinking and intuitive practice in nursing. Journal of Advanced Nursing, 22, 40-47.

Pearson, H.T. (1984) Competence : a normative analysis, in Short, E.C.(ed). Competence: Inquiries into its meaning and acquisition in educational settings. Lanhan, MD, University Press of America.

Polit, D.E. Hungler, B.P (1999) Nursing Research, Principles and methods. Philadelphia, PA; Lippincott.

Polit, D.E. Hungler, B.P (1993) Essentials of Nursing Research. Philadelphia, PA; Lippincott.

Polit, D.E., Beck, C.T, Hungler, B.P. (2001) Essentials of Nursing Research(5th edition) Philadelphia, Lippincott

Polyani, M (1967) The Tacit Dimension. New York, Doubleday

Proctor, S. (1998) Linking philosophy in the research process: the case for realism.Nurse Researcher, Vol 5 No 4, Summer 1998.

Putnam, R. (2001)Bowling Alone: the Collapse and Revival of American Community. Simon and Schuster Paperbacks.

Quinn, J.B. Intelligent Enterprise: A Knowledge and Service Based Paradigm for Industry, New York: The Free Press.

Rabiee, F. (2004) Focus –group interview and data analysis. Proceedings of the Nutrition Society, 63, 655 -660.

Raelin, J.A. Work based learning: The new frontier of management development. Prentice Hall, Englewood Cliffs,NJ.

Rapaport, R.N. (1970)Three dilemmas in action research. Human relations, 23(6), 499-513

RCN, (2004). The Future Nurse. London, Royal College of Nursing

Richardson, R (1995) Humpty Dumpty: Reflection and reflective nursing practice. Journal of Advanced Nursing, 21, 1044-1050

Reason, P (1988) <u>Human Inquiry in Action: Developments in New Paradigm Research</u>. Sage, London.

Robson, C. (1993) Real World Research: A Resource for Social Scientists and Practitioner Researchers. Oxford Blackwell Publishing.

Robson, C. (2002) <u>Real World Research: A Resource for Social Scientists and Practitioner Researchers (2nd edition).</u> Oxford Blackwell Publishing.

Runciman, P. (1990) Competency – based education and the assessment and accreditation of work based learning in the context of project 2000 programmes of nurse education: a literature review

Rousseau, D. (1990) New hire perceptions of their own and their employer's obligations: A study of psychological contracts. <u>Journal of Organisational Behaviour.</u>Vol 11, 389-400.

Rousseau, D. (1995) Psychological contacts in organisations, understanding written and unwritten agreements. London, Sage.

Ryan, Sharon and O'Connor, Rory (2012) *Social interaction, team tacit knowledge and transactive memory: empirical support for the agile approach.* In: <u>Researching Agile development of Information Systems (RAISE) Conference, 11 Oct 2012,</u> London, UK.

Sackett. J.E. Wenberg, J,E (1997). Choosing the best research design for each question. <u>BMJ,</u> Dec 20, 315(7123) p1636

Salovey, P. Grewal, D. (2005) The Science of Emotional Intelligence. <u>Current Directions in Psychological Science,</u> Vol 14, number 6, 281 -285

Salovey, P.&Mayer, J.D. (1990) "Emotional intelligence".<u>Imagination, Cognition, and Personality</u>, 9, 185-211

Salvage J (2002) <u>Rethinking Professionalism</u>: The First Step for Patient
Focused Care? www.ippr.org

Scally, G. Donaldson, I.J. (1998) Clinical Governance and the drive for quality Improvement in the new NHS in England. <u>BMJ</u>.317: 61-5

Schalk, R. Freese , C. (1993) New Trends in organisational behaviour, Vol 4. Chichester, John Wiley.

Schon, D. A. (1983).<u>The Reflective practitioner.</u> London,Temple Smith.

Schön, D. A. (1987) <u>Educating the reflective practitioner</u>.San Francisco, Jossey- Bass

Schroder, H.M. <u>Managerial Competence: the key to excellence</u>. Iowa Kendall/Hunt

Schuller, T. Watson, D.(2009) <u>Learning Through Life: Inquiry into the future for lifelong learning</u>. National Institute of Adult Continuing Education.

Schwandt, T.A. (2000) Three epistemological stances for qualitative enquiry: Interpretivism, Hermeneutics and Social Constructionism. In Denzin, N. Lincoln, Y (editors) <u>Handbook of Qualitative Research.</u> Sage Publications.

Seagraves, L. Osborne, N. Neal. P. (1996) <u>Learning in Smaller Companies, Final Report</u>, University of Sterling.

Shipman, M.D. (1988) The limitations of social research, 3rd edition, London, Longman

Shore, L.M. Shore, T.H. (1995) Perceived organizational support and organizational justice. In Cropanzano, R. Kacmar, K. (eds) Organizational politics, justice and support: managing the social climate of the workplace. Estport, Quorum books.

Short, E.C. (1984) 'Gleanings and possibilities' in Short, E.C. (ed) Competence: Inquiries into its meaning and acquisition in educational settings. Lanhan, MD, University Press of America.

Skills for Health. (2003)National workforce competence framework guide for coronary artery disease. Bristol: Skills for Health

Slevin, E. Sines, D. (2000) Enhancing the truthfulness, consistency and transferability of a qualitative study: utilising a manifold of approaches. Nurse Researcher Vol 7 No 2.

Smith, M. (2004) Lifelong learning, http://www.infed.org/lifelonglearning/b-life.htm. Last accessed 12/04/2011

Snelson, C.M., Martsolf, D.S, Dieckman, B.C. Anaya, E.R, Cartechine, K.A, Miller, B. (2002) Caring as a theoretical perspective for a nursing faculty mentoring program. Nurse Education Today, 22, 654 – 660.

Spouse, J. (2001) Work-based Learning in Healthcare Environments. Nurse Education in Practice. 1, 12-18.

Stake, R.E., Trumbell, D.J. (1982) Naturalistic Generalisations. Review Journal of Philosophy and Social Science, 7, 1-12

Stake, R.E. (1995) The Art of Case Study Research. Thousand Oaks, Sage

Stake, R, E (2000 a) Case Studies. In Denzin, N.K. and Lincoln, Y.S.Handbook of Qualitative Research.2nd edition, p 435 - 454. Sage Publications.

Stanley, L (1990) Feminist Praxis. London, Routledge Press.

Stasser, G., Vaughan, S. I., & Stewart, D. D. (2000), Pooling unshared information: The benefits of knowing how access to information is distributed among members.Organization Behavior and Human Decision Processes, 82, 102-116.

Stevens, J (2010) How to Step Up a Gear. In The Clock is Ticking. Health Service Journal Supplement, 9 December 2010

Stewart, D. Shamdasani, P.N. (1990) Focus Groups: theory and Practice. Newbury Park, California: Sage

Strauss, A. Corbin, J. (1990) Basics of Qualitative Research: Grounded theory Procedures and techniques. Sage Publications

Susman, G. Evered, R (1978) An assessment of the scientific merits of action research. Administrative Science Quarterly.Vol 23, p582 – 600

Swanson, J.M. (1986) The Formal Qualitative Interview for Grounded Theory. In Chenitz, C.C. Swanson. J.M. From Practice to Grounded Theory: qualitative research in nursing. Addison Wesley. California, pp 66 - 78

The General Council of the Bar (2010) Appointment as Queens Council. Appendix A - Competency Framework Bar Council website accessed October 5th, 2010

Thorne, S.E. (1997) Praxis in the Context of Nursing's Developing Inquiry. In Thorne, S.E. Hayes, V.E. (1997) Nursing Praxis: Knowledge and Action. Sage Publications.

Toffler, A, (1990) Powershift; Knowledge; Wealth and Violence at the Edge of the 21st Century. New York, Bantam Books

Tsoukas, H. (2003), Do we Really Understand Tacit Knowledge? In M. Easterby-Smith, M.Lyles (Eds.), The Blackwell Handbook of Organizational Learning and Knowledge Management, Massachusetts, Blackwell, pp. 410-427.

United Kingdom Central Council (1999) Fitness for Practice. London, UKCC

Vaishnavi, V. Keuchler, W. (2009) Design Research in Information Systems AIS. Site updated 20 August, 2009. Accessed 20 February, 2011.

Vygotsky, L.S. (1978) Mind in Society: The development of higher psychological processes. Cambridge MA: Harvard University Press

Wain, K. Philosophy of lifelong education, London: Croom Helm

Wallis, S (1998) Changing practice through action research. Nurse Researcher vol 6 No 2, 5 – 15 Winter 1998/1999.

Watkins, M. (2000). Competency for nursing practice. Journal of Clinical Nursing 9, 338 – 346.

Watson, R (2002) Clinical Competence: Starship Enterprise or Straitjacket, Nurse Education Today. 22, 476 - 480.

Watson, R. Stimpson. A, Topping, A. Porock, D. (2002)Clinical competence assessment in nursing: a systematic review of the literature. Journal of Advanced Nursing 39 (5), 421-431

Weick, K (1995) Sense making in Organizations. Thousand Oaks California and London, Sage publications

Wenger, E. McDermott, R. Snyder, W. (2002) Cultivating Communities of Practice. Harvard Business School Press., Boston Massachusetts

Wenger, E. (2006) Communities of Practice: a brief introduction.
http://www.ewenger.com/theory/communities_of oractice_intro.htm accessed 30th January, 2011

West, J. (2007) Ethical issues and new nurses: Preventing ethical distress in the work environment. Kansas Nurse.Vol 82, (4) p5 – 8.

Wenger, E. (2011) Communities of practice in and across 21- century organisations Sitios.ites.mx accessed15 October, 2012.

Wetherill, M. Taylor, S. Yates, S. Discourse as data: a guide for analysis. Sage Thousand Oaks, CA.

While, A. Competence versus performance: which is more important. Journal of Advanced Nursing, 20, 525 – 531.

Whyte, F.W (1984) Learning from the Field: a guide from experience. Sage Publications. P 443)

Whyte, F.W. (1991) Participatory Action Research, Sage publications

Wittgenstein, L (1953) Philosophical investigations. Oxford: Blackwell.

Wolfensperger- Bashford, C. (2002) Breaking in orthopaedic nurses: Preceptorship for novice nurses. Orthopaedic Nursing May / June 2002, Vol 21, issue 3, p14 -20

Zhang, Z. Luk, W. Arthur, D. Wong, T. (2001) Nursing Competencies: personal characteristics contributing to effective nursing performance. Journal of Advanced Nursing, Vol. 33: 467 – 474.

Yeaxlee, B.A. (1929) Lifelong Education. London: Cassell.

Yin, R (1994) Case Study Research: design and methods,2nd edition.Thousand Oaks California Sage

Yin, R (2009) Case Study Research: design and methods. 4th edition.Thousand Oaks California, Sage

Appendices

30. The following illustration demonstrates what could be possible by adopting the skills escalator approach.

The skills escalator approach	
Category	**Means of career progression**
Socially excluded individuals with difficulties in obtaining employment	Six month employment orientation programmes to develop basic understanding of the world of work.
The unemployed	Six month placements in 'starter' jobs, rotating into different areas of work, whilst undertaking structured training and development.
Jobs/roles requiring fewer skills and less experience Cleaning, catering, portering, clerical etc	Skills modules to support progression through job rotation training and development programmes including NVQs and NHS LAs, appraisal and personal development planning.
Skilled roles Healthcare assistants, other support staff	Modules of training and development through NVQs or equivalent vocational qualifications.
Qualified professional roles Nurses, therapists, scientists and junior managers	First jobs/roles following formal pre-registration education or conversion courses. Appraisal and personal development planning to support career progression. Achievement of a range of skills acquired at staged intervals.
more advanced skills and roles Expert practitioners, middle managers, training and non-training medical roles/graces	Further progression, supported and demonstrated through learning and skills development as above. Flexible working and role development encouraged in line with service priorities and personal career choices.
'Consultant' roles Clinical and scientific professionals, senior managers	Flexible 'portfolio careers' for newly appointed, experienced and supervising roles, planned in partnership with employers informed by robust appraisal, career and personal development planning processes.

Department of Health, Working Together – Learning Together, p18

Job Title: **Nurse (Qualified)**

Job Statement:
1. To provide planned nursing care for patients and their families
2. To assist in the management and organisation of work as required

Factor	Relevant Job Information	JE Level
Communication & Relationship Skills	Communicating complex & sensitive information, co-operation required & sometimes there are barriers to understanding Receives sensitive information concerning patient's medical condition, requires persuasive, reassurance skills. Some patients have special needs/learning disabilities	4
Knowledge, Training & Experience	Expertise within a specialism underpinned by theory Professional/clinical knowledge acquired through state registration	5
Analytical & Judgemental Skills	Range of facts or situations requiring analysis & comparison of a range of options Judgements on problems requiring investigation, analysis e.g. assessment of patient condition and suitability for discharge	3
Planning & Organisational Skills	Straightforward activities & plans Organises own time and that of junior staff and learners	2
Physical Skills	Highly developed physical skills where accuracy is important Dexterity and accuracy required for intravenous injections, syringe pumps and infusions; insertion of urinary catheters; removal of sutures.	3(b)
Responsibility for Patient/Client Care	Develops programmes of care Assesses, plans, implements & evaluates clinical care of patients	5(a)
Responsibility for Policy/Service Development	Follows policies determined by others Professionally responsible for adherence to Trust policies and procedures	1
Responsibility for Financial & Physical Resources	Little responsibility/responsible for patient valuables/maintains stock control/ Personal duty of care/handles patient valuables/orders supplies when necessary/signs agency time sheets	1/2(a) (c) (d)
Responsibility for Human Resources	Responsible for providing day to day co-ordination of staff/practical training Allocates and checks work of staff on ward/clinical supervision of junior staff	2(a) (b)
Responsibility for Information Resources	Little or no responsibility Maintains patient records	1
Responsibility for Research & Development	Little or no responsibility/occasionally/regularly undertakes R&D activity/clinical trials Rarely involved/occasionally/regularly undertakes R&D activity/clinical trials	1/2(a) (b)
Freedom to Act	Is guided by precedent , protocols & codes of conduct Works within codes of practice & professional guidelines	3
Physical Effort	Occasional/Frequent, light/moderate weights for several short/long periods per shift Walks, stands most of shift/Pushes and pulls trolleys & commodes; kneels and crouches to dress wounds/manoeuvres patients	2-4
Mental Effort	Frequent concentration, predictable/unpredictable work Concentration checking documents; calculating drug dosages for infusions; constant interruptions and demands	2(a)/3(a)
Emotional Effort	Occasional/frequent distressing/highly distressing Dealing with distressed relatives/care of terminally ill; deals with consequences of illness/terminal illness	2-4(b)
Working Conditions	Frequent unpleasant, occasional/frequent highly unpleasant working conditions Smell, noise, dust/body fluids, faeces, vomit, emptying bed pans and urinals, catheter bags (daily).	3(a), (b) 4(b)
JE Score/Band	JE Score 340 - 390	Band 5

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The NHS Knowledge and Skills Framework (NHS KSF) and the Development Review Process

OVERVIEW OF THE NHS KNOWLEDGE AND SKILLS FRAMEWORK

Dimensions	Level Descriptors			
CORE	1	2	3	4
1 Communication	Communicate with a limited range of people on day-to-day matters	Communicate with a range of people on a range of matters	Develop and maintain communication with people about difficult matters and/or in difficult situations	Develop and maintain communication with people on complex matters, issues and ideas and/or in complex situations
2 Personal and people development	Contribute to own personal development	Develop own skills and knowledge and provide information to others to help their development	Develop oneself and contribute to the development of others	Develop oneself and others in areas of practice
3 Health, safety and security	Assist in maintaining own and others' health, safety and security	Monitor and maintain health, safety and security of self and others	Promote, monitor and maintain best practice in health, safety and security	Maintain and develop an environment and culture that improves health, safety and security
4 Service improvement	Make changes in own practice and offer suggestions for improving services	Contribute to the improvement of services	Appraise, interpret and apply suggestions, recommendations and directives to improve services	Work in partnership with others to develop, take forward and evaluate direction, policies and strategies
5 Quality	Maintain the quality of own work	Maintain quality in own work and encourage others to do so	Contribute to improving quality	Develop a culture that improves quality
6 Equality and diversity	Act in ways that support equality and value diversity	Support equality and value diversity	Promote equality and value diversity	Develop a culture that promotes equality and values diversity

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Dimensions	Level Descriptors			
HEALTH AND WELLBEING	**1**	**2**	**3**	**4**
HWB1 Promotion of health and wellbeing and prevention of adverse effects on health and wellbeing	Contribute to promoting health and wellbeing and preventing adverse effects on health and wellbeing	Plan, develop and implement approaches to promote health and wellbeing and prevent adverse effects on health and wellbeing	Plan, develop, implement and evaluate programmes to promote health and wellbeing and prevent adverse effects on health and wellbeing	Promote health and wellbeing and prevent adverse effects on health and wellbeing through contributing to the development, implementation and evaluation of related policies
HWB2 Assessment and care planning to meet health and wellbeing needs	Assist in the assessment of people's health and wellbeing needs	Contribute to assessing health and wellbeing needs and planning how to meet those needs	Assess health and wellbeing needs and develop, monitor and review care plans to meet specific needs	Assess complex health and wellbeing needs and develop, monitor and review care plans to meet those needs
HWB3 Protection of health and wellbeing	Recognise and report situations where there might be a need for protection	Contribute to protecting people at risk	Implement aspects of a protection plan and review its effectiveness	Develop and lead on the implementation of an overall protection plan
HWB4 Enablement to address health and wellbeing needs	Help people meet daily health and wellbeing needs	Enable people to meet ongoing health and wellbeing needs	Enable people to address specific needs in relation to health and wellbeing	Empower people to realise and maintain their potential in relation to health and wellbeing
HWB5 Provision of care to meet health and wellbeing needs	Undertake care activities to meet individuals' health and wellbeing needs	Undertake care activities to meet the health and wellbeing needs of individuals with a greater degree of dependency	Plan, deliver and evaluate care to meet people's health and wellbeing needs	Plan, deliver and evaluate care to address people's complex health and wellbeing needs
HWB6 Assessment and treatment planning	Undertake tasks related to the assessment of physiological and/or psychological functioning	Contribute to the assessment of physiological and/or psychological functioning	Assess physiological and/or psychological functioning and develop, monitor and review related treatment plans	Assess physiological and/or psychological functioning when there are complex and/or undifferentiated abnormalities, diseases and disorders and develop, monitor and review related treatment plans
HWB7 Interventions and treatments	Assist in providing interventions and/or treatments	Contribute to planning, delivering and monitoring interventions and/or treatments	Plan, deliver and evaluate interventions and/or treatments	Plan, deliver and evaluate interventions and/or treatments when there are complex issues and/or serious illness
HWB8 Biomedical investigation and intervention	Undertake tasks to support biomedical investigations and/or interventions	Undertake and report on routine biomedical investigations and/or interventions	Plan, undertake, evaluate and report biomedical investigations and/or interventions	Plan, undertake, evaluate and report complex/unusual biomedical investigations and/or interventions
HWB9 Equipment and devices to meet health and wellbeing needs	Assist in the production and/or adaptation of equipment and devices	Produce and/or adapt equipment and devices to set requirements	Design, produce and adapt equipment and devices	Design, produce and adapt complex/unusual equipment and devices
HWB10 Products to meet health and wellbeing needs	Prepare simple products and ingredients	Prepare and supply routine products	Prepare and supply specialised products	Support, monitor and control the supply of products

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Dimensions	Level Descriptors			
ESTATES AND FACILITIES	**1**	**2**	**3**	**4**
EF1 Systems, vehicles and equipment	Carry out routine maintenance of simple equipment, vehicle and system components	Contribute to the monitoring and maintenance of systems, vehicles and equipment	Monitor, maintain and contribute to the development of systems, vehicles and equipment	Review, develop and improve systems, vehicles and equipment
EF2 Environments and buildings	Assist with the maintenance and monitoring of environments, buildings and/or items	Monitor and maintain environments, buildings and/or items	Monitor, maintain and improve environments, buildings and/or items	Plan, design and develop environments, buildings and/or items
EF3 Transport and logistics	Transport people and/or items	Monitor and maintain the flow of people and/or items	Plan, monitor and control the flow of people and/or items	Plan, develop and evaluate the flow of people and/or items

Dimensions	Level Descriptors			
INFORMATION AND KNOWLEDGE	**1**	**2**	**3**	**4**
IK1 Information processing	Input, store and provide data and information	Modify, structure, maintain and present data and information	Monitor the processing of data and information	Develop and modify data and information management models and processes
IK2 Information collection and analysis	Collect, collate and report routine and simple data and information	Gather, analyse and report a limited range of data and information	Gather, analyse, interpret and present extensive and/or complex data and information	Plan, develop and evaluate methods and processes for gathering, analysing, interpreting and presenting data and information
IK3 Knowledge and information resources	Access, appraise and apply knowledge and information	Maintain knowledge and information resources and help others to access and use them	Organise knowledge and information resources and provide information to meet needs	Develop the acquisition, organisation, provision and use of knowledge and information

Dimensions	Level Descriptors			
GENERAL	**1**	**2**	**3**	**4**
G1 Learning and development	Assist with learning and development activities	Enable people to learn and develop	Plan, deliver and review interventions to enable people to learn and develop	Design, plan, implement and evaluate learning and development programmes
G2 Development and innovation	Appraise concepts, models, methods, practices, products and equipment developed by others	Contribute to developing, testing and reviewing new concepts, models, methods, practices, products and equipment	Test and review new concepts, models, methods, practices, products and equipment	Develop new and innovative concepts, models, methods, practices, products and equipment
G3 Procurement and commissioning	Monitor, order and check supplies of goods and/or services	Assist in commissioning, procuring and monitoring goods and/or services	Commission and procure products, equipment, services, systems and facilities	Develop, review and improve commissioning and procurement systems
G4 Financial management	Monitor expenditure	Coordinate and monitor the use of financial resources	Coordinate, monitor and review the use of financial resources	Plan, implement, monitor and review the acquisition, allocation and management of financial resources
G5 Services and project management	Assist with the organisation of services and/or projects	Organise specific aspects of services and/or projects	Prioritise and manage the ongoing work of services and/or projects	Plan, coordinate and monitor the delivery of services and/or projects
G6 People management	Supervise people's work	Plan, allocate and supervise the work of a team	Coordinate and delegate work and review people's performance	Plan, develop, monitor and review the recruitment, deployment and management of people
G7 Capacity and capability	Sustain capacity and capability	Facilitate the development of capacity and capability	Contribute to developing and sustaining capacity and capability	Work in partnership with others to develop and sustain capacity and capability
G8 Public relations and marketing	Assist with public relations and marketing activities	Undertake public relations and marketing activities	Market and promote a service/organisation	Plan, develop, monitor and review public relations and marketing for a service/organisation

The scope of the NHS KSF is extremely broad – it covers the roles and functions of all staff in the NHS. To make it useful as a tool for individual review and development, the dimensions, levels and examples of application which are most relevant to specific posts have to be selected. This is done through the development of NHS KSF post outlines.

A post outline based on the NHS KSF will be developed in partnership for every post in the NHS. NHS KSF post outlines set out the actual requirements of a post in terms of the knowledge and skills that need to be applied when that post is being undertaken effectively. **Outlines must reflect the requirements of the post – not the abilities or preferences of the person who is employed in that post. They must be developed in partnership by people who understand the requirements of the post concerned.**

Every NHS KSF post outline must include an appropriate level from each of the six core dimensions, to which will be added a number of specific dimensions. There is no limit to the

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Hart & Bond's Action Research Typology

Consensus model of society
Rational social management

←———————————————————————————————→

Conflict model of society
Structural change

AR type Distinguishing Criteria	Experimental	Organisational	Professionalising	Empowering
1. Educative base	Re-education	Re-education/training	Reflective practice	Consciousness-raising
	Enhancing social science/administrative control and social change towards consensus	Enhancing managerial control and organisational change towards consensus	Enhancing professional control and individual's ability to control work situation	Enhancing user-control and shifting balance of power; structural change toward pluralist
	Inferring relationship between behaviour and output; identifying causal factors in group dynamics	Overcoming resistance to change/restructuring balance of power between managers and workers	Empowering professional groups; advocacy on behalf of patients/clients	Empowering oppressed groups
	Social scientific bias/researcher focused	Managerial bias/client focused	Practitioner focused	User/practitioner focused
2. Individuals in groups	Closed groups, controlled, selection made by researcher for purposes of measurement/inferring relationship between cause and effect	Work groups and/or mixed groups of managers and workers	Professional(s) and/or (interdisciplinary) professional group/negotiated team boundaries	Fluid groupings, self selecting or natural boundary or open/closed negotiation
	Fixed membership	Selected membership	Shifting membership	Fluid membership
3. Problem focus	Problem emerges from the interaction of social science theory and social problems	Problem defined by most powerful group; some negotiation with workers	Problem defined by professional group; some negotiation with users	Emerging and negotiated definition of problem by less powerful group(s)
	Problem relevant for social science/ management interests	Problem relevant for social science/ management interests	Problem emerges from professional practice/experience	Problem emerges from members' practice/experience
	Success defined in terms of social science	Success defined by sponsors	Contested, professionally determined definitions of success	Competing definitions of success accepted and expected
4. Change intervention	Social science, experimental intervention to test theory	Top-down, directed change towards predetermined aims	Professionally led, predefined, process led	Bottom-up, undetermined, process-led
	Problem to be solved in terms of research aims	Problem to be solved in terms of management aims	Problem to be resolved in the interests o research-based practice and professionalisation	Problem to be explored as part of process of change, developing an understanding of meanings of issues in terms of problem and solution
5. Improvement and involvement	Towards controlled outcome and consensual definition of improvement	Towards tangible outcome and consensual definition of improvement	Towards improvement in practice defined by professionals and on behalf of users	Towards negotiated outcomes and pluralist definitions of improvement: account taken of vested interests
6. Cyclical process	Research components dominant	Action and research components in tension; action dominated	Research and action components in tension; research dominated	Action components dominant
	Identifies causal processes that can be generalised	Identifies causal processes that are specific to problem context and/or can be generalised	Identifies causal problems that are specific to problem and/or can be generalised	Change course of events; recognition of multiple influences upon change
	Time limited, task focused	Discrete cycle, rationalist, sequential	Spiral of cycles, opportunistic, dynamic	Open-ended, process driven
7. Research relationships, degree of collaboration	Experimenter/respondents	Consultant/researcher, respondent/participants	Practitioner or researcher/collaborators	Practitioner researcher/co-researchers/co-change agents
	Outside researcher as expert/research funding	Client pays an outside consultant – 'they who pay the piper call the tune'	Outside resources and/or internally generated	Outside resources and/or internally generated
	Differentiated roles	Differentiated roles	Merged roles	Shared roles

Local Research Ethics Committee letter of approval to conduct research

HULL AND EAST RIDING LOCAL RESEARCH ETHICS COMMITTEE **NHS**

Room C24
College House
Willerby Hill Business Park
WILLERBY
HU10 6NS
Phone: 01482 335814
Fax: 01482 335813
e-mail: louise.carrison@herch-tr.nhs.uk

Mr. S Knight
Nursing Directorate
Alderson House
Hull Royal Infirmary
Anlaby Road, Hull
HU3 2JZ

5 April 2004

Dear Mr Knight,

LREC/ 03/04/042
Protocol number: Development of a Framework to enable an Incremental approach to Competency and Role Development for Registered Nurses

The Chair of the Hull and East Riding REC has considered the amendments submitted in response to the Committee's earlier review of your application on 15th March 2004 as set out in our letter dated 18th March 2004. The documents considered were as follows:

- Your letter dated 30th March 2004 addressing the concerns of the committee
- Informed Consent form as requested at the earlier review
- Revised Information leaflet version 2 dated 29th March 2004

The Chair, acting under delegated authority, is satisfied that these accord with the decision of the Committee and has agreed that there is no objection on ethical grounds to the proposed study. I am, therefore, happy to give you the favourable opinion of the committee on the understanding that you will follow the conditions set out below.

Conditions

- You do not undertake this research in an NHS organisation until the relevant NHS management approval has been gained as set out in the Framework *for Research Governance in Health and Social Care.*

- You do not deviate from, or make changes to, the protocol without prior written approval of the REC, except where this is necessary to eliminate immediate hazards to research participants or when the change involves only logistical or administrative aspects of the research. In such cases the REC should be informed within seven days of the implementation of the change.

- You complete and return the standard progress report form to the REC one-year from the date on this letter and thereafter on an annual basis. This form should also be used to notify the REC when your research is completed and in this case should be sent to this REC within three months of completion.
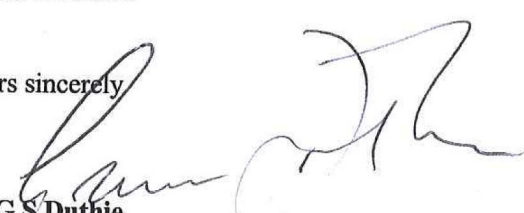
Hull and East Riding Local Research Ethics Committee Members

	Mr M Davidson	Dr CJ Brophy	Dr A Innes	Mrs E Dakkak	Dr D Horton
Mr GS Duthie Chair	Cllr K West	Mrs H Thornton-Jones	Dr L Cawkwell	Dr I Markova	Mrs S Floyd
	Mrs H Williams	Ms F Ashton	Mrs J Wild	Mrs F Shepherd	

An advisory committee to North and East Yorkshire and Northern Lincolnshire Strategic Health Authority

- If you decided to terminate this research prematurely you send a report to this REC within 15 days, indicating the reason for the early termination.

- You advise the REC of any unusual or unexpected results that raise questions about the safety of the research.

Yours sincerely

Mr G S Duthie
Chair of the Hull and East Riding REC

| LREC/ 03/04/042 | **Please quote this number on all correspondence** |

Subject Information Leaflet

INFORMATION LEAFLET

DEVELOPMENT OF A FRAMEWORK TO ENABLE AN INCREMENTAL APPROACH TO

COMPETENCY AND ROLE DEVELOPMENT FOR REGISTERED NURSES.

We wish to invite you to take part in a research study. Before you decide whether to do so please read the following information carefully and discuss it with your friends, relatives and colleagues if you wish. Please ask if there is anything that is not clear or if you would like more information.

What is the purpose of this study

You will have been made aware of the Systematic Training and Education for Practice programme (STEP's) which is being introduced in the clinical area in which you work. In brief STEPs is designed to assist nurses to attain and demonstrate acquisition of competencies required by nurses in clinical practice (NHS Knowledge and Skills Framework, 2003). STEPs is structured in a way that is intended to provide direction for continuous learning and to assist nurses to build upon existing skills and knowledge in an incremental fashion. The purposes for conducting this research project are to:

a)   refine the STEPs framework in light of feedback form programme participants regarding content and implementation process.

b)   elicit how this approach to competency development is viewed by programme participants and the wider nursing team in which they work.

c)   Conduct an initial qualitative assessment of the effectiveness of the STEP's framework in preparing individuals to achieve specified practice competencies.

Why have I been invited.

As you are working in an area where STEPs is being implemented you are in a good position to inform the team developing the is framework regarding it's strengths, weaknesses, potential for possible improvements and effects on the ward team. The research project will be conducted over the next 12 months. During this time the researchers and participants, like yourself, will work together to evaluate, make and implement changes to the programme and re-evaluate in order to determine a worthwhile development programme tailored to meet the needs of individuals and the clinical areas in which they are working.

We hope that you will accept this opportunity to positively influence the direction of development for newly qualified staff in order to continue to improve standards of care for future patients.

What do I have to do.

If you choose to participate you will be asked to keep a reflective diary which captures your thoughts and feelings about your development into your new role over time. You may wish to capture your thoughts on a particular experience or critical incident at that time or to make entries at other times to reflect on your overall experience over the period since your last entry. If you accept this invitation you should agree to make an entry at least every 2 weeks over the over the next 12 months. The diaries will be reviewed periodically by the researchers to establish similarities/differences in perceptions between participants in the participating clinical areas.

You will also be interviewed three times during this period. The first interview will be at the outset of the STEPs programme and then at 6 and 12 months after that. The interviews should last no longer than 30 minutes.

Do I have to take part.

No. Non – participation in the research component of the project will not preclude any new member of staff from undertaking the STEPs programme or any learning opportunities arising from it. However, we hope that you will seriously consider participating in this study as the effectiveness of the programme and its future development is dependent on evaluation, feedback and refinement, which can only be achieved through active involvement of willing participants.

Are there any risks involved

None

Are there any costs involved

None

Confidentiality

All information or data pertaining to you will be anonomisedfor access only by the research team. Study data will be stored on a database, on the principal researcher's personal computer, specifically designated for the purpose of this study and will be password protected. Data pertaining to this study will be deleted two years following the release of the written report.

INFORMED CONSENT

An Incremental approach to continuing professional development for registered nurses

NAME OF LOCAL LEAD RESEARCHER: Stephen Knight

SUBJECT ID :

Please initial box

1   I confirm that I have read and understand the information sheet dated March 2021 (version 2) for the above study and have had the opportunity to ask questions.

2   I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, without affecting my right to access the STEPs programme.

3   I agree to take part in the above study.

Name of Subject   _____

Date   Signature

Name of Person taking consent   _____

Date   Signature

Witness   _____

Date   Signature

1 copy for subject; 1 for researcher

New Registrant Respondents (pseudonyms) and constitution of focus groups.

Interviewees Name (Pseudonym)	Age range	Qualification	Unit
Paula	22-25	BSc Nursing	Neurosurgery
Karen	22-25	BSc Nursing	Neurosurgery
Cheryl	22-25	Ad.Dip. Nursing	Neurosurgery
Melanie	25 - 30	Ad.Dip. Nursing	Neurosurgery
Eve	22-25	Ad.Dip. Nursing	Neurosurgery
Sandra	25 - 30	BSc Nursing	Neurosurgery
Chris	+40	Ad.Dip. Nursing	High Dependency
Susan	25-30	Ad.Dip. Nursing	High Dependency
Ray	22-25	BSc Nursing	High Dependency
Hayley	+40	BSc Nursing	High Dependency
Linda	22-25	Ad. Dip Nursing	High Dependency
Sharon	22-25	Ad.Dip. Nursing	Urology
Janet	+40	Ad.Dip. Nursing	Urology
Ian	30-40	BSc Nursing	Urology
Lucy	21-25	Ad. Dip Nursing	Urology
Ellie	25-30	Ad. Dip Nursing	Urology

Focus Groups Participants

Speciality	No	Qualification	Age Range	Years in the specialty
High Dependency	4	Ad. Dip Nursing (2) BSc Nursing (2)	25 -35 years	4 -9 years
Urology	3	Dip Nursing (2) Registered Nurse (1)	25 – 40 years	4 -15 years
Neurosurgery	8	Registered Nurse (5) BSc Nursing (3)	30 – 42 years	10 – 23 years

An example of the process of coding of interview transcripts and identification of one theme (Transition from student to staff nurse roles).

Open coding

Clinical Area	Examples of participant's statements	Open codes derived from participant's statements
Neurosurgery	A relative would ring and they (other staff) would say "I will just get the Staff Nurse". I was terrified. I would think 'oh that's me"	• Lack of confidence • Anxiety • Coping with the expectations of others
Neurosurgery	As a student you don't have any accountability so it is a hard transition to go through. From absolutely nothing and it doesn't matter to doing a full 12 hour shift it is all on your head and you go home crying at night.	• Accepting role change • Sudden awareness of responsibility. • Unable to switch off from work . • Coping with change
Neurosurgery	I didn't give my patient suppositories…I was absolutely devastated that I hadn't had time, that I hadn't made time	• omitted procedure • devastated • overstretched • prioritization of work
Neurosurgery	I had not given medicines rounds alone anywhere at all. When you go round with somebody (as a student) you haven't got time to look through every single thing and see what it does. They are sort of rushing through it all. Whereas on here I need to make sure that what I am giving is what it is meant to be, I need to know why	• Adequacy of preparation for conducting medicine rounds alone. • Lacking experience in medicine administration. • Concern for patients well being
Neurosurgery	It's when your patient's situation changes… so you do as much as you can but if you don't tell the doctor then it is on your head.	• Fear of getting things wrong / • concern for patient's well being. • Anxiety
Neurosurgery	I had a lady who deteriorated rapidly, a subarachnoid haemorrhage I think, she didn't get enough fluids in and deteriorated rapidly. If a staff nurse didn't check and get her sent to ICU she could have died ….I do not think I could live with that.	• Assessment skills • Recognising the deteriorating patient • Involvement of experienced staff. • Lack of experience with diagnostic group . • Accepting responsibility for own actions/inactions

Clinical Area	Examples of Participant's words	Open codes
Urology	Sometimes the pressure of the workload you are given is too much. The stress levels on a busy day are like nothing I could ever of imagined. People say 'ooh you should come and ask' (for help) but there isn't really anybody to ask because they are really busy as well.	• Feels overstretched • Anxiety • Feeling vulnerable • Accepting responsibility
Urology	They used to go on about it a lot at university (accountability). You are prepared for it but it is just a bit of a shock to the system when you do have to do it for yourself.	• Reality check • Realisation of responsibility • Shock
Urology	With some of the more poorly patients I just feel out of my depth. Sometimes I feel I needed more support as I did not have enough knowledge to look after a patient properly for what they needed	• Lack of confidence in own ability • Lack of experience with diagnostic group . • anxiety • Lack of confidence
Urology	Just knowing all the responsibility you have when you have got your PIN number. I don't think anything prepares you for when you are out there and you are no longer supernumerary. You just have to deal with things. You are out there on your own really	• Awareness of responsibilities post registration. • Dealing with things. • Feeling isolated
Urology.	The most daunting thing for me was at handover to be given 6 patients, maybe 8 patients and you are on your own. I'd just think I have got to take care of these patients.	• Daunting Workload • Responsibility for delivering care • Working alone • Everyone busy / reluctant to ask for help
Urology	Before I qualified I thought going from a student to a staff nurse. I was like …how am I going to do that. Asking doctors things, as a student I was so petrified and nervous about doing it. But when I put on the uniform it felt right. I fitted in and feel that I am doing okay.	• Confidence • Fitting in

Clinical Area	Examples of Participant's words	Open codes
High dependency	Some things you are fine with on the clinical skills side of things but it is having the clinical judgement. They (lecturers) didn't challenge us with a module that gives us scenarios or get you to thinking well that's not right, and so what do you do.	• Assessment skills not developed adequately before registration. • Analysing situations • Experience in recognising abnormalities lacking. • Weighing up options
High dependency	I was more terrified after that (supernumerary period). I still am. I still get like that. Sometimes, some days I feel like I am flying by the seat of my pants and I am winging it. That's how I feel.	• Increased anxiety following • Flying by the seat of one's pants
High dependency	I became stressed. I was taking my work home with me. I was going in early coming home late and it was getting beyond a joke	• Anxiety • Inability to shut off thinking about work
High dependency	Just so scary…people just saw me and said, "oh you are a staff nurse you must know". They saw me dressed as a staff nurse and doctors and others just assumed… and I thought please be gentle as I am just getting my head around things.	• Anxiety • No clear identification of new registrant status on uniform • Feeling vulnerable • Lacking confidence

Axial coding (Clustering of open codes to identify higher order categories)

Examples of related open codes	Axial codes
Anxiety. Devastated Fear of getting things wrong. Vulnerability. Reality shock. Daunted. Inability to shut off from work.	**Stress**

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Sudden awareness of responsibility. Concern for patients well being. Awareness of responsibilities post registration. Dealing with things. Accepting responsibility for own actions/inactions.	**Accountability**
Assessment skills not developed adequately before registration. Experience in recognising abnormalities lacking. Involvement of experienced staff. Analysing situations. Weighing up options.	**Decision making**
Recognising the deteriorating patient. Adequacy of preparation for conducting medicine rounds alone. Lacking experience in medicine administration. Lack of experience with diagnostic group. Experience in recognising abnormalities lacking.	**Knowledge and skills**
No clear identification of new registrant status on uniform. Confidence / lack of confidence. Accepting role change. Coping with the expectations of others. Fitting in.	**Role identity**
Overstretched. Flying by the seat of one's pants. Working alone. Everyone busy / reluctant to ask for help. Responsible for delivering care to group of patients. Prioritisation of work problematic.	**Workload**

Identification of the theme 'Transition from student to staff nurse roles' derived throughintegration of axial codes

Axial codes	Theme
Stress Accountability Decision making Knowledge and skills Role identity Workload / time management	**Transition from student to staff nurse roles**

ANALYSIS OF FOCUS GROUP INTERVIEWS

Extracts from focus group interview notes with examples of opencoding.

Neurosurgical Focus Group	Open codes
Junior nurses on ward had developed decisionmaking skills at one level as they knew when to refer a problem onto more senior nurses or medical staff for advice. Band 6s recognise that further help could be given in relation to developing assessment skills and would explore potential for using *roleplay*, developing *scenarios*. They also recognized that improvement of their own documentation would help junior nurses to understand how they arrived at decisions. STEPs content more detailed and in depth than expected. Junior nurses have high expectations of themselves. Junior nurses often required reassurance even though they were safe and coping well. Specialist Nurse has interest in clinical decision making and has previously done literature search which she will share with colleagues The group felt that it was necessary to ensure that junior nurses used such devices as protocols, policies and benchmarks such as Essence of Care to inform decisions Any development framework should include clinical application of knowledge and practical skills. Band 6 right level for supervisor due to experience and this leads to consistency of support and assessment but one Band 6 nurse said " we should stop and listen to what junior nurses are saying' Group agreed that there is potential for input by experienced Band 5 nurses and more thought should be given to this	Juniors know when support advice needed. Support needed to develop assessment skills. Teaching methods. Improved documentation needed to aid tacitknowledge transfer. Lack of awareness of new registrants knowledge levels. Supervisor development Junior nurses have high expectations of themselves. New registrants need frequent reassurance. New registrants practice is safe Availability of evidence based decision making literature Evidence based decision making. Skills and knowledge development. Praxis Identification of appropriate supervisor Realization that junior nurses have concerns about supervision Consideration of alternative approaches to supervision
High Dependency Focus Group	**Open codes**
Raised time element as crucial factor in success of programme. Identified the university CAP document as time consuming. This led to discussion on the role of the supervision of qualified staff as opposed to unqualified staff & Students and the professional responsibility of	Time Time pressures due tomultiple supervisory responsibilities

individual registered staff. Possibility of rotas being managed to ensure that supervisor /supervisee work together on a regular an frequent basis Possibility of rotating to nights with supervisor.	Supervisory arrangements
Group aware that some new staff feel that their decision making skills needed developing as this was not adequately addressed in training. This related to.	Confidence lacking in relation to decision making identifying potential/real problems and taking appropriate & timely action Decision making comes with experience
Approach taken to implementation - several approaches = All supervisors given participant pack prior to receiving supervisor pack – aim = to identify expected level of achievement of participants and check own knowledge	Preparation of supervisors
Each Element of STEP 1 assigned to a unit lead to oversee education of unit content for all HDU	
Supervisors identified – obligations to students and non registered staff as onerous and therefore input with qualified staff could be difficult.	Preparation of unit /Continuing professional development
Supervisors recognised that new registrants lack confidence particularly regarding making decisions but believed felt that both of these issues naturally resolve over time. " everyone learns about decision making over time as they become more experienced". Assessment skills crucial to making right decisions	Time pressures Skills deficits acceptable for stage of career Skills and confidence issues resolve over time
Group consensus was the development of assessment skills was most important as without accurate assessment decisions were unlikely to meet patient need or situation.	Assessment skills crucial to decision making.
Group recognise that wearing scrubs resulted in medical and other transient staff expectations junior staff being unrealistic sometimes. This is anxiety provoking for some junior staff	New registrant status not identified to transient staff Unrealistic demands on new registrants by staff unaware of level of experience
Supervisors felt that sometimes new staff would work on those aspects of care and management that they were comfortable with but do not address the aspects of care that stretched/challenged them	Decision making improves with clinical experience New registrants tend to stay within their comfort zone. Some new registrants resist

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	exposure to new situations and opportunities for learning. Responsibility for personal development
Urology	**Open codes**
Difficulties in rostering to allow supervisors and supervisees to work together. Group member stated " working together is a big issue for us and not just about STEPs " Time management & workload hinders ability to address STEPs at work Group members felt involvement with STEPs renewed their awarenessof policies and roles and refreshes experienced staff on laws and evidence based practice. One group member claimed that completion of resuscitation element has refreshed her about policy and procedure for DNR and resuscitation procedure.	Rotas incompatible with supervision. Time. Workload. Improved knowledge of policies and procedures. Enhanced patient safety / competence and accountability
Identification as new staff nurse could help new registrants deal with embarrassment at lack of knowledge or information when approached by staff who are unaware of their junior status Time management and workload prioritisation could be useful inclusions to STEPs but group believe these abilities are addressed through practice and come with experience	Role conflict and identity Stress reduction Time management and prioritisation comes with experience
Group claim that geography of ward hinders ability of staff to work together and junior nurses become isolated in bays for extended periods without assistance or supervision. This is a particular issue where patients are or care needs are demanding Group state that night staff allocate patients for day staff and this is not always conducive to continuity of care or supervision of new staff.	Isolation Lack of supervision Patient safety Appropriate allocation of experienced staff to support junior nurses essential.

Example of identification of axial codes relating to specific theme (Transition from studentto staff nurse roles)

Open code	Axial code

New registrants have high expectation of themselves Junior nurses lack confidence Frequently need reassurance Junior nurses have concerns about supervision arrangements. Anxiety caused by new registrant status not beingidentified to transient staff Unrealistic demands on new registrants by staff unaware of theirlevel of experience Skills and confidence issues resolve over time.	**Stress**
Identifying potential/real problems and taking appropriate & timely action. Juniors know when support or advice is needed. New registrants tend to stay within their comfort zone Some new registrants resist exposure to new situations and opportunities for learning. Responsibility for personal development	**Accountability**
New registrants practice is safe. Juniors know when support or advice is needed. Assessment skills crucial to decision making. Decision making improves with clinical experience	**Decision making**
Skills deficits acceptable for stage of career Support needed to develop assessment skills. Improved documentation needed to aid tacit knowledge transfer. Skills deficits acceptable for stage of career Teaching methods Evidence based decision making literature	**Knowledge and skills development**
New registrant status not identified to transient staff. Unrealistic demands on new registrants by staff unaware of level of experience Lack of awareness of new registrants	**Role identity**

knowledge levels.	
New registrants time management and workload prioritisation Degree of supervision of expected to be provided for registered nurses unclear. Multiple supervisory responsibilities. Time management and prioritisation comes with experience.	**Workload / time management**

Example of original STEPs documentation of competency

Step 1 Practice	Core Competencies Element 1
	Resuscitation

Assessment Methodology: -   O   = Observation

Q   = Questioning

U   = Underpinning Knowledge/portfolio evidence

Outcome:

- Nurse to be knowledgeable re: the theoretical principles, which underpin adult Drug Administration
- Nurse can competently implement the theoretical principles within the clinical setting

Clinical Competency	Achieved		Index of Evidence	Supervisors
	Yes	No		Signature/Date
1.0 Nurse can discuss the following in the event of a cardiac/respiratory arrest: • Own role and responsibilities. • Role of other team members (nursing and medical staff).				
1.1 Nurse can, in relation to the clinical area, identify the following: • Location of Drug Administration trolley. • Method of summoning assistance in the event of a cardiac/respiratory				
1.2 Nurse can confidently locate the following on the Drug Administration trolley: • Emergency drug box • Cardiac Monitor/defibrillator • Intubation equipment				

• Intravenous access equipment • Suction Equipment				

1.3 Nurse can confidently demonstrate the use of the following equipment
 	
   • Suction
 	
   • Oxygen Bag and mask
 	
   • Cardiac monitor
 	
   • Setting up of defibrillator
   • Insertion of oropharyngeal & nasopharyngeal airway
 	
   • Pre - loaded syringes				

1.4 Nurse is able to state the signs and symptoms of a cardiac – respiratory arrest				
1.5 Nurse can discuss possible causes of a cardiac - respiratory arrest Reference should be made to the following - • Hypoxia • Hypovolaemia • Hypothermia • Hypo/hyperkalaemia • Thromboembolism • Tension pneumothorax • Tamponade • Toxicity – drug or metabolic				

Practitioner Self-Assessment Sheet

The following check sheet is designed for you to aid in recording your own perception of your developing competency against each element of STEP1. Simply tick each component that you feel you confident in fulfilling. The unshaded areas indicate the component parts of the element. When your supervisor agrees that your practice matches the standards/competencies for an element, he/she will sign the supervisor's progress report for each individual element.

Element	1	2	3	4	5	6	7	8
0.0								
0.1								
0.2								
0.3			▓					
0.4			▓					
0.5			▓					
0.6			▓					
0.7			▓					
0.8			▓					
0.9			▓					
0.10			▓					
0.11			▓					
0.12							▓	
0.13			▓				▓	
0.14	▓		▓		▓		▓	
0.15	▓		▓	▓	▓		▓	
0.16	▓		▓	▓	▓		▓	▓
0.17	▓		▓	▓	▓		▓	▓
0.18	▓		▓	▓	▓		▓	▓
0.19	▓		▓	▓	▓		▓	▓
0.20	▓		▓	▓	▓		▓	▓
0.21	▓		▓	▓	▓		▓	▓
0.22	▓		▓	▓	▓		▓	▓
0.23	▓		▓	▓	▓		▓	▓
0.24	▓		▓	▓	▓		▓	▓
0.25	▓		▓	▓	▓		▓	▓
0.26	▓		▓	▓	▓		▓	▓
0.27	▓	▓	▓	▓	▓		▓	▓
0.28	▓	▓	▓	▓	▓		▓	▓
0.29	▓	▓	▓	▓	▓		▓	▓

0.30	▓	▓	▓	▓	▓		▓	▓

Practitioner Self Assessment Sheet

Element	9	10	11	12	13	14 Part	14 Part	14 Part
0.0								
0.1								
0.2								
0.3								
0.4								
0.5								
0.6								
0.7								
0.8					▓			
0.9					▓			
0.10			▓		▓			
0.11			▓		▓			
0.12			▓		▓			
0.13			▓		▓			
0.14			▓		▓			
0.15			▓		▓			
0.16			▓		▓	▓		
0.17			▓		▓	▓		
0.18			▓		▓	▓		
0.19			▓	▓	▓	▓		
0.20			▓	▓	▓	▓		▓
0.21			▓	▓	▓	▓	▓	▓
0.22			▓	▓	▓	▓	▓	▓
0.23			▓	▓	▓	▓	▓	▓
0.24			▓	▓	▓	▓	▓	▓
0.25			▓	▓	▓	▓	▓	▓
0.26		▓	▓	▓	▓	▓	▓	▓
0.27		▓	▓	▓	▓	▓	▓	▓
0.28		▓	▓	▓	▓	▓	▓	▓
0.29		▓	▓	▓	▓	▓	▓	▓
0.30		▓	▓	▓	▓	▓	▓	▓

	Evidence of achievement
Step 1 Practice	

This page should be used to provide evidence of your achievement of competency in each element of STEP 1.

Performance Statements on Competency Achievements

Evidence should include the following:

- Your Role in achieving competency (ies): Observer, participant
- New Knowledge and skills acquired
- Application of experience gained
- Summary of how you have acquired new skills and knowledge

This evidence relates to element (State number and title of Element in box below)
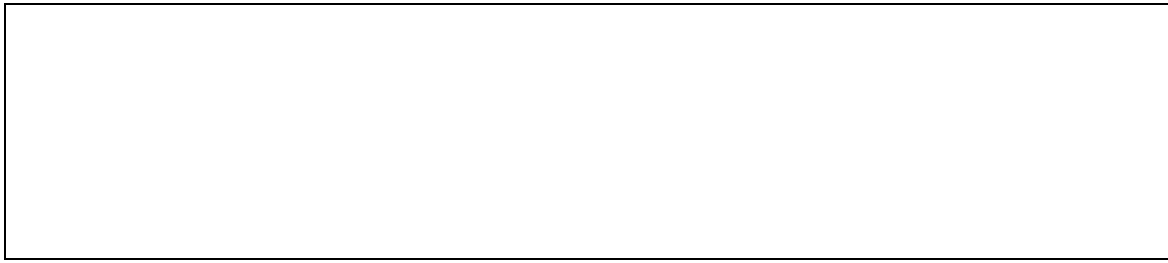
Date:_____

Supervisors Progress Report

Name of Practitioner: _____

	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec
Element 1												
Element 2												
Element 3												
Element 4												
Element 5												
Element 6												
Element 7												
Element 8												
Element 9												
Element 10												
Element 11												
Element 12												
Element 13												
Element 14												

When the supervisor agrees that the practice of the practitioner matches the standards/competencies for an element, he/she will sign date the supervisor's progress report for each individual STEP 1

STEPs element including NHS KSF mapping (New Registrant Pack)

Step 1 Practice	Core Competencies Element 1
	Resuscitation

Overview of Element

The primary objective of cardiopulmonary Resuscitation is to prevent irreversible cerebral damage due to anoxia by maintaining an Artificial Circulation. Respiratory and cardiac arrest may produce similar signs but there is one important difference: in a cardiac arrest there is No arterial pulse or other signs of circulation - In a respiratory arrest a pulse is present.

The basic technique involves the 10 second "ABC" Assessment followed by the initiation of Cardiopulmonary Resuscitation, when necessary/appropriate.

"Scram!"

Cardiopulmonary Resuscitation Training Requirements

A cardiac arrest is the most acute medical emergency faced by nursing staff.

The situation is frequently unexpected, and its successful management requires staff that are well trained and rehearsed in Cardiopulmonary Resuscitation.

Evidence based practice and technology in the field of Cardiopulmonary Resuscitation has improved. In the last few years, this has been reflected in an increase in the number of people successfully resuscitated. (Handley & Swain 1996)

However, Cardiopulmonary Resuscitation is often poorly performed if there is a lack of training and refresher courses (Gwinutt 1998)

Outcome Statement

This element is for the practitioner's development in regard to the theoretical principles, which underpin adult Resuscitation. The primary outcomes for this element are that the practitioner can competently implement the theoretical principles within the clinical setting.

Step 1 Practice	Core Competencies Element 1 Resuscitation

Source documents used in order to formulate competencies for this element:

The European Resuscitation Council Guidelines for cardiopulmonary resuscitation 2005.

Royal Marsden Manual of Clinical Procedures Chapter 8 Cardiopulmonary Resuscitation 5th edition (2000) Blackwell Science

Comprehensive Coronary Care Jowett & Thompson Scutari Press (1989) Chapter 11

http://intranet/resus/documentation.asp

Hull & East Yorkshire Hospitals NHS Trust – Resuscitation Service

The Resuscitation Service

Contacting the Department

To discuss booking or clerical issues call Peter Goodwin HRI 4971

To contact John Parks Resuscitation Manager at HRI telephone 4867

To contact Sally Waters Resuscitation Officer at HRI telephone 4970

To contact Neil Jennison Resuscitation Officer at CHH telephone 2493

The Trust's Resuscitation Department provides all Cardiopulmonary Resuscitation training. Information on how to access sessions is available via the trust's intranet Resuscitation website. There are numerous dates each year, this training is mandatory and must be accomplished every year.

The trust intranet website contains a plethora of information from the Resuscitation Department, examples below illustrate the value of visual as well as documentary information that is available: -

Now Available: Unsure what Crash Trolley Equipment looks like?

Photographs available on our new online learning page

Streaming videos:
Crash Trolley Suction equipment
Crash Trolley Suction equipment cleaning
Laryngoscope checks

New Crash Trolley check lists now available in the Document Store; these lists supersede all previous unused check lists.
http://intranet/resus/documentation.asp

Step 1 Practice	Core Competencies Element 1 Resuscitation

It is essential that you complete mandatory Resuscitation set training session BEFOREyou commence this element of your STEPs Programme.
This session should be booked at the time of corporate induction and must be completed within your first 3 months of employment, if you are in doubt your practice supervisor will arrange for you.
Components of the Resuscitation Study Day

This is especially designed for the ward based Registered Practitioner to enable them to build an action plan to use in the event of a cardiac arrest call. Other professions' i.e. ODA, ODP would also be eligible for this course.
Course includes:
Basic life support for the healthcare worker.
Chain of Survival
Resuscitation Council guidelines 2005
Airway adjuncts
Special circumstances
Resuscitation Trolley
Role of drugs
Safe defibrillation

Ethics of Resuscitation
Do Not Attempt Cardiopulmonary Resuscitation orders.
Simulated cardiac arrest
The Trust requires that all clinical staff attend annually for Resuscitation training.

<u>Record of attendance</u>

Resuscitation Study Day		Venue	Date(s)	Facilitator
Clinical update for Practitioner s & ODP's *Adult Resuscitation Study Day*				

Core / Specific	Number	Dimension	Second Gateway (Full Outline)	
			Level	Indicator
Core	C1	Communication	3	b, e, f
Core	C2	Personal And People Development	2	Not met in this element
Core	C3	Health, Safety And Security	2	c, d, e
Core	C4	Service Improvement	2	Not met in this element
Core	C5	Quality	2	b, c, e
Core	C6	Equality And Diversity	2	Not met in this element
Specific	HWB2	Assessment And Care Planning To Meet Health And Wellbeing Needs	3	a ,b, c, d, e, f, g
Specific	HWB5	Provision of care to meet health and wellbeing needs	3	b, c, d ,e ,f, g, h
Specific	HWB7	Interventions And Treatments	2	a, c, d, ,g
Specific	IK1	Information Processing	1	a, d, e
Specific	G6	People Management	1	Not met in this element

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STEP 1 Element 1 – Resuscitation provides examples of application for the following dimensions/indicators

Assessment Methodology: -   O   = Observation
                                  Q   = Questioning
                                  Ukn = Underpinning Knowledge/portfolio evidence

Outcome:
Practitioner to be knowledgeable re: the theoretical principles, which underpin adult resuscitation
Practitioner can competently implement the theoretical principles within the clinical setting

Clinical Competency	KSF Dimension	KSF Level	KSF Indicator
1.0 Practitioner can discuss the following in the event of a cardiac/respiratory arrest: Own role and responsibilities. Role of other team members (nursing and medical staff).	C 5 HWB 2 HWB 5 HWB 7	2 3 3 2	(b),c e b, d a
1.1 Practitioner can, in relation to the clinical area, identify the following: Location of resuscitation trolley. Method of summoning assistance in the event of a cardiac/respiratory	C 3 HWB 5	2 3	d e

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	HWB 7	2	(g)
1.2 Practitioner can confidently locate the following on the resuscitation trolley: Emergency drug box Cardiac Monitor/defib Intubation equipment Intravenous access equipment Suction Equipment	HWB 5 HWB 7	3 2	d (g)

Clinical Competency	KSF Dimension	KSF Level	KSF Indicator
1.3 Practitioner can confidently demonstrate knowledge in the use of the following equipment: Suction Oxygen Bag and mask Cardiac monitor Setting up of defibrillator Insertion of oropharyngeal & nasopharyngeal airway Pre - loaded syringes	HWB 5 HWB 7	3 2	c, d, f (g)
1.4 Practitioner is able to state the signs and symptoms of a cardiac - respiratory arrest.	C 3 HWB 2	3 3	e d

1.5 Practitioner can discuss possible causes of a cardiac - respiratory arrest Reference should be made to the following:- Hypoxia Hypovolaemia Hypothermia Hypo/hyperkalaemia Thromboembolism Tension pneumothorax Tamponade Toxicity – drug or metabolic	HWB 5	3	d
1.6 Practitioner can discuss the Normal complexes on an ECG recording in relation to the physiological function of the heart.	HWB 5	3	d

Clinical Competency	KSF Dimension	KSF Level	KSF Indicator
1.7 In relation to Basic Life Support the practitioner can discuss/demonstrate knowledge in relation to the following:- Main objective of Basic Life Support. Assessment of the patient's level of consciousness. Opening of airway Assessment of breathing Assessment of circulation Reference should also be made to the actions required at each of the above stages. Practitioner will also be required to provide supportive evidence with their Drug Administration passport	C3 HWB 2 HWB 5 HWB 7	2 2 3 2	c, d d, e, g c, d, e (g)
1.8 In relation to Advanced Life Support the practitioner can discuss/ demonstrate a knowledge in relation to the following:- Appropriateness of a Precordial Thump Pathway for management of asystole and PEA Pathway for the management of Ventricular Fibrillation/pulseless Ventricular Tachycardia. Reference should also be made to the actions required at each of the above stages	HWB 2 HWB 5 HWB 7	3 3 2	d, e, f, g c, d, e, f, g, h (g)

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Clinical Competency	KSF Dimension	KSF Level	KSF Indicator
1.9 Practitioner can discuss in detail the rationale for the use of the following drugs, which maybe used in a cardiac - respiratory arrest situation. Adrenaline (Epinephrine) Amiodarone Atropine Calcium - Chloride Sodium Bicarbonate.	HWB 5	3	d
1.10 Practitioner can discuss the treatment of an anaphylactic reaction.	HWB 5 HWB 7	3 2	d (g)
1.11 Practitioner can discuss and demonstrate what documentation needs to be completed following a cardiac arrest. Reference should be made to-	C 1 HWB 2 HWB 5	3 3 3	e f h

Nursing records Audit Form	HWB 7	2	d, (g)
	IK 1	1	(a), d, e

Clinical Competency	KSF Dimension	KSF Level	KSF Indicator
1.12 Practitioner can re-stock the crash trolley following an arrest Reference should be made to:- Obtaining stock from the emergency drug cupboard out of hours	C 5 HWB 5	2 3	e c
1.13 Practitioner is aware of Hull and East Yorkshire Hospitals NHS Trust DNAR order. Reference should be made to the following:- The process for initiating a DNAR order.	C1 HWB 2 HWB 5 HWB 7 IK 1	3 2 3 3 1	b, e, f (c), d d, g, h a, b, c, d, e, f, (g) (a), d, e

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STEPs element including NHS KSF mapping (Supervisor Pack)

Step 1 Practice	Core Competencies Element 1 Resuscitation

Overview of Element

The primary objective of cardiopulmonary resuscitation is to prevent irreversible cerebral damage due to anoxia by maintaining an **Artificial Circulation.**

Respiratory and cardiac arrest may produce similar signs but there is one important difference: in a cardiac arrest there isNo arterial pulse or other signs of circulation - In a respiratory arrest a pulse is present.

The basic technique involves the **10** second **"ABC"** Assessment followed by the initiation of **Cardiopulmonary Resuscitation**, when necessary/appropriate.

"Scram!"

Cardiopulmonary Resuscitation Training Requirements

A cardiac arrest is the most acute medical emergency faced by nursing staff.

The situation is frequently unexpected, and its successful management requires staff that are well trained and rehearsed in Cardiopulmonary Resuscitation.

Evidence based practice and technology in the field of Cardiopulmonary Resuscitation has improved. In the last few years, this has been reflected in an increase in the number of people successfully resuscitated. (Handley & Swain 1996)

However, Cardiopulmonary Resuscitation is often poorly performed if there is a lack of training and refresher courses (Gwinutt 1998)

Outcome Statement

This element is for the practitioner's development in regard to the theoretical principles which underpin adult resuscitation. The primary outcomes for this element are that the practitioner can competently implement the theoretical principles within the clinical setting.

Step 1 Practice	Core Competencies Element 1 Resuscitation

Source documents used in order to formulate competencies for this element:

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It is essential that you complete mandatory resuscitation set training session **BEFORE** you commence this element of your STEPs Programme.

This session should be booked at the time of corporate induction and must be completed within your first 3 months of employment, if you are in doubt your practice supervisor will arrange for you.

Components of the Resuscitation Study Day

This is especially designed for the ward based Registered Practitioner to enable them to build an action plan to use in the event of a cardiac arrest call. Other professions' i.e. ODA, ODP would also be eligible for this course.

Course includes:

Basic life support for the healthcare worker.
Chain of Survival
Resuscitation Council guidelines 2005
Airway adjuncts
Special circumstances
Resuscitation Trolley
Role of drugs
Safe defibrillation
Ethics of resuscitation
Do Not Attempt Cardiopulmonary Resuscitation orders.
Simulated cardiac arrest
The Trust requires that all clinical staff attend annually for resuscitation training.

Record of attendance

Resuscitation Study Day	Venue	Date(s)	Facilitator

Clinical update for Practitioners & ODP's ***Adult Resuscitation Study Day***			

Step 1 Practice	Core Competencies Element 1 Resuscitation

Assessment Methodology: -   O   = Observation
                        Q   = Questioning
                        Ukn   = Underpinning Knowledge/portfolio evidence

Outcome:
Practitioner to be knowledgeable re: the theoretical principles, which underpin adult resuscitation
Practitioner can competently implement the theoretical principles within the clinical setting

Clinical Competency	Evidence
1.0 Practitioner can discuss the following in the event of a cardiac/respiratory arrest: Own role and responsibilities. Role of other team members (nursing and medical staff).	Please identify with your practitioner the location of the Crash Trolley within your clinical setting and method of summoning help (2222). Alert systems within the clinical setting - for example bedside call systems Roles and responsibilities of team the team and ward staff are identified in the Resuscitation Policy CP199
1.1 Practitioner can, in relation to the clinical area, identify the following: Location of resuscitation trolley. Method of summoning assistance in the event of a cardiac/respiratory	**Areas to be discussed:** As above or 2222 clinical alert systems Summoning help Obtaining Crash Trolley Implementing Basic Life Support Assisting with the implementation of advanced life support Checking of Resuscitation Trolley following completion of incident Completion of post arrest audit form

1.2 Practitioner can confidently locate the following on the resuscitation trolley: Emergency drug box Cardiac Monitor/defib Intubation equipment Intravenous access equipment Suction Equipment	Please observe practitioner locating equipment - use resuscitation trolley equipment checklist **-** (current trolley content lists can be located on the Hull & East Yorkshire Hospitals NHS Trust **Resuscitation Department** Intra net site. Pictures of equipment located on the crash trolley can be viewed on the Hull & East Yorkshire Hospitals NHS Trust **Resuscitation Department** Intra net site. **http://intranet/resus/documentation.asp**

Step 1 Practice	Core Competencies Element 1 Resuscitation

Clinical Competency	Evidence
1.3 Practitioner can confidently demonstrate knowledge in the use of the following equipment: Suction Oxygen Bag and mask Cardiac monitor Setting up of defibrillator Insertion of oropharyngeal & nasopharyngeal airway Pre - loaded syringes	Ensure that the practitioner is able to demonstrate the use of all the equipment listed. (Information with regards to the operation of the suction equipment can be found on the resuscitation department's intra net site). Ensure that the supervisee can demonstrate how to assess the required size of a nasopharyngeal and oropharyngeal airway and discuss how they would insert each of the above airways. A guide for choosing the correct size of a **Oropharyngeal Airway** is to place the airway beside the patient's mandible, orienting it with the flange at the **first incisor** and the tip at the angle of the jaw. The tip should reach the angle of the jaw. **Insertion** **-** While inserting the airway you want to avoid pushing the tongue into the posterior pharynx. This can be accomplished by starting

	with the curve of the airway inverted and then rotate the airway **180 degrees** as the tip reaches the posterior pharynx. If there are problems ventilating the patient after insertion of the airway then it should be removed and reinserted. **Nasopharyngeal airway** – tragus to tip of nose **Insertion** - in order to insert the nasopharyngeal airway it should be lubricated with a water-soluble lubricant or anaesthetic jelly. Insert airway along the floor of the nostril into the posterior pharynx behind the tongue. The tube is bevelled for insertion into the **Right** nostril. The tube maybe inserted into the left nostril, rotate into a medial position
1.4 Practitioner is able to state the signs and symptoms of a cardiac - respiratory arrest.	The patient may present with **ALL** or some of the following: Unresponsive Absence of pulse Change in skin: Colour Pallor Cyanosis

Step 1 Practice	Core Competencies Element 1 Resuscitation
Clinical Competency	**Evidence**
1.5 Practitioner can discuss possible causes of a cardiac - respiratory arrest Reference should be made to the following:- Hypoxia Hypovolaemia Hypothermia Hypo/hyperkalaemia Thromboembolism Tension pneumothorax Tamponade Toxicity – drug or metabolic	**Hypoxia**- there are many reasons why a patient may become severely hypoxic the most common being: Acute respiratory failure Airway difficulties Acute lung injury Severe anaemia Neuromuscular disorders For healthy cell metabolism the body requires a constant supply of oxygen. When this interrupted for more than **3**minutes in most situations (except where there is severe hypothermia) cell death occurs, followed by lactic acidosis and very rapidly a cardiorespiratory arrest. **Hypovolaemia**- becomes critical when the patient loses so much of their circulating volume that they have an inability to carry oxygen. This is because the **HAEM** molecule in the red blood cell has the affinity for oxygen and if the haemoglobin is reduced below **8 gl-dl** there will be an intolerable oxygen deficit at cellular level. The most common causes of severe blood loss are:- Trauma Surgical Procedure Gastrointestinal Mucosa erosion Oesophageal varices Peripheral vessel erosion (by tumour usually). Clotting abnormality

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	Clinical indicators:- Hypotension Cool peripheries Tachycardia **Treatment** - for hypovolaemia is to replace the volume with appropriate fluid - therefore if the patient has lost blood it is imperative that they receive blood - other colloid fluids e.g. plasma expanders can be used while waiting for blood, but only blood can carry oxygen and over transfusion with other fluids will dilute the red cells further and result in greater oxygen delivery problems. **Hypothermia**- is defined, as a drop in the core body temperature below **35 degrees Celsius** it maybe classified as:- Mild (32 - 35 degrees Celsius) Moderate (30 - 32 degrees Celsius) Severe (below 30 degrees Celsius).

Clinical Competency	Evidence
	When the core body temperature falls below approximately 30 degrees Celsius there is a resultant shift in the pH of the blood. This alteration in the pH severely effects cell metabolism and results in rapid progression to cell death and lactic acidosis. Such severe hypothermia is usually associated with being exposed to severe weather conditions or submersion/immersion. **Treatment** -is to warm the patient by using warming blankets (e.g. Bair -hugger) and the instillation of warm fluids into the abdomen as well as intravenously via a warming device especially designed for this purpose. **(H&EY Clinical Guidelines for Medical Emergencies CMP 0221 Section 5 Hypothermia) (appendix 1)** http://intranet/clinicalgovernance/Corporate_documents/Guidelines/0221.pdf **Hypo/Hyperkalaemia** - Because potassium is so closely linked with muscle and nerve excitation any imbalance will effect both the nervous conduction and the muscular working of the heart. Therefore a severe **FALL** or **RISE** in potassium can cause arrest arrythmias. Examples of the potential causes of Hyper/Hypokalaemia: Gastrointestinal fluid losses Renal/Endocrine disorders Drugs that affect cellular potassium Treatment for Hypokalaemia-the immediate treatment for hypokalaemia

	which has resulted in an arrest is the infusion of intravenous potassium as prescribed.
	Treatment for Hyperkalaemia - infusion of Calcium Chloride as prescribed.
	<u>Thromboembolism</u> - which maybe Fat or Air Embolism, Thrombus, Amniotic Embolism
	Treatment -Good quality cardiac compression may help dissipate or disperse obstruction.

Clinical Competency	Evidence
	Pneumothorax- A Pneumothoraxis the presence of air or gas in the **PLEURAL SPACE** caused by a rupture in the visceral pleura (which surrounds the lungs) or the **PARIETAL PLEURA** and the chest wall. As air separates the visceral and parietal pleurae, it destroys the negative pressure of the pleural space. This disrupts the state of equilibrium that normally exists between the elastic recoil forces of the lung and the chest wall. No longer held in check by the recoil forces of the chest wall, the lung fulfils its tendency to recoil by collapsing towards the **HILUS (McCance and Huether 1994)**

In a TENSION PNEUMOTHORAX the site of pleural rupture acts as a one way valve permitting air to enter on **Inspiration** but preventing its escape by closing up during expiration. As more and more air enters the pleural space, air pressure in the pneumothorax begins to exceed **Barometric pressure** (McCance and Huether 1994).
The pathophysiologic effects of a tension pneumothorax are life threatening because as the air pressure in the pleural space pushes against the already recoiled lung causing **Compression Atelectasis**
Which also pushes against the mediastinum, compressing and displacing the heart and great vessels (McCance and Huether 1994).

Common causes -
Trauma
Chronic Obstruction Pulmonary Disease.
Surgical Intervention (e.g. central line insertion)

Treatment - The immediate treatment is the insertion of an intra - venous

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cannula into the second intercostal space on the affected side by an individual skilled within this technique. As soon as the air is heard exiting through the cannula a formal intercostal drain should be inserted in the mid - axillary line on the affected side.

Tamponade -Cardiac Tamponade occurs when fluid accumulates in the pericardial space. Effusion fluid maybe blood or fluid secondary to injury/disease. Pressure exerted by the pericardial fluid causes compression of the chambers of the heart which will lead to eventual   decreased stroke volume and reduced cardiac output and possible life threatening circulatory collapse (McCance and Huether 1994).

Treatment - Aspiration of accumulated pericardial fluid by medical practitioner.

Step 1 Practice	Core Competencies Element 1 Resuscitation

Clinical Competency	Evidence
	Toxicity - Drug or Metabolic- In this case the heart or its control mechanism the (Central Nervous System) has been directly affected by a noxious stimulant. This toxin may be external or endogenous to the body. Examples of external toxins are drugs with therapeutic intent or recreationally. Internal toxins might be Lactic Acid, Diabetic Keto - Acidosis or thyrotoxicosis. **Treatment** -identify toxic substance, administration of antidote where possible to reverse the cause (information maybe obtained from the **UK National Poisons Information Service 0870 6006226**

1.6 Practitioner can discuss the Normal complexes on an ECG recording in relation to the physiological function of the heart.	
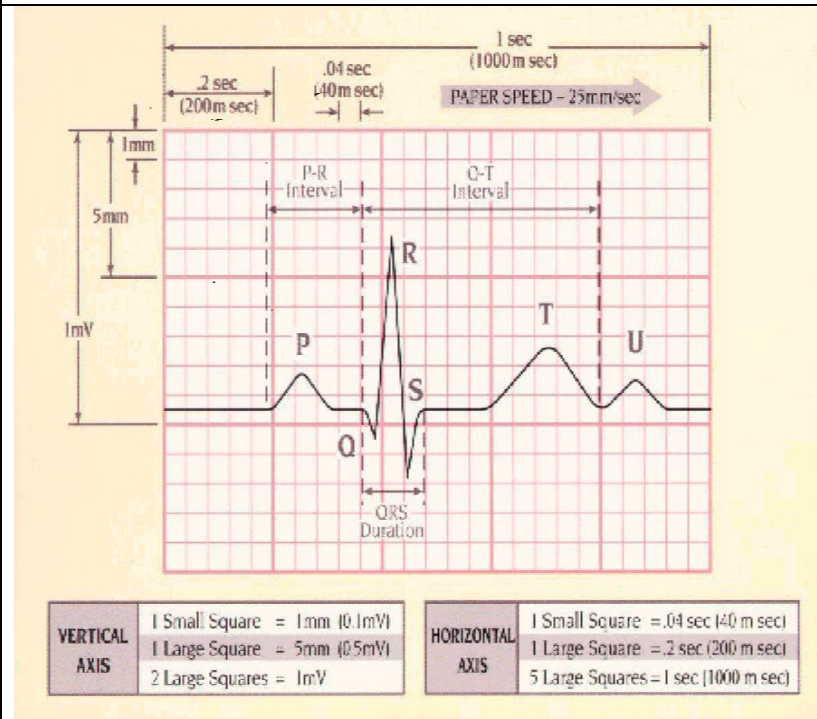
Normal E.C.G. Tracing as pictured above shows **5** waves, which by convention have been named **P, Q, R, S, and T.**

P Wave - arises from the Sinuatrial Node (SA Node) causing depolarisation of the atria.

QRS Complex - represents the very rapid spread of the impulse from the Atrioventricular node (AV Node) through the Atrioventricular Bundle of HIS causing depolarisation of the ventricles.

T Wave - represents the repolarisation of the ventricular muscle

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Clinical Competency	Evidence
1.7 In relation to Basic Life Support the practitioner can discuss/demonstrate knowledge in relation to the following:- Main objective of Basic Life Support. Assessment of the patient's level of consciousness. Opening of airway Assessment of breathing Assessment of circulation Reference should also be made to the actions required at each of the above stages. Practitioner will also be required to provide supportive evidence with their resuscitation passport	The main objective of CPR is to provide oxygen to the vital organs (brain, heart and Kidneys) until oxygenation returns or until definitive medical treatment (Advanced Cardiac Life Support) can be initiated. The lungs can withstand long periods of anoxia, although the heart and kidneys can survive for 30 minutes before irreversible ischaemic changes result. However, the neurons within the cerebral cortex undergo irreversible changes after 3 to 5 minutes (Heymans 1950) In an event of a cardiac arrest immediate initiation **of Basic Life Support** is Paramount. See appendix 2 for Basic Life Support Algorithm ensure that you discuss each element of the algorithm with the supervisee. **Opening of airway:** **Diagram 1 - Head Tilt & Chin Lift =** The head is tilted back by firm backward pressure on the patient's forehead with the palm of the hand. The fingers of the other hand are placed under the point of the Chin, to Lift and Open the Airway. **Diagram 2 - Jaw Trust =** Place your index and other finger behind the angle of the mandible, at the same position your thumbs to slightly open the mouth with a downward pressure.

Diagram 1

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Diagram 2

Step 1 Practice	Core Competencies Element 1 Resuscitation
Clinical Competency	**Evidence**
1.8 In relation to Advanced Life Support the practitioner can discuss/ demonstrate a knowledge in relation to the following: Appropriateness of a Precordial Thump Pathway for the management of **Shockable ryhthms** Pathway for management of **Non – shockable rhthyms** Reference should also be made to the actions required at each of the above stages.	It is appropriate to use the Pre cordial thump if the cardiac arrest is witnessed, recent and of brief onset. The patient must have been monitored at time of arrest – Resuscitation Council Guidelines 2005 See appendix 3a and 3b for the algorithms for shockable rhythms **Ventricular Fibrillation** and **PulselessVentricular Tachycardia** and non - shockable rhythms **Asystole and Pulseless Electrical Activity (P.E.A.).** Ensure practitioner is aware of what energy levels are required for: Defibrillation energy will be: 150 joules biphasic 360 joules monophasic Single shocks followed immediately by 2 minutes of basic life support is required before the rhythm is reassessed. Basic life support should only be interrupted if the patient shows signs of response.
1.9 Practitioner can discuss in detail the rationale for the use of the following drugs, which maybe used in a cardiac - respiratory arrest situation.	Adrenaline is an adjunct to Basic Life Support. Administration of adrenaline results in peripheral vasoconstriction which augments the effect of chest compression, leading to increased cerebral and coronary perfusion (Jowett & Thompson 1989).

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Adrenaline (Epinephrine) Amiodarone Atropine Calcium - Chloride Sodium Bicarbonate.	Amiodarone is an antiarhythmic agent used in broad complex and narrow complex arrythmias. Atropine alters vagal tone, increases the rate of discharge of the sinoatrial node and increases the speed of conduction through the atrioventricular node. Calcium - Chloride is a cell membrane stabilizer and is used for the treatment of Pulseless Electrical Activity when the cause is Hyperkalaemia, Hypocalcaemia or overdose of calcium channel blocking drugs. Sodium Bicarbonate is used in prolonged cardiac arrest when there is evidence of metabolic acidosis.

Step 1 Practice	Core Competencies Element 1 Resuscitation

Clinical Competency	Evidence
1.10 Practitioner can discuss the treatment of a anaphylactic reaction.	See appendix 4 for algorithm for the treatment of a anaphylactic reaction. Ensure you discuss each stage with your practitioner. Location of anaphylactic box HEY Trust Anaphylaxis guidelines
1.11 Practitioner can discuss and demonstrate what documentation needs to be completed following a cardiac arrest. Reference should be made to- Nursing records Resuscitation Report form	See appendix 5 for example of audit form. Care plan Medical notes
1.12 Practitioner can re-stock the crash trolley following an arrest Reference should be made to: Obtaining stock from the emergency drug cupboard out of hours.	Ensure that the supervisee is aware of how to access drugs and equipment from the emergency drug cupboard. Via 208/229 bleep holder

1.13 Practitioner is aware of Hull and East Yorkshire Hospitals NHS Trust DNAR order. Reference should be made to the following: The process for initiating a DNAR order. Patient & carer DNAR leaflet	Refer to Hull & East Yorkshire Hospitals NHS Trust CP199 `**Do Not Attempt Cardiopulmonary Resuscitation**.

HYPOTHERMIA

Definition

A core temperature of less than 35°C

Diagnosis

Measure rectal or tympanic temperature

Clinically important features

High index of suspicion for hypothermia in confused or moribund patients

When hypothermia is the primary diagnosis – there is usually an underlying

medical or traumatic problem that has reduced mobility and consequently precipitates hypothermia (e.g. CVA, #NOF)

Hypothermia with a GCS of less than 8/15 is a pre arrest condition!

Airway sensitivity – pharyngeal stimulation can cause cardiac arrest

·Manipulation of patients can cause arrest.

Management

General

Airway + oxygen via mask - *remember airway sensitivity*

Breathing – ensure adequate ventilation

Circulation – IV access and warmed fluids – (see note 1)

Blood for FBC, U&Es, amylase, glucose. Consider blood cultures, gases and thyroid function

Monitoring – ECG, O^2 saturation and blood pressure & respirations

Urinary catheter – monitor urinary output.

Identify cause

History

Thorough examination – remember possible trauma e.g. #NOF

Rewarming

Rewarm at speed of cooling or 0.5 - 1°C an hour – except in arrest (see below)

· Methods:

Warmed humidified oxygen

Passive – blankets and gamgees hat (patient warming themselves)

Warm IV fluids

Bair hugger

Avoid local heat

Beware of hypovolaemia – monitor BP regularly during rewarming   (see note 1)

Treat underlying medical conditions as appropriate

Step 1 Practice Appendix 1	Core Competencies Element 1 Resuscitation

Cardiac arrest

Seek senior/experienced advice

CPR as per normal protocols – prolonged attempts may be of benefit but

dependant on underlying medical condition

For severe hypothermia:

Rapid rewarming in cardiac arrest – VF may not revert in temps under 30°C.

Rapid warming by peritoneal lavage
If defibrillation not successful after 3-6 shocks wait until temperature
above 30°C

Other considerations
Bradycardia – avoid treating
Consider hypoglycaemia and treat
Pancreatitis may occur – relates to poor splanchnic circulation during
hypothermia
Consider antibiotics for underlying infection and complications e.g. aspiration.

Note 1

Hypovolaemia occurs during warming due to the reduction in circulating volume
that occurs during cooling. On cooling contraction of vessels in skin sends blood
centrally – volume of central circulation limited (approx 3L) – therefore circulating
volume is reduced by cold induced diuresis and shunting across membranes.
This is compounded by dehydration and results in a high haematocrit.

On rewarming relative hypovolaemia occurs as vascular beds open – often occurs in
a step wise manner, hence repeated sudden drops in BP. *This is the
commonest cause of death!*

CLINICAL GUIDELINES FOR MEDICAL EMERGENCIES
CMP 0221 pp 51, 52 Edition 4 July 2001

![Resuscitation Council (UK)]

Adult Basic Life Support

```
┌─────────────────────────────┐
│        UNRESPONSIVE ?        │
└─────────────────────────────┘
              │
              ▼
        ┌──────────────┐
        │ Shout for help│
        └──────────────┘
              │
              ▼
        ┌──────────────┐
        │  Open airway │
        └──────────────┘
              │
              ▼
┌─────────────────────────────┐
│    NOT BREATHING NORMALLY ?  │
└─────────────────────────────┘
              │
              ▼
        ┌──────────────┐
        │   Call 999   │
        └──────────────┘
              │
              ▼
        ┌──────────────┐
        │   30 chest   │
        │ compressions │
        └──────────────┘
              │
              ▼
        ┌──────────────┐
        │2 rescue breaths│
        │ 30 compressions│
        └──────────────┘
```

Resuscitation Council (UK)
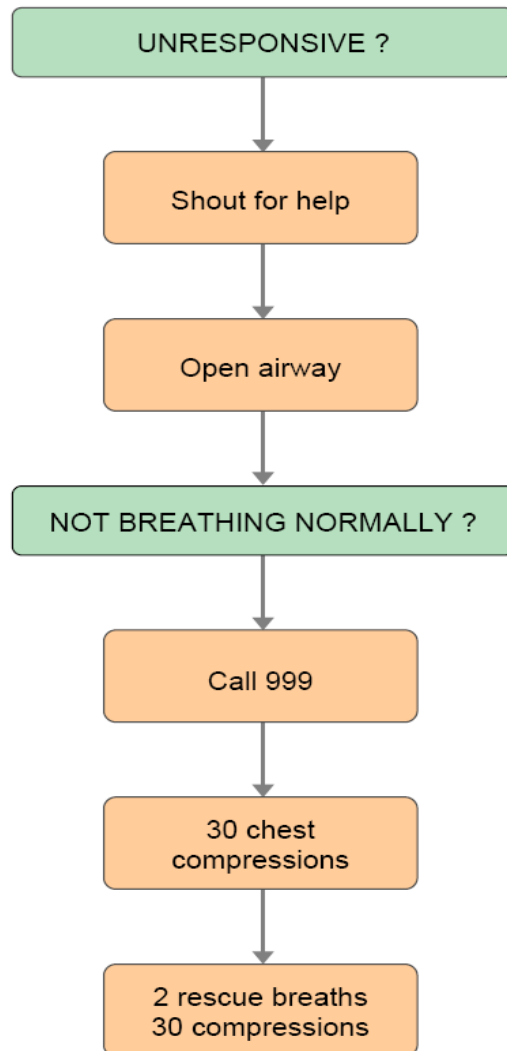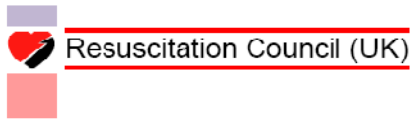
Adult Advanced Life Support Algorithm

Resuscitation Council (UK)

AED Algorithm


```
                    ┌─────────────────┐
                    │  Unresponsive   │──────────────┐
                    └─────────────────┘         ┌──────────────┐
                             │                  │ Call for help│
                             ▼                  └──────────────┘
                 ┌─────────────────────┐
                 │    Open airway      │──────────┐
                 │ Not breathing normally│        │   ┌──────────────────┐
                 └─────────────────────┘          └──▶│ Send or go for AED│
                             │                        │     Call 999     │
                             ▼                        └──────────────────┘
                 ┌─────────────────────┐
                 │     CPR 30:2        │
                 │ Until AED is attached│
                 └─────────────────────┘
                             │
                             ▼
                      ◇ AED assesses rhythm ◇
              ┌──────────────┴──────────────┐
              ▼                              ▼
      ┌──────────────┐              ┌──────────────┐
      │    Shock     │◀────────────▶│   No Shock   │
      │   advised    │              │   advised    │
      └──────────────┘              └──────────────┘
              │                              │
              ▼                              │
      ┌──────────────┐                       │
      │   1 Shock    │                       │
      │150-360 J biphasic│                   │
      │or 360 J monophasic│                  │
      └──────────────┘                       │
              │                              ▼
              ▼                      ┌──────────────┐
      ┌──────────────┐               │Immediately resume│
      │Immediately resume│           │   CPR 30:2   │
      │   CPR 30:2   │               │   for 2 min  │
      │   for 2 min  │               └──────────────┘
      └──────────────┘                       │
                                             ▼
                          ┌───────────────────────────────┐
                          │Continue until the victim starts to│
                          │       breathe normally        │
                          └───────────────────────────────┘
```

Step 1 Practice	Core Competencies Element 1
Appendix 4	Resuscitation

Figure 1 Anaphylactic Reactions: Treatment Algorithm for Adults by First Medical Responders

Consider when compatible history of severe allergic-type reaction with respiratory difficulty and/or hypotension especially if skin changes present

↓

Oxygen treatment when available

↓

Stridor, wheeze, respiratory distress or clinical signs of shock[1]

↓

Adrenaline (epinephrine)[2,3] 1:1000 solution 0.5 mL (500 micrograms) IM

↓

Repeat in 5 minutes if no clinical improvement

↓

Antihistamine (chlorphenamine) 10-20 mg IM/or slow IV

↓

IN ADDITION

For all severe or recurrent reactions and patients with asthma give Hydrocortisone 100-500 mg IM/or slowly IV

If clinical manifestations of shock do not respond to drug treatment give 1-2 litres IV fluid.[4] Rapid infusion or one repeat dose may be necessary

1   An inhaled beta$_2$-agonist such as salbutamol may be used as an adjunctive measure if bronchospasm is severe and does not respond rapidly to other treatment

2.   If profound shock judged **immediately** life threatening give CPR/ALS if necessary. Consider **slow** IV adrenaline (epinephrine) 1:10,000 solution. This is **hazardous** and is recommended only for an experienced practitioner who can also obtain IV access without delay. Note the different strength of adrenaline (epinephrine) that may be required for IV use.

3.   If adults are treated with an Epipen, the 300 micrograms will usually be sufficient. A second dose may be required. Half doses of adrenaline (epinephrine) may be safer for patients on amitriptyline, imipramine, or beta blocker.

4.   A crystalloid may be safer than a colloid.

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ADULT CARDIOPULMONARY RESUSCITATION

Date:	Onset of arrest
Time:	Onset of resuscitation
Ward	Resuscitation abandoned / success (please delete)

Time	Drug	Dose	Route

PERSONNEL PRESENT - Place number in boxes

Nursing Staff

    Manager ☐   Charge Nurse ☐ Staff Nurse ☐

    Enrolled Nurse ☐   Care Assistant ☐ CMU / ICU Staff ☐

Physician

    Consultant ☐   Registrar ☐ SHO ☐ HO ☐

Anaesthetics

    Consultant ☐   Registrar ☐ SHO ☐ ODA ☐

Other Medical Staff

    Consultant ☐   Registrar ☐ SHO ☐ HO ☐

Other Hospital Staff State:

Band 5 Broad Role Outline for Nurses, Midwives and Operating Department Practitioners

Core / Specific	Number	KSF Dimensions,	Second Gateway (Full Outline)		Foundation Gateway (Subset Outline)	
			Level	Indicator	Level	Indicator
Core	C1	Communication	3	a,b,c,d,e,f	3	a
Core	C2	Personal And People Development	2	a,b,c,d,e,f	2	c
Core	C3	Health, Safety And Security	2	a,b,c,d,e,f	2	a
Core	C4	Service Improvement	2	a,b,c,d,e,f	2	b
Core	C5	Quality	2	a,b,c,d,e,f	2	b
Core	C6	Equality And Diversity	2	a, b, c, d	2	a
Specific	HWB2	Assessment And Care Planning To Meet Health And	3	a,b,c,d,e,f,g	3	c

		Wellbeing Needs				
Specific	HWB5	Provision of care to meet health and wellbeing needs	3	a,b,c,d,e,f,g	3	a
Specific	HWB7	Interventions and Treatments	2	a,b,c,d,e,f,g	2	g
Specific	IK1	Information Processing	1	a,b,c,d,e	1	a
Specific	G6	People Management	1	a,b,c,d,e	1	a

Implementation Action Plan

Actions	Time scale	Comments	Outcome
Raise awareness of the STEPs framework in all divisions	Ongoing with 1st review 30/09/2006	<u>Resources required</u> Powerpoint Presentation Posters Leaflets. CDs containing practitione & supervisor packages.. Action review to be standing item on monthly meeting agenda.	Staff can outline the aims and structure of the STEP framework at the point of implementation in their clinical area
Identify key stakeholders in each clinical area and develop their understanding of the STEPs framework	07/08/2006	<u>Resources required</u> Power point presentation be provided to Implementation group members.	Stakeholders can discuss their responsibilities in driving implementation of STEP 1 and ensuring development of STEP 2 in their area
Identify all Band 5 Staff (commenced in post since 01/09/05)	30/06/06	<u>SK to obtain list from Personnel (attached).</u> Group members to check the list is complete & accurate with C/Ns / N/Managers + add names of prospective starters for September, 2006	All areas identified to have staff from this group will be targeted for initial implementation
Determine divisional plans for identifying and developing supervisors.	31/07/06	Plans to be presented and agreed at the next Implementation group meeting - ??/ 07/06	
Determine requirements for	31/07/06		

practitioner prepararation			
Evaluation plan - Initial discussions on evaluation of implementation to be developed and definitive plan produce	TBC	Agenda item for July meeting	

APPENDIX 17

INTRODUCTION

TO THE STEPS

PROGRAMME

A leaflet for

Registered Practitioners

working within xxx Trust

What is the STEP'S Programme

The STEP's Programme is being produced to guide the development of registered practitioners and support them in their role.

STEP 1 has been developed. This is for newly registered practitioners, although all registered nurses in post since September 2005 will undertake the programme. STEP 1 was developed by Steve Knight (Assistant Director of Nursing) in conjunction with Practice Development Nurses and Trainers in Surgery and Critical Care.

STEP 1 is core across the Trust the following elements were the ones deemed necessary following consultation with Charge Nurses/managers;

1. **Resuscitation**

2. **Drug Administration**

3. **Hygiene**

4. **Nutrition**

5. **Pain Assessment**

6. **Tissue Viability**

7. **Record Keeping**

8. **Continence**

9. **Infection Control**

10. **Preparation for Invasive Procedures**

11. **Cannula Care**

12. **Bereavement and Dying**

13. **Discharge Planning**

14. **Critical Care Training Module Level 2**

The Knowledge and Skills Framework is a development tool, using this tool STEP's has been developed.

- This will provide direction and support in gaining clinical competency

- Breaks personal development into bite size chunks

- Promotes minimum standards of care across the organisation

The STEP's Programme has been mapped to Band 5 broad outline KSF dimensions. Therefore completion of STEP 1 will provide evidence that all the foundation indicators have been met.

How is STEP 1 being

implemented within the Trust?

In the first instance there will be

meetings with Charge Nurses and

Matrons. This will ensure that the

implementation has support at ward

level. Matrons will be asked to be

champions of the project to ensure that

once in place the STEP's Programme

continues.

Charge Nurses/managers will be

asked for the names of supervisors to

ensure that the practitioner has support

in the working environment. The

supervisors will be experienced

practitioners in the field they are

working in.

Supervisors will have training to

support them in this role and they will

be given the STEP's Supervisors

Programme on CD.

Once supervisors are in place the

practitioners can be given their CD.

This is going to be a controlled roll out

of the programme to enable audits to

be conducted. It is important that there

is a record of all supervisors and

practitioners.

Supervisors can also use STEP's as

evidence in their development review.

It is envisaged that all Registered

Practitioners in post since Sept 2005

will commence the programme by Sept

2006

WHAT NEXT?

STEP 2 is being developed, some of the elements in STEP 2 will be core but others will be specific to a speciality. Advice will be sought from registered practitioners in speciality areas so that STEP 2 meets their requirements.

What Else Should I Know?

There will be a Trust STEP's web site.

Currently the Trust are involved in promoting MLE (Managed Learning Environment) This is an on line tool which will supports STEPS and the KSF as information can be passed between sites.

For more information on MLE contact ******* ****** on ext 605302

For further information about STEP's, please contact:

CONTACTS

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Clinical Skills Facilitator
Nursing Directorate

******* ****** ext 5110

******** ******ext: 6479

******* *******ext: 602750
Practice Development Nurse
Women's & Children's

******** *******Via Switch
Teacher Practitioner
Women's & Children's (Paediatrics)

********** ********ext 4131
Training Advisor
Theatres

*********** *******ext 4131
Teacher Practitioner
Theatres

********* ******** ext 3179
Teacher Practitioner
Critical Care

******** ********ext: 5018
Nurse Manager
Medicine

********* ********ext 6555
Education & Development Co-ordinator
Cancer & Diagnostics

Produced by ************
STEP's and KSF Lead for the Medical Division