Forward Escaping: a grounded theory study of becoming a nurse in Saudi

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List of acronyms

AACN	American Association of Colleges of Nursing
ANA	American Nurses Association
ANMAC	Australian Nursing & Midwifery Accreditation Council
CBAHI	Central Board for Accreditation of Healthcare Institutions
CRN	Clinical Resource Nurse
ETEC	Education and Training Evaluation Commission
GCC	Gulf Cooperation Council
HN	Head Nurse
JCI	Joint Commission International
JDC	Job Demand-Control
JDCS	Job Demand-Control-Support
M	Manager
MOE	Ministry of Education (Saudi)
MOH	Ministry of Health (Saudi)
NMC	Nursing and Midwifery Council (UK)
NQN	Newly Qualified Nurse
SCFHS	Saudi Commission for Health Specialties
WHO	World Health Organisation

Abstract

Background:

The transition from student to registered nurse has been a concern for policymakers for many years. It has been associated with increased stress, job dissatisfaction and early attrition amongst newly qualified nurses. Despite multiple initiatives to resolve this longstanding concern (such as preceptorship and nursing residency programmes) this transition period remains a challenging time. The literature on role transition tends to focus on job extrinsic factors influencing the transition process, overlooking intrinsic factors such as job content. Thus, to date, there is a paucity of research on how newly qualified nurses manage role transition and what concerns them the most.

Aim:

To explore the transition experience of newly qualified nurses from school to practice.

Study design:

This study followed the principles of classic grounded theory. Data were collected through interviews and relevant documents. The sample consisted of 19 newly qualified nurses and 14 other key informants working collaboratively to facilitate the role transition process.

Findings:

Newly qualified nurses were mainly concerned about accepting their new role as "bedside" nurses, particularly due to the low social status traditionally ascribed to this role in Saudi culture. They attempted to resolve this concern through a strategy of *Forward Escaping*. *Forward Escaping* is a three-stage process: (1) temporarily acquiescing to bedside nursing; (2) reconciling work demands, personal aspirations and social expectations; and (3) persevering in the face of social and work pressures while concurrently developing an escape plan from their current role.

Implications:

Prospective student nurses need to be fully aware of their potential role in clinical practice. This would help students to make an informed career choice, minimising risks of career regrets and early attrition. A development of a standardised formal career framework for nurses could also help in improving role clarity and positively influence their job satisfaction.

Declaration

No portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other institute of learning.

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Chapter One: Introduction and Context

This chapter is split into two sections, Introduction and Context. The first section intends to present a broad overview of what constitutes role transition, in order to contextualise the current literature review and this research study. It provides a summary of a student's journey of studying an undergraduate nursing programme, variations in regulatory standards between educational institutions, the challenges that both students and health employers face to meet the public increasing demand for health services. The second section, gives an overview of the background and current position, as well as contextualising the study setting. It specifically highlights the socioeconomic development of the study site (Saudi Arabia or Saudi), the education and healthcare sectors, with a greater focus on the nursing profession. The focus of this research is presented at the end of this chapter to set the scene for the following chapters.

1.1 Introduction

The shortage of health professionals continues to be a global challenge in which health institutions struggle to deal with an increase in healthcare demands and a reported shortage in health professionals (Wismar et al., 2018). Nurses, in particular, are an integral part of the workforce because they often make up the largest group of staff in any health system (Haddad et al., 2020). The shortage of nurses is a well-recognised and complex global issue, influenced by political, economic, demographic and societal factors (Drennan and Ross, 2019). The World Health Organization (WHO) continues to report a shortfall of registered nurses every year, including a shortage of nearly 6 million worldwide in its latest publication (WHO, 2020). This shortage of registered nurses has been linked to low ratios of registered nurses to patients which, in turn cause a decrease in the quality of healthcare provided and an increase in patient mortality rates (Aiken et al., 2014; Ball et al., 2018; Harrington et al., 2020).

In attempts to address this complex issue, many countries have adopted strategies that focus on the supply pipeline, via nurse education (Colombo, 2016). Recently published figures show an increase in the number of nursing schools worldwide, and more graduates joining the workforce

in the last few years. This increase according to the WHO, supplied the profession with 4.7 million new nurses between 2013 and 2018 (McCarthy et al., 2020). The sustainability of the flow of nurses, however, is threatened by the level of student dropouts, which can sometimes be as high as 25% of a cohort, and the significant attrition rate of newly qualified nurses (NQNs) leaving their jobs within a year of employment (Kovner et al., 2014; Buchan et al., 2019).

Although multiple factors contribute to the global shortage of nurses, nurse attrition is one of the key factors. The attrition rate of qualified nurses has been commonly reported to range between 10% and 20% of the total workforce (Kovner et al., 2014; Roche et al., 2015). However, the recent COVID-19 pandemic, according to a report from the International Council of Nurses (ICN), is thought to have exacerbated this rate as several studies from different parts of the world reported a further increase in numbers of nurses leaving their jobs, or intending to leave, as a result of the job stress and burnout associated with the pandemic. However, it is imperative to note that the terms “attrition”, “turnover”, “leave” and “resignation” are used interchangeably in the studies and it is unclear whether the reported rates included those who moved between different nursing jobs or those who left the profession altogether (ICN, 2020). Attrition is attributed to various reasons including high workload pressure, insufficient resources, stress, and inadequate orientation and support from management (Heinen et al., 2013; ICN, 2020). Support from managers and senior clinicians during role transition seems of particular importance for NQNs, given their relative inexperience in clinical practice.

The first few years of working in a professional capacity are a challenge for many nurses. Duchscher (2009) explained that entering a complex healthcare setting and taking care of critically ill patients can put nurses under great physical and emotional pressure, especially fresh graduates who may not have sufficient clinical experience. The initial experiences of NQNs while transitioning from school to professional practice have long been reported and referred to as a “reality shock”, which is thought to be a major reason for nurses leaving (Kramer, 1974). This shock-like feeling is generally attributed to a number of factors: the mismatch between NQNs’ expectations and the reality of the nursing profession, lack of confidence in working independently, an inability to consistently sustain multitasking, and a failure to establish

supportive networks (Duchscher, 2009; Freeling and Parker, 2015). All of these have been linked to the dissatisfaction prevalent among NQNs which may result in a desire to leave the profession (Duchscher, 2008; Higgins et al., 2010; Rudman and Gustavsson, 2011). Prior to further exploration of the experiences of NQNs in professional practice, it will be helpful first to shed light on the preparation of these nurses and discuss the aims, structure, content and intended outcomes of Bachelor of Science in Nursing (BSN) programmes.

1.1.1 Nursing education and transition to practice: the international context

Nursing qualifications, type of education and scope of practice vary between countries. This is particularly relevant in view of the global competition for qualified nurses, and the increasing reliance by many countries on nurses trained elsewhere. This section describes undergraduate nursing programmes and their intended outcomes, the various routes to qualification that exist in different countries, and some strategies that have been used to improve the outcomes of these programmes.

- An overview of BSN programmes

Most undergraduate nursing programmes share a similar overarching goal, which is to produce graduate professionals who have the essential knowledge and skills to deliver safe, evidence-based and high-quality patient care (Shalala et al., 2011). The design, content and delivery of these programmes, however, vary considerably around the world. There are also differences depending on whether pre-qualifying student nurses are trained at bachelor's degree level (BSN) or other levels. These include, sub-degree level qualifications such as diplomas or in a minority of cases higher degree qualifications such as master's. The differences include prerequisites for entry, length of course, number of theoretical and practice-based hours required, and the qualification awarded. Morin (2011) explained that although many countries agreed on making BSN the minimum entry for registered nurses, the course requirements vary significantly from one country to another.

In the United Kingdom (UK), for instance, BSN courses require students to complete 2,300 hours of practice-based learning to become qualified nurses, whereas the requirement in Australia is 800 hours (NMC, 2018; ANMAC, 2019). Indeed, wide variability between nursing programme requirements exists even within the same country, for example between different states and universities in the United States (US) (Cipher et al., 2021). This variation could be attributed to what is seen as the optimal number of practice hours to ensure students' competence and/or calls from some experienced nurses, as well as students, who felt that more practice-based training was needed for NQNs to feel more prepared to enter the nursing profession (Clark and Holmes, 2007; Al Awaisi et al., 2015; Jamieson et al., 2019).Furthermore, the length of a BSN course is another source of significant variation between nursing schools. It is generally four years in countries such as US, Canada and Australia; however, this is not the case in other parts of the world. In the UK, programmes that offer BSN are normally three years in length, while such programmes extend to five years in Saudi Arabia (NMC, 2018; SCFHS, 2020).

Nursing education standards vary around the world, particularly in respect of the differing requirements for clinical practice hours, and standards for practice-based learning lack a substantial evidence base (Cipher et al., 2021). This variation in regulations can restrict nursing graduates' geographical mobility and impose additional challenges on nursing regulatory bodies responsible for assessing nurses from different countries. This is, especially the case where high-income countries rely increasingly on foreign-trained nurses who may have different educational backgrounds and experiences (Marć et al., 2019; Buchan et al., 2020). Therefore, there have been calls to try and align standards in nursing education and licensing requirements worldwide to ensure that similar levels of educational quality and ensure "the safe and efficient mobility of practitioners" to practise nursing wherever they go (WHO, 2020).

Nursing education curricula have undergone significant transformations in many countries in order to keep up with ever-changing healthcare systems and the increased complexity of healthcare problems (AACN, 2021). Some of the most significant changes, in the last few decades, include the move from apprenticeships (hospital-based) to university-based programmes and the focus on degree-level education as a minimum for registered nurses. The preference for BSN-

prepared nurses has been supported by multiple studies, including several that found an association between increased numbers of BSN-level nurses and decreased patient mortality (Aiken et al., 2014; Griffiths et al., 2016a; Harrison et al., 2019). Although the university-based teaching model is one solution for improving the theoretical knowledge of nurses, it is not without its perceived issues, including concerns over graduates' competence in clinical skills (Rusch et al., 2019). There have been concerns that the balance between theory and practice learning has tipped in favour for theory in some countries (Hickerson et al., 2016; Cochran, 2017).

- Intended outcomes of BSN programmes

Monaghan has suggested that the move of nursing programmes to the higher education sector has brought advantages in improving students' theoretical knowledge –that is, 'knowing what' (Monaghan, 2015) and it has also been suggested that it has improved professional and ethical behaviour (Rusch et al., 2019). University-trained students are able to gain a stronger theoretical foundation before they apply their knowledge in practice in a real nursing environment (Monaghan, 2015). However, the ability to transfer knowledge gained into practice has become an issue amongst nursing graduates. Recent studies have reported that NQNs demonstrated deficits in clinical/technical skills (Missen et al., 2016) and critical thinking and clinical judgment (Kumm et al., 2016), which may mean that some of the intended outcomes of BSN programmes were not met.

To improve the clinical readiness of students and keep up with constant changes in healthcare systems, nursing schools in the US were urged to revise and update their curricula (Shalala et al., 2011). In response, many nursing schools began to increase the required practice-based learning hours assuming it would improve their educational outcomes. However, evidence to support an association between increased practice-based training hours and improved student performance is lacking (Cipher et al., 2021). Moreover, this strategy of "adding clinical hours" was often difficult to implement due to a lack of practice-based training sites (National League of Nursing, 2019). The limited capacity of clinical practice-based sites has often led to fewer opportunities for students to experience hands-on procedures and overcrowding at sites that offer clinical

training (Bradley et al., 2019). Furthermore, the increased complexity of patients' conditions, the high workload of senior nurses and a lack of qualified instructors (mentors and supervisors) are additional challenges to the strategy of adding more practice-based training hours to nursing programmes (Hayden et al., 2014b; Jeffries et al., 2015). Thus, many countries have explored using simulation as an adjunct to practice based hours to ensure student nurses readiness for professional practice (Maas and Flood, 2011; Hayden et al., 2014; Bradley et al., 2019).

- Readiness for independent practice

The debate surrounding readiness for independent practice is an age-old concern within the field of nursing. Although it has been argued about for decades, the topic is not becoming any less important (El Haddad et al., 2017). This longstanding debate appears to be causing tension between some nurse managers and nurse academics over whether NQNs are work-ready (Numminen et al., 2014). It is a global issue that is being debated in many countries, including the UK (Monaghan, 2015), the US (Williams et al., 2014), Australia (Missen et al., 2016) and Saudi (Aboshaiqah and Qasim, 2018). The focus of the debate is generally on the expectations of nurse managers, but is sometimes conflated with what is called the "theory-practice gap" (Monaghan, 2015). This is another issue that had been debated before the move of nursing education from hospitals to higher education institutions.

Nurse managers have often expressed the view that NQNs lack sufficient competence for autonomous practice. Such managers expect NQNs to "hit the floor running" (El Haddad et al., 2017). However, it could be unrealistic to expect a novice in any profession to function at the same level as a senior practitioner who has been in the job for a while. Indeed, some nursing regulatory bodies, such as the US-based National Council of State Boards of Nursing (NCSBN), expect NQNs to lack some expertise and suggest a 12-month entry-level period for an NQN to become competent (Williams et al., 2014). Moreover, Benner (1982) suggests that NQNs will require two to three years of work to acquire competence and become proficient. This divergence of perception between and within these bodies and varying between countries in regard to NQNs' expected level of readiness for work inhibits a general agreement being reached.

Furthermore, it should be noted that competence is defined quite variably in the literature, and there is not necessarily a shared understanding of what it means (Church, 2016). Moreover, there is no general agreement about the level of competence that would be acceptable for newly qualified nurses since assessing competence levels can be subjective (Clark and Holmes, 2007). This lack of shared expectations of competence between different organisations and countries is a key issue. There are multiple definitions of competence, for example, Fukada (2018) states that it is the ability to integrate acquired knowledge, practical and managerial skills, professional values, and communication and interpersonal skills to deliver comprehensive services for all clients. In addition, the specific competencies required of NQNs may vary depending on the setting and role they have been assigned to. Therefore, it can be challenging to identify an overall set of standards.

The terms “competence”, “proficiency”, and “mastery” are used interchangeably among nursing regulatory bodies and employers to explain requirements for students at the point of qualification as professional nurses, which can be confusing. Using different ill-defined terms interchangeably to outline what is expected of a new qualified nurse does not seem to help the contradictory views of nurse managers and academics to converge. The regulator of the nursing profession in the UK, for instance, used the term ‘competence’ as a measure for a few years but lately has returned to using ‘proficiency’ instead (NMC, 2014; NMC, 2018). However, neither term was explicitly defined by the regulator.

BSN programmes, in spite of reported development, are often perceived to produce NQNs who lack readiness for transition to professional practice. However, most of these studies and editorials largely rely on the perceptions and thoughts of managers, which are subjective. In the next section, I will discuss the transition from student to registered nurse role and its related issues.

- Role transition and associated impacts on NQNs

Transition in general has been defined as a movement to an unfamiliar state, condition or environment which can bring significant changes to the lives of individuals transitioning and their significant others (Schumacher and Meleis, 1994). The transition of NQNs from a student to a professional role may involve alterations in their social, financial, socio-cultural and/or psychological statuses. The process of transition was notably explained by Kramer (1974) while studying 'why nurses leave nursing'. Kramer thought that nurses progress through a honeymoon phase, where they feel excited about starting a new job; then as the new role responsibilities build up and workloads become higher than expected, negative feelings start to dominate. These negative feelings, or the 'shock phase', at worst, may cause nurses to leave the profession. Nurses who successfully overcome this challenge start to achieve balance and gain control of their work/life commitments: this is "the recovery and resolution phases" (Kramer, 1974).

International literature has long reported the challenges associated with role transition of NQNs. Despite having been long identified, these challenges seem to persist; recent studies show that NQNs still struggle during transition with not feeling competent or confident in clinical decision-making, and with anxieties about professional accountability (Kumaran and Carney, 2014; Mawson, 2020). To address this issue, many leading health organisations, such as the National Academy of Medicine (previously known as the Institute of Medicine) in the US (IOM, 2011), reinforced their recommendations that healthcare institutions develop nursing residency programmes that focus on streamlining the transition process for NQNs, with the aim of improving NQN retention rates and preventing anticipated increases in nurse turnover.

- Attempts to streamline the transition process

In an endeavour to support NQNs during the transition from student to independent registered nurse, a number of programmes have been developed and implemented to streamline the transition experience worldwide (Graf et al., 2020). These strategies aim to enhance NQNs' professional and clinical skills and help them adapt to the new working environment. They range from informal and less structured to more intensive programmes. These programmes have been

given different names in different settings, such as “nursing residency programme” (Pittman et al., 2013; Slate et al., 2018), “preceptorship” (Allan et al., 2018), ”internship” (Al Awaisi et al., 2015), and “transition support” (D’Addona et al., 2015; Ankers et al., 2018). The term “nursing residency programme” (NRP) is used throughout this thesis as it is commonly used in the international literature and it is the official name of the programme delivered in the study context.

A nursing residency programme (NRP) can be defined as a post-licensure programme that is longer and more structured than a typical orientation programme (Pittman et al., 2015). It facilitates the transition of NQNs from student status to employee status through a series of steps intended to prepare them to work competently and independently. Many researchers have found such programmes to be positive and beneficial, and to offer useful strategies for NQNs to improve their levels of confidence and competence (Glynn and Silva, 2013; Spiva et al., 2013; McKillop et al., 2016). They may also allow employers to reduce the costs associated with the turnover of NQNs (Bérubé et al., 2012). However, there have also been reports that some NRPs provide insufficient support and misleading information about training opportunities (Lea and Cruickshank, 2005; Hussein et al., 2017).

1.1.2 Significant transition theories

In the international literature, there are three main theories that have often been used as a theoretical basis to develop nursing residency programmes. These are Kramer’s reality shock theory (1974), Benner’s novice to expert theory (1984) and Duchscher's (2008) stages of transition theory. In her study, Kramer used the term “reality shock”, a concept which includes that of “culture shock” first introduced by Oberg (1960), to describe the feelings of uncertainty and confusion experienced by a new employee in an unfamiliar working environment. Kramer's (1974) study claims that newly qualified nurses (NQNs) experience similar emotions to “culture shock” when commencing their first posts as registered nurses, and these emotions were thought to stem from the discovery of an unexpected reality. An unexpected or undesirable incident that happens to someone in an unfamiliar environment can lead to a shock-like feeling. Similar to

Oberg's theory, Kramer argues that reality shock progresses through four stages: honeymoon, shock, recovery, and resolution.

The reality shock theory explains that NQNs experience social, cultural, and emotional changes when transitioning from student to registered nurse status (Wakefield, 2018). This theory begins with a honeymoon stage which reflects the NQNs' success and feelings of excitement following graduation. However, not all graduates necessarily experience the honeymoon phase, particularly those who feel ambivalent about their choice of subject or career. The shock phase occurs as NQNs discover the differences between what is learned in school and the reality, and feel confused and disillusioned as to which set of values to uphold: those of school vs. those of the new workplace. During this period, NQNs experience a drop in self-confidence and heightened uncertainty, which often leads to rejecting the new work culture (Freeling and Parker, 2015). This mismatch between expectations and reality leads to intrapersonal conflict, which provokes feelings of annoyance and frustration towards the new working environment. Kramer (1974) explains that the feelings of anger can be extended to the education system, which is blamed for not preparing them well for the professional nurse role.

The third phase, recovery, commences when NQNs start to settle into their new role, find their feet within the new working team and adjust to the new environment. Afterwards, they enter the fourth and final phase, which is described as the resolution phase (Wakefield, 2018). During this phase, NQNs focus on professional growth and explore different attainable opportunities. Martin and Wilson (2011) explain that during the resolution phase NQNs weigh up different available options, which include continuing in their current role, transferring between institutions or areas and seeking to exit from nursing altogether. The four phases of Kramer's theory do not necessarily occur in sequential order, as some NQNs skip one phase and jump straight to the following one (Kramer, 1974). Moreover, the theory can be seen as a cyclic process as NQNs may re-experience the shock phase when they move to a new working area.

The shock phase during NQNs' transition into the workplace has been studied extensively in the literature and is often linked to a lack of hands-on experience in the nursing curriculum (El

Haddad et al., 2013). In addition to a lack of clinical experience, NQNs were consistently reported to encounter negative experiences during their initial experience of employment, i.e. the first few months (Rush et al., 2013). Considering that NQNs may be in a state of shock when commencing their first job and may experience heightened self-doubt, they would be more likely to be anxious about executing even a simple clinical procedure due to fear of failure (Kumaran and Carney, 2014). This understanding of the transition through Kramer's work, along with the other two theories of transition, have heavily influenced the development of nursing residency programmes to meet the needs of NQNs during the four phases of transition (Graf et al., 2020).

The second principal transition theory is that of Benner (1982), known as "novice to expert" theory. This theory used the model of skill acquisition, originally developed by Dreyfus and Dreyfus (1980), as a foundation to demonstrate the professional growth of nurses. Benner developed a model of clinical competence and categorised it into five stages: novice, advanced beginner, competent, proficient and expert. The novice stage refers to student nurses who might have very limited clinical experience and therefore limited ability to recognise changes in a particular patient condition. The advanced beginner stage refers to nurses who have the knowledge and know-how but lack in-depth clinical experience; Benner expects NQNs to be at this level when commencing their first professional job. In recent years, however, expectations have been raised as NQNs are expected to demonstrate a certain level of competence upon qualification, i.e. to be at Stage 3 (Marks-Maran et al., 2013). It is as yet unclear whether this is due to the recent development of nursing education, or to managerial and organisational changes in clinical areas, such as work pressures and staff shortages. The following diagram illustrates Benner's novice to expert model.

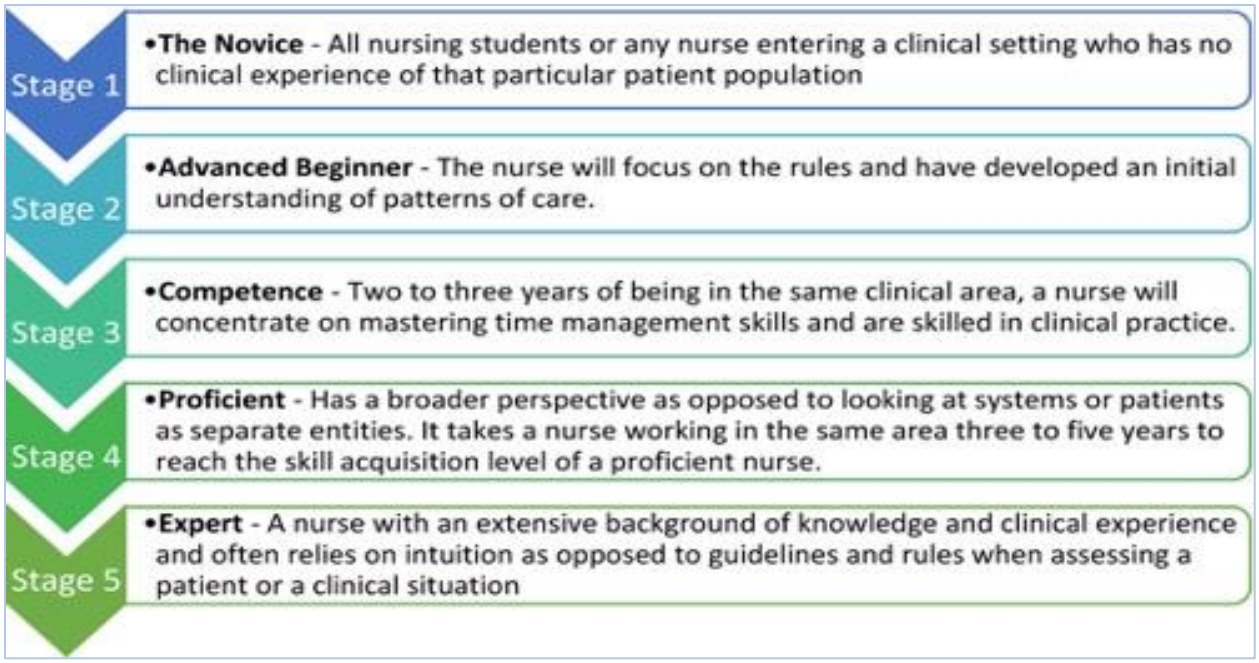


Figure 1: Benner's (1982) stages from novice to expert

Similar to the model of skill acquisition, novice to expert theory supports the idea of experiential learning. A learner, in this case a nurse, develops through engagement in various clinical situations which allows them to adjust to their new culture and adapt skills prior to progressing to the next stage (Benner, 2004). The theory focuses on NQNs' development of both professional and clinical skills and is useful to recognise the different levels of competence that nurses attain to reach the mastery or the "expert" stage. It helps to highlight the qualities expected of nurses at each stage and their areas of development. This transition theory has provided insights for advocates of nursing residency programmes in terms of what is expected of NQNs and the type of support required in each phase to successfully promote their professional development.

The third main transition theory is Duchscher's (2008) theoretical framework. Duchscher's theory was influenced by the two theories discussed earlier: reality shock (Kramer, 1974) and novice to expert theory (Benner, 1982). Based on a study of 14 female NQNs, a "staged experience of transition" framework emerged that reflected the role transition from student to registered nurse during the first 12 months (Duchscher, 2008, p.442). The framework divided the process of role transition into three stages: "doing", "being" and "knowing" stages. The "doing" stage

refers to the first three months of the transition experience. During this period, in addition to the burden of sociocultural and physical changes, the unexpectedly heavy workload can put tremendous additional pressure on NQNs, resulting in loss of confidence and increased self-doubt (Lea and Cruickshank, 2005). Thus, at this stage, NQNs tend to focus only on completing tasks and routines imposed by their work unit (Duchscher, 2008).

The "being" stage of the transition experience occurs within the fourth to eighth months of employment. NQNs settle in and become familiarised with their work environment and forget the past. They notice the development in their nursing skills and confidence, compared to the previous "doing" stage. Success in completing tasks and meeting experienced staff's expectations makes NQNs more confident to accept more responsibilities and more engaged within their professional team (Duchscher, 2008). At this stage, NQNs begin to better manage their time, balance work/life commitments and feel comfortable to critique work. This feeling takes NQNs to the next stage, "knowing".

This third stage of the transition framework, "knowing", occurs within the last quarter of the transition year, the first year of employment. NQNs become more independent, start to develop their own professional identities and gain the capability to look at work with a wider lens, searching for solutions to improve their professional and working environment. This achievement marks the end of the "journey of becoming", as NQNs feel more confident, are fully aware of what is going on around them in their work environment, and become full members of the working team (Graf et al., 2020). At this stage, frustration may appear again, but this time it is more likely due to organisational or systemic issues rather than personal ones (Duchscher, 2008). The three-stage transition framework helps to clarify the needs of NQNs during the first 12 months of employment, which can be of assistance in developing nursing residency programmes that are more relevant and effective. The following figure (figure 2), as explained by Duchscher, illustrates the stages NQNs go through during their first year of employment.

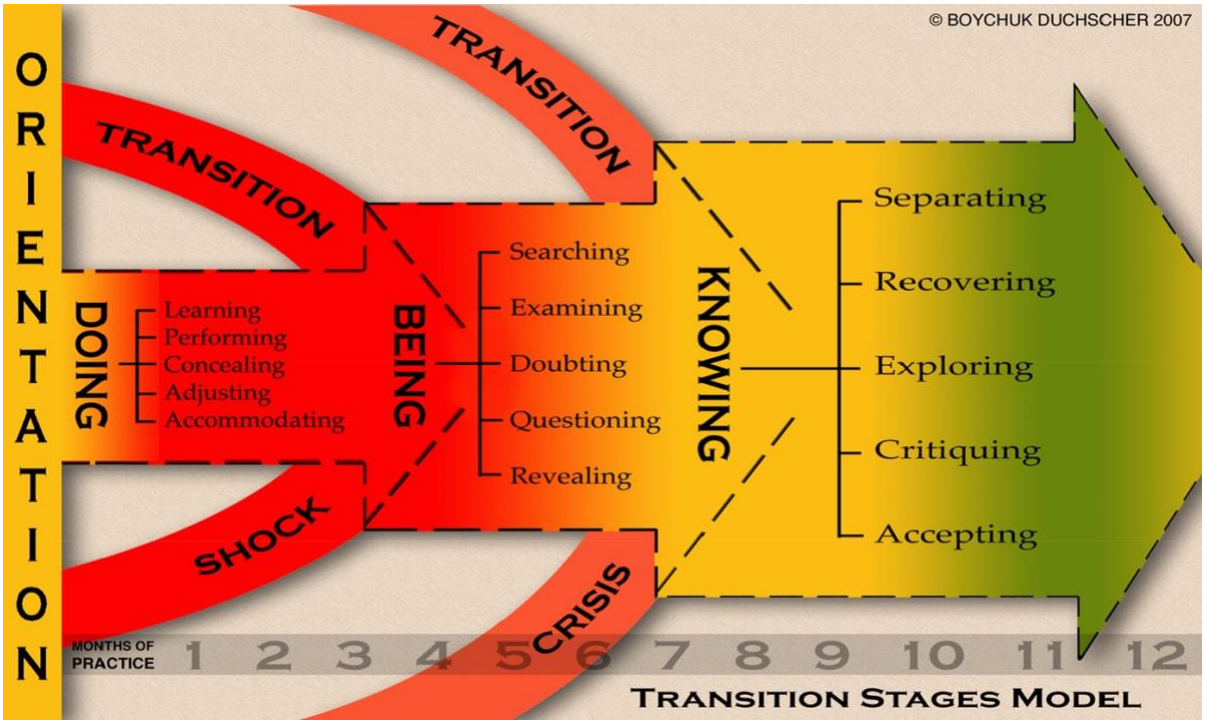


Figure 2: Taken from the stages of Duchscher's (2008) transition theory.

The cumulative work of the three transition theories discussed earlier (Kramer, 1974; Benner, 1982 and Duchscher, 2008) have enriched the international literature with NQNs' experiences during the transition period, explanation of the transition process, common challenges that delay or interrupt the process of becoming an independent registered nurse and suggestions to eliminate these barriers. However, these theories seemed to largely focus on job extrinsic factors influencing the transition process such as working conditions, overlooking intrinsic factors such as the nature of work itself, which may influence the acceptance and satisfaction of the job.

In summary, this section, *1.1 Introduction,* has covered the variations in nursing education standards, the phenomenon of nursing transition and its associated consequences, attempts to resolve the tensions between the reality of what can be completed with 3, 4 or 5 years' study and the expectations of what newly qualified nurses should be able to do at the point of registration, and some of the theoretical foundations that underpin these attempts. The issue of assessing the educational outcomes of BSN programmes is twofold: first, there is no substantial evidence to determine the number of clinical hours required for a student to qualify as a

professional nurse and ensure their readiness for transition to practice; second, expectations of NQNs change as their role sits within an increasingly complex healthcare arena. Therefore, the evidence to support reports that NQNs are not adequately prepared for role transition is questionable. Moreover, the attempts to facilitate the transition process, through nursing residency programmes, have had limited impact in improving the transition experience of NQNs to professional practice.

The contexts where student nurses learn and develop professionally vary greatly from one country to another and can have a significant impact on learning outcomes. Nursing education in Saudi, as mentioned in this section, differ in many respects from those in other countries. The gender ratio of Saudi nurses is also another striking difference from the common global ratio of male to female nurses, in that the average ratio of men to women worldwide is about 1:9, compared with 4:6 in Saudi (HEA, 2017; NMC, 2019; MOH, 2020). Moreover, the proportion of overseas-trained nurses in practice in Saudi healthcare system is usually high, at 57%, compared with, for example, 15% in the UK and 6% in the US. Therefore, since the context of the empirical work in this thesis is Saudi Arabia, it is necessary to provide an overview of the study context, including its healthcare and education systems, and the profession of nursing within the Saudi context.

1.2 Context

This section presents an overview of the study context, Saudi, including its geographical, demographic and socioeconomic characteristics. It also sheds light on the history of the state and its historical, social and economic development. The healthcare and education systems, and the profession of nursing in particular, are discussed in depth as elements which are central to this current study. Moreover, nursing education and how students are prepared for role transition, through internships, are detailed to illustrate the uniqueness of the undergraduate nursing curriculum in Saudi, and to identify the similarities and differences between the nursing curriculum in Saudi and that of other countries.

1.2.1 Geopolitical characteristics of Saudi

The Kingdom of Saudi Arabia (Saudi) is situated in southwest Asia, constituting the vast majority of the Arabian Peninsula. Geographically, it is the largest of the Gulf Cooperation Council (GCC) countries, which are Saudi, Emirates, Oman, Qatar, Kuwait and Bahrain. Compared with the UK, for instance, Saudi is eight times bigger in terms of land mass: 830,000 sq miles compared with 94,000 sq miles. It borders Jordan and Iraq to the north, the Red Sea to the west, the Arabian Gulf to the east and Oman and the Republic of Yemen to the south.

Saudi is connected, through the Red and the Mediterranean Seas, to three continents: Asia, Africa and Europe. The capital city of Saudi is Riyadh, while the city of Jeddah on the west coast is known as the country's commercial hub. Makkah (also known as Mecca) is another famous Saudi city; it is considered the holiest city in Islam, and millions of Muslims from around the world regularly visit it for religious reasons. The figure below shows the country's geographical location, borders and main cities. (Figure 3).

The modern state of Saudi was founded in 1932 by King Abdulaziz who unified most of the Arabian Peninsula (currently known as the GCC countries). According to the Basic Law of Governance, the state has a monarchical system of rule and its constitution is largely influenced

by Sharia (Islamic) law (The Shura Council, 2021). However, contemporary governance has been described as a theo-monarchy that is shaped by religion and culture (Al-Atawneh, 2009). The Basic Law, which can only be proposed by the King or proposed to the King by the Consultative Council (known as the Shura Council), has been amended many times, most recently in 2017. One of the major recent amendments to the Basic Law allowed women to vote and run for municipal council elections, including the Royal decree that at least 20% of the Consultative Council seats shall be allocated to women (CIA, 2022; The Shura Council, 2022) .

The legislature is headed by the King and consists of 30 ministers representing different ministries and 150 members from the Consultative Council. The Consultative Council includes experts and specialists from different fields who advise the monarch and ministers to facilitate the state's development. The legislature has the authority to amend or develop new laws to address issues that have no clear explanation in Islamic law, and the courts apply both Sharia law and any law promulgated by the legislature that does not clash with Islamic rules/traditions (Articles 48, The Shura Council, 2021).

Figure 3: Map of Saudi Arabia (source: Wikipedia)

1.2.2 Demographic characteristics of Saudi

The latest statistics (2020) show that the total population of Saudi is just over 35 million (GASTAT, 2020a). In comparison with the country's land mass, Saudi has a low population density at 42 people per square mile compared to 700 people per square mile in the UK. With roughly 65% of Saudis under 34 years old, it is considered one of the youngest populations in the world (GASTAT, 2020b). Nearly 35% of the population are immigrants (non-citizens) and the vast majority of these are foreign workers. Recently, the country witnessed a noticeable jump in immigrant numbers following the Syrian civil war (2011-present), as nearly 2 million Syrians fled their homes and are now temporarily residing in Saudi. The country relies heavily on foreign workers, who represent about 50% of the total national workforce (GASTAT, 2021). The majority of foreign workers come from India, Pakistan, Philippines and Egypt, followed by lower numbers from other countries. Figure 7 illustrates the Saudi population pyramid.

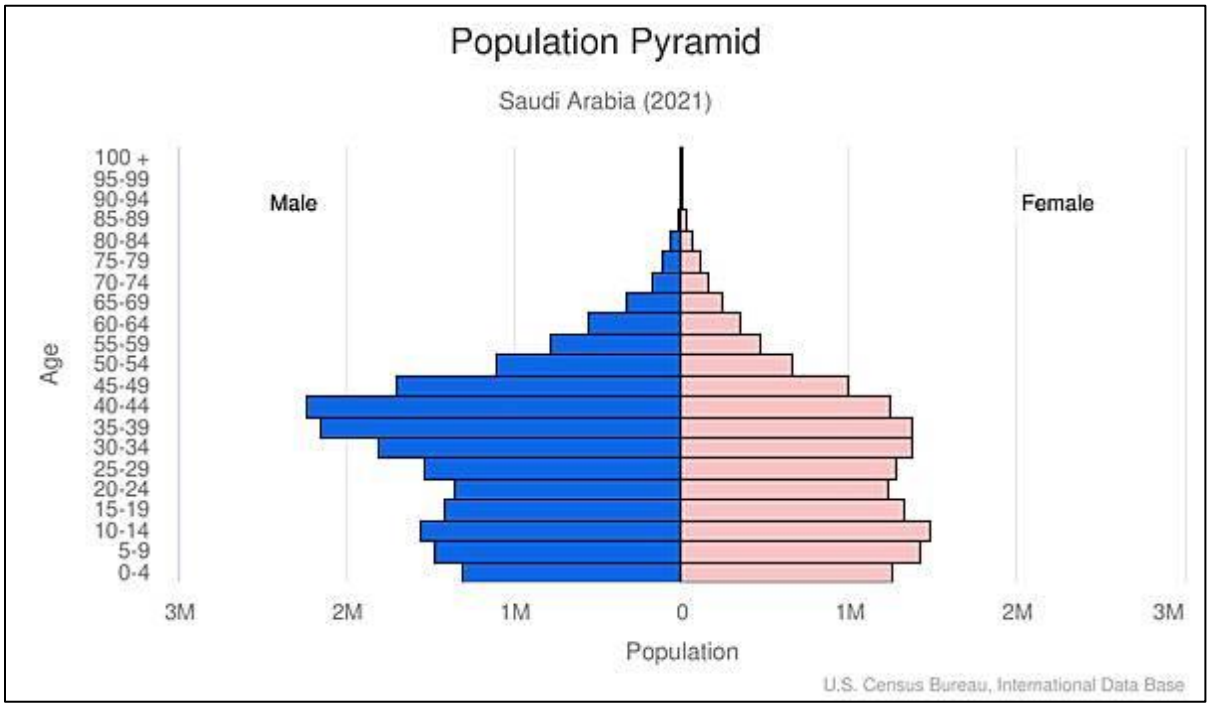


Figure 4: Saudi population pyramid (Source: The World Factbook 2021)

Saudi is mainly an urbanised country where the vast majority of the population (85%) reside in urban metropolitan areas, mainly Riyadh (the capital), Jeddah and Mecca. The annual population

growth rate is 2.38, with an increasing average life expectancy which is currently 76 (males: 74 and females: 78) and a decreasing fertility rate which is currently 1.9 (MOH, 2020). Life expectancy in Saudi is relatively low, compared with 81 in the UK and 83 in Canada, while the fertility rate is higher compared with the same two countries (UK: 1.8 and Canada: 1.5) (CIA, 2021).

1.2.3 Socioeconomic characteristics of Saudi

- *Economic status*

Following the oil boom during the 1970s and 80s, the Saudi economy dramatically expanded, turning what used to be an underdeveloped desert into a modern state (Al-Naimi, 2016). Since then, Saudi has become one of the largest economies globally and a common destination for job seekers from around the world. The rapid growth of the economy coupled with a shortage of educated national citizens, at that time, led to an influx of large numbers of foreign workers recruited by the government to help build the current modern state of Saudi (Alghamedi, 2016). As a result, in the early 90s, the national workforce became greatly reliant on foreign workers, who made up nearly 85%. Although rates today remain relatively high, current statistics report that this percentage has shrunk to just over 50% (GASTAT, 2021).

The government has traditionally considered oil revenue to be a primary source of income to finance all governmental sectors, including healthcare, education and transportation. However, the volatility of the oil market has given the Saudi government a clear indication that total reliance on oil income risks the sustainability of the development of the national economy (Horschig, 2016). In the last decade, the oil market witnessed a brutal slump, falling from $114 per barrel in 2011 to $20 in 2020. This plunge in oil prices reaffirmed the need to end reliance on rentier state resources (i.e. oil) and diversify the sources of income to sustain the development of the national economy and ensure prosperity. This crisis was not unpredicted; indeed, it was seen as an opportunity to accelerate the progress of plans to move beyond the era of oil.

Therefore, in 2016, the government introduced a major comprehensive plan, "Vision 2030", as a roadmap for economic transformation (Nurunnabi, 2017). Moreover, Hilmi et al. (2020) explains that the vision appears to be in line with the United Nations (UN) agenda for sustainable development to tackle climate change and its impact by reducing the use of non-renewable energy and promoting a cleaner and healthier environment. However, Banafea and Ibnrubbian (2018), perceived that the process of diversifying the country's economy, which includes moving away from the use of fossil fuel, is slow and suggested improving the legislative environment to accelerate the transition to green economy.

- Cultural consequences of economic boom

Saudi's Vision 2030 is not limited to the economic sector, but also places great emphasis on ensuring and sustaining social development. One of the Vision's goals is to reform the social lives of the people and create a happier and more fulfilling lifestyle in a safe environment that every individual can enjoy while increasing access to world class healthcare and education (vision2030.gov.sa). The rapid economic growth, as discussed above, simultaneously increased the standard of living of citizens so that conspicuous consumption became a social norm (Al Dossry, 2012). Reliance on foreign workers to do almost all jobs, frequent replacement of cars and furnishings and the hiring of two to three domestic workers (maid, cook and chauffeur) per household became a common way of living in the Saudi community (Al Dossry, 2012; Al-Matary and Ali, 2013). Moreover, due to the Saudi family tradition, sons and daughters are financially protected, for as long as they wish, by their parents (Wilson et al., 2004), which contributes to a perception amongst the youth that getting a job is inessential. Giving the fact that oil is a finite resource, it is necessary for both the government and the citizens to consider alternative economic resources to ensure the state's sustainable development and enjoy prosperity.

Having the majority of citizens living a bourgeois lifestyle, however, had its negative consequences on the national economy as the contribution of citizens is relatively low. According to Alghamedi (2016), the government realised this deficit in the 1990s and since then began investing heavily in educating its citizens through development of tertiary education institutions

and by promoting thousands of full scholarships to study abroad. Educating and recruiting more citizens was intended to increase their engagement in the development of the national economy, assure a secure domestic supply of workers and stabilise the national workforce through a localisation initiative (known as Saudisation), which is discussed later.

- Belief/religion

Islam is the official religion in Saudi and its constitution rests on the Holy Quran and Sunnah (Al-Atawneh, 2009). Islamic principles are deeply rooted in the local community. However, some cultural norms that have no basis in Islam also exist (Hamdan, 2005). For instance, although it had no backing from the Quran, the belief that women should be banned from driving cars existed in the community for decades before it was recently changed by the new government in 2018. Thus, the Saudi culture is a unique mixture of religious, traditional values and modern secular ones, and sometimes it can be difficult, particularly for foreigners, to understand whether any given aspect of life is derived from an Islamic or Arabic tradition (Al Lily, 2011).

The Saudi community tends to be socially and religiously conservative, with strong tribal traditions and family ties (Al Alhareth et al., 2015). It is shaped by an intertwining of traditional social, religious, and tribal norms that influences the layers of Saudi society and people's day-to-day lives (Alrahaili, 2019). This can be clearly observed, for example, in the education system, where single-sex schooling is preferred due to religious and traditional beliefs (Wiseman, 2010). However, these strong norms have gradually softened over time as globalisation has brought more connections to the outside world and brought exposure to different cultures and beliefs (Al Dossry, 2012). As the new generation of Saudis try to adapt themselves to a contemporary global technological culture, they are, at the same time, trying to retain traditional values in their social lives (Alrashidi and Phan, 2015).

- The spoken and official language

In terms of language, Saudis speak Arabic as their mother tongue. Arabic is the official language of the state and is highly respected, mainly due to its connection to Islam. The Islamic religion, through the Holy Quran, was revealed in Arabic; therefore, preserving the Arabic language is seen as a way of upholding Islamic identity (Elyas, 2008). Nouraldeen and Elyas (2014) contend that the Saudi community prefers Arabic because the country has never been colonised by a foreign power. While this might be true, there is also widespread concern that routine use of foreign languages might affect the Islamic and Arabic identity of the community, and of the younger generation in particular (Elyas, 2008). However, today, connection with the non-Arabic speaking world is a necessity for social, economic, and political ends; thus, the use of other languages was inevitable. As one of the most widely-spoken languages in the world, English became the official second language in the country. English has taken its place as a core subject in the Saudi education system alongside Arabic. Using English in the country permitted the rapid spread of technology and accelerated the globalisation of Saudi society (Alshahrani, 2016). Currently, major local companies use English and most university courses – including nursing courses – are delivered in English. Yet the use of English remains limited to work and it is used for work purposes only, as citizens tend to use Arabic in their social lives, i.e., when communicating with peers and family (Alrashidi and Phan, 2015).

- Family

Similar to other family-oriented cultures, the role of family in Saudi society is vital and has a significant influence on the lives of family members (Almalki and Ganong, 2018). Family beliefs and preferences normally take precedence over individuals' wishes or dreams, e.g. a young person may choose to forgo a career of interest due to their parents not liking the chosen job, or a student may not choose to study a subject without permission from their parents. Again, this tradition is derived from a mixture of social, cultural and religious norms. However, recent socioeconomic and demographic transformation in the state has slightly changed the structure of local families by decreasing their size and number of connections, and subsequently their influence and decision-making power (El-Haddad, 2003). In Saudi, this movement has been linked

to improvements in educational and occupational opportunities for citizens, particularly for women (Al-Khraif et al., 2020). The social status of women has exhibited a speedy process of modernisation in recent years.

- Women

Historically, women's rights, such as suffrage or education, suffered from painfully slow progress worldwide. In the US, for instance, advocates of women rights had to fight for nearly two centuries to win government approval for women to access higher education (Dentith, 2016). However, this was not the case in Saudi, where, perhaps because it is a relatively new country, the process of getting the right for girls to obtain formal education was relatively quick – under 40 years. Saudi was founded in 1932 and the first girls' college was established in 1970 (AlMunajjed, 1997). It was reported that in the 1960s there were some public demonstrations opposing girls' education, which were ignored by the king, at that time, King Faisal, and his wife, Princess Iffat, who both enthusiastically supported education for women in the country and ordered the opening of more schools for girls in various cities (Lacey, 1981).

In the 1970s, although girls were granted access to study at university level, they were banned from studying courses that would lead to a career that required mixing with men. However, in the late in 1970s, King Saud University in Riyadh admitted girls to various subjects, such as public administration, economy, medicine and nursing (Hamdan, 2005). In less than 40 years (1932-1970) the lives of many Saudi women were transformed from being almost illiterate to becoming highly educated individuals. Within the same period, the government provided several full scholarship grants for citizens to study abroad, and Fatin Amin Shaker became the first Saudi woman to receive a PhD from Purdue University (US) in 1972. Still today, the government continues to send citizens, nearly 43% of whom are women, abroad for educational purposes, mainly to the US (55%), UK (15%), and Australia (7%) (Ministry of Education, 2019).

Moreover, Saudi legislative law has witnessed significant reforms in relation to the rights of women, enabling them to participate more effectively in the country's developmental plan. Some

of these recent changes include the royal decree to allow women to vote and stand for seats in Shura Council (Consultative Council), the appointment of the first female as Vice President of the Shura Council, the lifting of the male guardianship system that restricted women's movements and freedom to travel, and the appointment of the first three female ambassadors, to the US, Sweden and Norway (Alshammri, 2021). Although contemporary Saudi women still encounter inequalities in some aspects of their social lives, it is unclear whether these restrictions are based on legislation or the Saudi culture. For instance, despite the media hype, and the importance of the decision to lift the ban on women driving, it is still a novel to see a woman behind the wheel (Wheeler, 2020). Nevertheless, the recent ongoing socio-economic reforms, although they sound promising, need to be continually assessed and critically appraised, if the government wants to develop a fairer, more inclusive and gender-equal society.

I turn now to the Saudi healthcare system: its history, and how it is being transformed, particularly in regard to the nursing profession.

1.2.4 The Saudi healthcare system

- *History of the healthcare system*

There has been a marked improvement in healthcare services in the last few decades, particularly following the expansion of the Saudi economy discussed earlier (Al-Hanawi et al., 2019). In 1925, a royal decree from King Abdulaziz (the founder of modern Saudi) announced the establishment of the first government healthcare department (Alharthi et al., 1999). This department, through building regional hospitals and healthcare centres, was responsible for delivering free healthcare services for all residents and pilgrims to Makkah (Mecca) and other holy sites. However, at that time, a poor economy made the development of quality healthcare services difficult, turning people back to traditional medicine, which contributed to increased rates of morbidity and mortality (Almalki et al., 2011a).

In 1950, the Ministry of Health (MOH) was established by another royal decree, replacing the former Department of Health (Alharthi et al., 1999). Since then, the MOH has continued to work as the major government body responsible for planning, implementation, and development of

healthcare services. The MOH followed a welfare policy and provided universal free-at-the-point-of-use health services, including for undocumented immigrants (Almalki et al., 2011a). This continuous effort contributed in improving the population's health status, which can be seen in the reduced rates of mortality in the last few decades. For instance, the infant mortality rate per 1,000 fell from 22 in the 1990s to 3.6 in 2019, and life expectancy at birth rose from 45 in 1960 to 75 in 2020 (MOH, 2020).

- Structure of the healthcare system

Currently, health care services are delivered through three sectors: government (the MOH), semi-government (e.g., military and university hospitals), and the private sector. The MOH is a fully government-funded system and is considered the largest healthcare provider in Saudi, covering almost 60% of the total health services (MOH, 2020). The service provided by MOH hospitals is divided into four tiers: The following table (Table 1) illustrates the four levels.

Tier One	Provision of promotive, preventive and basic curative care services. Examples of these facilities include primary healthcare centres and school health clinics. These facilities are the first point of contact in the healthcare system.
Tier Two	Provision of diagnostic curative care. Examples of these facilities include general and peripheral hospitals. They provide services through emergency departments, outpatient clinics, hospitalisation and surgeries. Cases that require more advanced diagnostic or surgical procedures are referred to Tier-Three hospitals.
Tier Three	Provision of advanced diagnostic, curative and rehabilitative care. Examples of these facilities include regional and mental hospitals. These facilities are larger and technologically more advanced than general and peripheral hospitals.
Tier Four	Provision of specialised, diagnostic, curative and rehabilitative care. Examples of these facilities include teaching hospitals and medical cities. Admission to these facilities is often limited to employees, their dependents and patients referred from regional hospitals.

Table 1: levels of health care provision.

The semi-governmental sector refers to health centres that are collaboratively managed and funded by the MOH and relevant governmental ministries. For instance, National Guard Hospitals are primarily run by the Ministry of the National Guard but supervised by the MOH. Hospitals in the semi-government sector provide health services to a defined population, usually employees and their families. This sector covers just over 15% of the health services provided nationally – the lowest amongst the three sectors.

The third sector is the private sector, which provides a paid-for service and covers nearly 25% of total health services. This private sector relies financially on employee insurance and direct payments from health service users. Its health centres are normally managed by non-government agencies, national or international companies, not-for-profit organisations or private individuals. However, both the semi-government and private sectors provide free-of-charge health services for patients referred from the MOH hospitals. Furthermore, in cases where treatment is not available within the country, patients can be referred abroad to international advanced hospitals. The MOH will cover all fees including hospitalisation costs, travel and out-of-pocket expenses for the patient and a carer (MOH, 2021).

- Overview of the healthcare system

The Saudi health care system uses a government-funded model, where the MOH largely relies on state funding. The government expenditure on the MOH has been steadily increasing: 6% of the total government budget in 2009 to 8.1% in 2021 (MOH, 2020). This equates to 6.4% of GDP, which is relatively low compared to OECD countries, where the average is 9.9% of GDP (stats.oecd.org). The bed capacity in MOH hospitals has increased by more than 10%, from 40,000 beds in 2014 to just over 45,000 in 2020. Despite the increase in health expenditure, the percentage of total government budget (8.1%) remains low compared to other high-income countries, such as the US (16%) (WHO, 2019). Indeed, the recent drop in oil prices, the main revenue for the country, has had an impact on the government's annual health spending. The percentage of health expenditure dropped from 11% in 2016 to 8.1% in 2020 (MOH, 2020).

In terms of human resources in healthcare systems, the Saudi health care system has 27 physicians, 6 dentists, 8 pharmacists, 56 nurses for every 10,000 inhabitants (MOH, 2020). These numbers are slightly above the average ratio of health professionals to population worldwide, as reported by the World Health Organisation (WHO), which is 10 physicians, 5 dentists, 5 pharmacists and 40 nurses and midwives per 10,000 population (WHO, 2021). However, the ratio of nurses in Saudi (56 per 10,000) is significantly lower than high-income countries such as UK and Ireland, where the rates are 81 and 130 respectively (ibid). Furthermore, Saudi has 22 hospital beds per 10,000 population, which is far lower than some countries with similar population density, e.g., 35 in Norway and 36 in Finland.

The Saudi government, in recent years, has been dealing with escalating challenges to sustain the health sector and the provision of free health services to the public (Young, 2015). The challenges include decreased income from oil sales, increased health care costs, demographic changes and cultural movement towards a modernised lifestyle that is associated with changes in patterns of morbidity. Moreover, the vast majority of foreign workers (35% of the total population) are also entitled to free health care at the point of delivery (Walston et al., 2008). This government-funded health care system is ideal for providing equitable health services for all; however, economic fluctuations can threaten the sustainability of the system (Rahman and Al-Borie, 2020). Collectively, all of these socioeconomic challenges put the health care system (the MOH) at risk.

Traditionally, the Saudi MOH system has followed the National Health Service (NHS) model. This model, as explained by Blank et al. (2017), has the most state involvement in terms of funding, provision and regulation of the world's healthcare services. However, recent governmental transformation reforms (e.g. Vision 2030) have focused on increasing engagement of the private sector in the delivery of health services to the public on behalf of the MOH. On this subject, Rahman and Al-Borie (2020) propose that the Private Insurance model appears to be a suitable solution to overcome the constraints associated with the current Saudi healthcare system, mainly costs, quality of care and long waiting lists.

Privatising the healthcare sector has been suggested to improve the quality of care provided (Resneck et al., 2004). However, it seems to have little impact on reducing the financial burden on the government. The US, for instance, despite following the Private Insurance model, spends nearly twice as much as other high-income countries e.g. Canada (Papanicolas et al., 2018). In a comparative study between four international health systems in the US, UK, Australia and Singapore, Al-Hanawi (2017) argues that the Private Insurance model (adopted in the US) is the least preferable and suggests using the Public Private Partnership (PPP) model (adopted in Singapore) to reform the current Saudi health care system. At time of writing this thesis, the Saudi MOH, as part of the transformational Vision 2030 plan, has started two pilot projects, in collaboration with private sector, to assess whether the PPP model would be an adequate alternative to the current government-funded model (MOH, 2020).

- *Transformation of the healthcare system*

As previously mentioned, the government's strategic plan, Vision 2030, was launched in 2016. The plan provides a blueprint for the state's general direction, policies, aims and objectives for the next 15 years, preparing it for the era beyond oil. It was developed around three themes: vibrant society, thriving economy and ambitious nation (Mitchell and Alfuraih, 2018). It is intended that Saudi society will be reshaped by moderate principles of Islam, where members can enjoy their lives in a beautiful environment while being supported by adequate social and health care systems. The second theme, "thriving economy", includes leveraging the strategic geographical location of the country, which connects three continents, Africa, Asia and Europe, unlocking promising economic opportunities, and diversifying the economy's revenue sources. The third theme is based on effective, enabling and transparent government that promotes equal opportunities for all.

The public healthcare sector, as discussed earlier, is fully funded by the government and is increasingly perceived to be putting a financial burden on the national budget. Therefore, the Vision 2030 plan promotes the participation of the private sector in the provision of health services to increase capacity and productive efficiency, rationalise financial spending and reduce

the burden on the general budget (MOH, 2019). According to the MOH strategic plan, 295 hospitals and more than 2,000 primary healthcare centres are proposed to be shifted from government to private sector management by 2030. However, the government, via the MOH, will remain in charge of planning and supervising the health sector. Sama'a et al. (2021) explored the perceptions of managers and clinicians towards privatisation of the healthcare system in the eastern region of Saudi, suggesting that it empowers hospitals by increasing their autonomy, minimises bureaucracy and enhances efficiency. However, the participants also reported some ambiguity in terms of monitoring and accountability due to conflicting governance structures and a lack of effective communication.

The plan to develop a hybrid model of a health care system where public and private sectors share responsibilities is seen as a viable solution to overcome the deteriorating services in the public sector and meet the increasing demand for efficient and equitable health services. Some of the concerns include the shortage of qualified health professionals and consequent long waiting patient lists and technical inefficiency in many public hospitals (Yusuf, 2014; Alatawi et al., 2020). Therefore, in recent years, health services in private facilities gained more popularity amongst consumers, who prefer to pay for high-quality health services in private hospitals rather than receive inadequate care in the public sector free of charge (Mohanty and Farooq, 2018; Alumran et al., 2020). In a comparative study to determine satisfaction among health care users in the public and private sectors, 77% of participants were satisfied with the quality of health care provided in private hospitals, compared with 59% for the public sector (Mohamed et al., 2017). This indicates that the private sector is perceived positively by the public. However, further studies to determine the impact of other variables, such as cost and geographical distance, on consumers' choice of healthcare provider are warranted.

The transformation in the healthcare sector also focuses on the development of human resources as a core enabler of the transition process. The MOH has implemented a workforce programme that aims to enhance the quality and number of health professionals (MOH, 2019). The intention is to achieve this aim through three objectives: firstly, improve the capacity and quality of tertiary teaching in healthcare subjects (in partnership with the Ministry of Education); secondly, expand

professional development opportunities for current workers; and thirdly, increase the attractiveness to citizens of nursing as a career choice. These three objectives, particularly the third, are important to this research study as they focus on updating the education sector, ensuring continuous professional development for current nurses and resolving the issue of nursing being traditionally a less desirable career choice for the public. In the following section, first, light is shed on the education system in general with more focus on nursing education, followed by a discussion of the history of the nursing profession in the region, its current status, contemporary challenges and development plans e.g. – workforce *localisation.*

1.2.5 The education system in Saudi

The first formal Directorate of Education was established by a royal decree in 1926. Prior to this date, education was mainly delivered in mosques and Quranic schools, where students learn to read and write Arabic and recite the Holy Quran (Alrashidi and Phan, 2015). In 1952, the Ministry of Education (MOE) was founded, replacing the Directorate of Education, to supervise and develop public education. In 1975, a separate Ministry for Higher Education (MOHE) was established to execute the government's policies on tertiary education. However, later in 2015, the Ministry of Education and the Ministry of Higher Education were merged into one, the Ministry of Education, with the suggestion that this merger would reduce the bureaucratic procedures between the two ministries, combine efforts, accelerate implementation of new policies and programmes and ensure effective coordination in improving educational outcomes (MOE, 2020).

The primary education system is divided into four stages: early childhood, elementary school (6 years), middle school (3 years) and high school (3 years). Education is mandatory for children aged between 6 and 15, which covers elementary and middle school (Alghamdi and Al-Salouli, 2013). Following the completion of middle school (normally at the age of 15), students can choose to either continue general high school education or move to specialised institutions that offer vocational and technical education at high school level. During general high school (16-18 years old), students can choose between two paths: science or humanities. The science path is

for students who wish to pursue their studies in fields such as mathematics, medicine, nursing or engineering, while the humanities path is for those interested in linguistic studies, management or law. At end of high school, students sit a general final examination. On passing this examination, students gain a secondary education certificate, which is one of the prerequisites for applying for tertiary education.

- Tertiary education in Saudi Arabia

Currently, there are 43 universities, in addition to a number of colleges, that offer tertiary education for national and international students, including 29 state and 14 private universities (MOE, 2021). Education in the state universities is free of charge – indeed, students receive a monthly stipend from the government during their study. Access to university-level education generally depends on pre-admission criteria: the cumulative secondary school average, the Standard Achievement Admission Test (SAAT, known as *Tahsili*), and the General Aptitude Test (GAT, known as *Qudrat*) (Education and Training Evaluation Commission, 2021). These three examinations are the prerequisites that secondary school graduates are required to undertake should they wish to pursue their studies at institutions of tertiary education. However, the validity of these examinations, particularly SAAT and GAT, for determining the students' academic abilities and readiness for tertiary education has been debated. Alamoudi et al. (2021) and Hassan and Al-Razgan (2016) found weak or no correlations between scores at SAAT and GAT and students' overall achievement in university, and they suggested that the pre-university tests should be revisited.

Nearly ten years ago, the MOE introduced a new policy that requires all new university students to complete a preparatory (foundation) year programme (PYP), with the aim of improving their academic and self-directed learning skills and further advancing their English proficiency (Alamoudi et al., 2020). The PYP is designed by each institution and thus differs slightly from one university to another, but it is generally divided into three tracks: scientific, medical and humanities. Prospective students interested in pursuing a degree in health-related subjects such as medicine or nursing may apply for the medical track, while those interested in engineering or

computing apply for the scientific track (Hagler, 2014). As an example, the following table shows the different tracks of the PYP and associated courses at one university, Umm Al-Qura University (UQU).

PYP track	Courses include
1. Scientific track	Engineering, computing and information systems.
2. Medical track	Medicine, dentistry, pharmacology, nursing, medical laboratory, anaesthesia and health administration.
3. Humanities track	Language, art and history.

Table 2: preparatory year programme tracks and associated courses.

Following the successful completion of the PYP, students are assigned to available courses based on three criteria: the student's interest (a preference list of 4-6 subjects), GPA during the preparatory year and availability of places; however, according to the students' manual at UQU, some courses also require interviews to evaluate the student's ability (UQU, 2021). Furthermore, as English is becoming a medium of instruction on many courses such as nursing, English proficiency is used as an additional weighting factor during the assessment of students' applications (Alghamdi, 2021).

In 2020, the MOE announced major development plans for the tertiary education system, which include splitting the academic year into three trimesters instead of two semesters and revoking the policy of a preparatory year. Based on unpublished papers, these decisions are to be effective starting from the academic year (2023-2024). The announcements were delivered by the MOE officials in a brief public conference, and it was unclear whether the cancellation of the preparatory year would include all subjects or whether there will be certain prerequisites for students to be exempted from the preparatory year. According to the officials, a comprehensive written document of the development plans is to be released later (summer 2022). It will be interesting to see whether this decision (cancellation of preparatory year) will have an impact on the inflow of students into nursing programmes. This decision could be a pull factor attracting

more students to nursing, if they knew that the overall length of a BSN course would be reduced from five to four years. However, it could also be a push factor, pushing students away from nursing, based on the idea that many students would have a better chance to discover and develop an interest in nursing during the preparatory year; thus, cancellation of this year could mean students were less likely to learn more about nursing.

- Nursing education

The country's economic boom in the 1960s and 1970s, as discussed in *Economic status*, resulted in major development in the healthcare and education sectors. Nursing education, which was run under the MOH umbrella at that time, has developed accordingly. In 1958, the first official nursing school opened, exclusively for male applicants who had completed at least six years of elementary school education (Tumulty, 2001). The nursing course was one year long and students graduated as nurses' aides. In 1961, three nursing schools (termed "health institutes") were operational, and by 1975 the number had increased to 27 (Miller-Rosser et al., 2006). As nursing education progressed, nursing programmes were stretched to three years and limited to students who had completed secondary school (Year 12). A graduate from a health institute received a Diploma in Nursing and was employed as a Nurse Technician (sometimes refer to as nurse assistants). At that time, prior to 1992, there was no separate registration/licensure department, as the Saudi Commission for Health Specialties (SCFHS) was only established in 1992.

Between 2000 and 2010, health institutes that offered diplomas in nursing were gradually phased out, as the MOH shifted its focus to creating a BSN-prepared nursing workforce (Miller-Rosser et al., 2006). During the same period, in an ambitious attempt to bring all the Saudi nursing workforce up to degree level, the MOH offered several full scholarships for diploma nurses to top up to a BSN level through nursing bridging courses (Aljohani, 2020). These bridging courses were either 24 or 30 months, depending on the applicant's clinical experience. However, a recent report on Saudi nursing workforce showed that the majority of Saudi nurses (65%) hold diploma in nursing and (35%) hold a BSN (SHC, 2019). In the report, the number of Saudi nurses who hold

postgraduate qualifications, e.g. master's or PhD, were not mentioned. The relatively high percentage of diploma nurses indicates that the MOH appears to be struggling with its ambitious plan due to a lack of schools that offer the bridging programmes and the difficulty of granting study leave for diploma nurses amid a shortage of nursing staff in their respective workplaces. This probably contributed to the decision, in 2008, to move responsibility for nursing education from the MOH to the Ministry of Education, where greater focus was placed on the Bachelor of Science in Nursing (Almalki et al., 2011a).

The Bachelor of Science in Nursing (BSN) programmes started to emerge in 1976. They were first introduced by King Saud University, followed by King Abdulaziz University in 1977 and King Faisal University in 1987. These programmes were five years long and on completion students were awarded a BSN. In contrast to the first nursing schools that enrolled only males, the BSN programmes were limited to female students and universities started to accept male applicants on their BSN programmes only in 2004 (Aljohani, 2020). This radical change in nursing education from being exclusive to males then exclusive to females reflected the significant social and cultural transformation at that time, and the conflict between the community's traditions and the government's plans for developing the country, highlighted in *Socioeconomic characteristics of Saudi.*

Currently, there are 39 accredited schools that offer BSN programmes across the country: 25 state and 14 private schools. The duration of BSN programmes is typically five years, which includes preparatory and internship years. The first year (preparatory year: medical track) includes general modules such as Chemistry, Medical Physics, Human Genetics, Cell Physiology and English. The second, third and fourth years focus on theoretical nursing knowledge in addition to practice in simulation labs and clinical settings. The ratio of theory to practice (real and simulation) learning is 1:2. Successful completion of the first four years qualifies students to commence their internship year (Year 5). The internship year is hospital-based training, which exposes students to real nursing practice and prepares them for role transition to become registered nurses. During the internship, students move from a student to an intern role, which

includes working full-time shifts (8 hours a day, 5 days a week), and they receive about 30% of the basic salary of a new registered nurse.

In terms of postgraduate studies, there are only a few universities that offer master's degrees. Although the first Master of Science in Nursing was introduced 33 years ago (in 1987), master's programmes today remain sparse. Moreover, there is only one university that offers a PhD in nursing (King Saudi University), and that started only recently, in 2019. One of the reasons for the stagnation of the process of local universities offering PhDs in nursing could be the lack of research-expert and doctoral-educated nurses. Hence, many Saudi nurses, in the last few years, have been offered scholarships to complete their PhDs abroad in countries such as the UK, US and Ireland. This focus on postgraduate studies is expected to contribute to improving the status of nursing education, and the profession in general, within the state.

1.2.6 Nursing in Saudi

- *History of nursing*

Nursing practice in the Arab peninsula (now Saudi) can be traced back to the early period of Islam fourteen centuries ago, when Rufaida Al-Asalmiya used her nursing skills and medical knowledge to treat wounded soldiers during battles. The Prophet Muhammed (PBUH) acknowledged the work of Rufaida and encouraged her to erect a tent to provide nursing care and train other women to become nurses (Miller-Rosser et al., 2006). In addition to launching the first school for nurses, Rufaida devoted her life to the provision of preventive care and health education in the region (Miller-Rosser et al., 2006). More recently, in modern Saudi, two women have had the greatest influence on nursing: Lutfia Al-Khateeb and Samira Islam. Al-Khateeb obtained her nursing-midwifery diploma from Egypt in 1941, which was nearly 20 years before the establishment of the first nursing school in Saudi. She returned to Saudi where she encouraged other women to challenge general misconceptions about women's education and employment. Al-Khateeb's effort was influential and gained support from government leaders at that time, contributing to the opening of many schools for girls (Miller-Rosser et al., 2006). Samira Islam received her pharmaceutical degree in Alexandria, Egypt, in 1960. In 1975, Islam became the first

Saudi woman to be appointed as a vice dean of a faculty of medicine and allied science, where she opened the doors for girls to study science e.g. Chemistry, Physics and Biology. Moreover, she developed the first nursing programme at a degree level, and was appointed the lead of the programme, dedicating her work to promoting the acceptability of nursing as a suitable career for women in the Saudi culture (Jradi et al., 2013).

Nursing as a career in modern Saudi is relatively new, compared to other developed countries. As mentioned above, it was only 63 years ago, in 1958, that the first nursing aide school was established, and that was limited to male students. Three years later, an additional two nursing schools were opened by the Ministry of Health (MOH); but this time targeting female students. The ministry's decision to educate women to be become nurses sparked a controversy. It was against the local community's tradition, culture and religious beliefs that often perceived women's main role as mothers and wives (Miller-Rosser et al., 2006). Moreover, the public was largely influenced by religious leaders who believed that nonreligious education was a waste of time (Miller-Rosser et al., 2006). The public's rejection of jobs such as nursing that contradicted its culture and values, coupled with the rapid expansion of healthcare facilities at the time, forced the government to start recruiting foreign nurses, who still form the majority of the workforce today (57%) (MOH, 2020). Since then, the country has undergone a rapid socioeconomic transformation, yet nursing still seems to be an unfavourable career choice.

- Status of nursing

- Organisational

The profession of nursing in Saudi has historically encountered issues that have hampered its development, including the absence of a professional regulatory body. This absence has led to an underrepresentation of nurses in the decision-making bodies, and consequently to decisions that were later found to be harmful rather than beneficial to the profession. For example, the initial nursing curriculum was developed in Arabic, whereas the universal language used in hospitals is English. This compromised the graduates' English language skills and thus their ability to communicate effectively with other health professionals in their practice (Tumulty, 2001). In

2002, the Saudi Commission for Health Specialties (SCFHS) that professionally regulate all healthcare professions, established a nursing board with the aim of improving the professional status of nursing, focusing on providing a definition of the profession and its associates, determining nurses' scope of practice, and developing educational and competency standards and credentialing processes. The board was also responsible for the licensing and registration of national and foreign nurses. However, despite being partially successful in its mission, this board had little direct impact on nursing clinical practice. Even today, a comprehensive national scope of practice and clear job descriptions and titles for nurses are still lacking (Hibbert, 2021).

Recently, and in line with the national health system transformative plan, the SCFHS, which is responsible for the classification and accreditation of all health professionals across the country, has approved the establishment of two nurse-led professional entities: first, the Nursing Scientific Board with responsibility for designing and supervising continuous professional development for nurses, developing specialty assessments and advising SCFHS on credentialing and licensing; second, the Saudi Nurses Association (SNA), which aims to enhance the profession of nursing through various initiatives, such as launching professional practice standards, promoting nursing research, improving the nursing working environment, nursing advocacy and nurturing E-learning as a core element in professional development (SNA, 2019). These professional bodies, if given full authority and autonomy, have the potential to enhance the quality of health care and national nursing education systems.

- Social

Socially, the characteristics of the Arabic way of life have a significant effect on nursing discipline (Miller-Rosser et al., 2006). This includes the traditional role of women, protection of women and strong family ties. Traditionally, women take on the vast majority of household chores in addition to childbearing; thus, long working hours or irregular shift work often clashes with family expectations. Falatah and Salem (2018) suggest that nursing as well as other shift-work jobs are incompatible with family expectations and social commitments, and thus remain unattractive for Saudi women. Therefore, the difficulty in balancing work and social commitments seems to constrain many women from entering the labour market.

Furthermore, gender segregation seems to be another social factor that makes nursing a difficult option for nationals – and women in particular. Separation of genders is a respected value in the Saudi community, and healthcare employers normally designate separate areas for female and male patients, staffing them with professionals of the same gender if possible (Amin et al., 2020). This culture, however, imposes challenges for many managers as they cannot fill staffing gaps in female wards with male nurses. Similarly, national nurses, both male and female, prefer not to care for patients of the opposite sex (Alboliteeh et al., 2017). This social norm could explain the government's effort to balance percentage of male and female national nurses, which is currently 42% to 58% (MOH, 2020). However, having one to one male and female nurses in the workplace is not always possible, particularly in highly specialised area such as ICU, due to shortages and imbalanced geographical distribution of nurses. Therefore, the use of foreign nurses, who are thought to be more relaxed in terms of gender segregation, became a suitable solution to overcome this social requirement. This is an additional reason why, the majority of the nursing workforce in Saudi are foreigners (MOH, 2020).

- Workforce

Similar to many healthcare systems, the Saudi healthcare sector has been struggling for many years to staff its facilities with adequate numbers of qualified nurses. Currently, the ratio of nurses to population in Saudi is relatively low, as explained in *Status of the healthcare system*. However, the continuous expansion of health care facilities, increasing life expectancy and the government's 2030 plan to raise the quality of health services means the shortage of nurses will last for longer. Alsufyani et al. (2020) expect that the need for nurses will double over the next ten years. The following table (Table 3) summarises the nursing workforce in the Saudi healthcare system.

		Saudi	Non-Saudi	Total	Saudis in %
Government hospitals	Male	19,749	1,945	21,694	91%
	Female	31,181	36,218	67,399	46%
	Total	50,930	38,163	89,093	57%
Primary care centres	Male	5,779	36	5,815	99%
	Female	10,234	2,348	12,582	81%
	Total	16,013	2,384	18397	87%
Semi-government sector	Male	8,186	3,693	11,879	68%
	Female	5,542	26,866	32,386	17%
	Total	13,728	30,559	44,287	31%
Private sector	Male	1,321	5,608	6,929	19%
	Female	2,006	35,633	37,639	5%
	Total	3,327	41,241	44,568	7%
Total number of nurses in all settings	Male	35,035	11,282	46,317	75%
	Female	48,963	101,065	150,028	33%
	Total	83,998	112,347	196345	43%

Table 3: Nursing workforce in Saudi health system (MOH, 2020)

The Saudi health system has long used an immigrant nursing workforce to meet the urgent demand for nurses across the country. However, this heavy reliance on foreigners may be unsustainable as a strategy in the future for reasons that will be outlined below.

Firstly, the use of foreign nurses is associated with high turnover rates. Kaddourah et al. (2018) studied 364 foreign nurses' turnover intentions, reporting that although 45% of participants were satisfied with their jobs, 342 (94%) had an intention to leave their current posts. Secondly, many foreign health professionals, including nurses, use the Saudi health system as a stepping stone to advance their knowledge and professional skills before moving on to other countries with better work opportunities (Falatah and Salem, 2018). This is understandable, giving that foreign nurses

have difficulties of getting permanent permission to reside permanently in the country (Almansour et al., 2022). Moreover, high dependence on an expatriate workforce has been associated with compromised quality of care and increased recruitment costs (Walston et al., 2008; Aboshaiqah, 2016). Professional nurses are now in worldwide demand and it is likely that the labour market for nurses will be even more competitive, particularly following the onset of COVID-19, as many healthcare systems are increasingly calling for immigrant nurses to fill gaps in their nursing staff (WHO, 2020). Therefore, to minimise this burden of overreliance on immigrant nurses the government has started a strategy to educate, train and recruit its own citizens, through a Saudisation programme, which could help secure domestic supply of nurses and stabilise the national nursing workforce.

- Workforce localisation

It was not until the Gulf War in 1990 that the government realised that overdependence on an expatriate workforce as the backbone of a national industry was very risky (Aboul-Enein, 2002). During the war many foreign workers fled the region for safety reasons, which left the government stranded with abandoned facilities including schools, factories and hospitals. Fortunately, the war was over in less than two months. In 1992, the government initiated a long-term strategic plan for localisation of the workforce, known as *Saudisation*, to educate, train and recruit citizens to increase the proportion of national workers, and ultimately ensure the sustainability of the national economy. The health system is one of the major sectors that was targeted by the localisation policy. However, a large body of literature has highlighted the limited success of the policy in increasing the employment rate of nationals in many sectors, including nursing (Alsheikh, 2015; Albejaidi and Nair, 2021). For example, the MOH needed more than 20 years to increase the proportion of Saudi nurses from 10% in 1998 to 43% in 2020 (MOH, 2020). Nevertheless, Saudi nurses are still a minority.

Notably, the MOH, a government department, has shown better numbers in terms of localisation compared to the semi-governmental and private sectors: 60%, 30% and 5%, respectively (MOH, 2020). Contrary to the perception that the Saudisation plan is unachievable, particularly in the private industry, the banking sector (private), has reported significant results, localising 80% of

its workforce (SAMA, 2020). This achievement in the banking sector could be attributed to the incentives provided by the state for companies complying with the localisation policy, or as Edgar et al. (2016) suggested, it could be linked to the perception of a career in banking as a white-collar occupation, making it easier to recruit more nationals.

Despite the achievement of 43% of the total nursing workforce being nationals, both the MOH and the Ministry of Education (MOE) have been under criticism for not meeting the government's expectations. The localisation of the nursing workforce faces multiple challenges, including inadequate nursing school capacity, gender disparities and the low social perception of nursing (Aljohani, 2020; Alluhidan et al., 2020). Moreover, the clinical aspect of nursing programmes faces multiple challenges including the inadequate number of clinical educators and lack of efficient preparation (AlMutair, 2015). Therefore, as part of the 2030 transformative plan, various education and quality assurance commissions and committees have been merged or reformed. In 2018, the Education and Training Evaluation Commission (ETEC) was introduced with a mission to monitor, redesign, and improve the quality of the higher education sector. The ETEC has four divisions, two of which have a responsibility towards nursing education: the National Commission for Academic Assessment and Accreditation and the National Framework System.

To improve workforce localisation in nursing, there have been calls to increase the quantity and quality of nursing schools (Almalki et al., 2011). Although the number of nursing schools has increased significantly in the last decade, their output of graduates is projected to meet only 25% of the health sector's need for nurses (Alomran et al., 2017). This anticipates that the heavy dependence on foreign nurses will remain steady in the near future. Moreover, the health sector will find it challenging to sustain the increased percentage of national nurses, knowing that many of them have a tendency to leave the profession for socio-cultural or work-related reasons (Falatah and Salem, 2018; Alghamdi et al., 2019).

1.2.7 Transition to practice: Saudi context

As explained in *An Overview of BSN Programmes*, undergraduate nursing curricula vary greatly from one country to another. In the context of Saudi, nursing programmes generally comprise four years of theoretical and clinical learning, plus a fifth (internship) year which is intended to prepare students for role transition from student to registered nurse. In terms of contact hours, students are required to complete 1,425 hours of theory and 3,150 hours of practice-based learning, according to one of the accredited BSN programmes. The requirement in the Saudi nursing curriculum to complete an internship year (1,920 hours) prior to qualification differs from other countries. Nursing students in many countries do not normally receive such an extended period of practice-based training to make them work-ready upon qualification, e.g. the requirement is 800 hours in Australia. The international literature, therefore, strongly recommends adding a residency of 6-12 months during the first year of employment to assist newly qualified nurses during role transition. In Saudi, however, the internship year basically serves the same purpose as a residency; thus, Saudi students are expected to be practice-ready upon qualification, i.e. after completing the internship.

Student nurses, in Saudi, undergo two cycles of preparation for role transition. First, when they commence their internship year, they transfer from a student to an intern role. While students during clinical placements are restricted to observation and limited hands-on experience, as interns they enjoy more authority and autonomy to practise their clinical nursing skills. The level of authority and autonomy during internship also varies depending on the policies of the institution where the interns are training. Some hospitals are more flexible and allow more hands-on experience; others tend to be stricter and limit training to observation of how senior nurses carry out different nursing procedures. This variation is likely to impact on the student learning outcomes at the end of their internship in terms of competence and confidence.

The second cycle of role transition occurs when interns graduate and begin their first posts as registered nurses. In spite of completing one year of internship prior to qualification, some employers hire newly qualified nurses (NQNs) and place them into a nursing residency

programme (NRP) with the aim of assisting their role transition from intern to registered nurse. These kinds of programmes have been suggested by the international literature (Glynn and Silva, 2013; Morton et al., 2017) to overcome the challenges associated with role transition, as most NQNs studied did not seem to receive support for role transition prior to qualification. In Saudi, however, NQNs are prepared for role transition prior to qualification; thus, the aim of implementing a residency programme by some employers and making it a requirement for NQNs is unclear.

Considering that many NQNs still struggle with transition to practice today, a new study that explore the transition process of current NQNs may help to better understand their experiences and perceptions of the role transition. This can ultimately assist in developing more effective programmes to better prepare NQNs for role transition.

1.3 Focus of the project

The practice of preparing NQNs for role transition through two consecutive programmes, namely internship (prior to qualification) and residency (post-qualification), is a relatively new phenomenon. There is very limited research that scrutinises the experiences of NQNs who were trained for role transition prior to qualification; thus, their transition experience remains underexplored. The focus of this PhD project is to explore the transition experience of newly qualified nurses (NQNs) in Saudi context. It intends to investigate how NQNs experience role transition while attending a nursing residency programme, what are their concerns and how they attempt to resolve it. By understanding their experiences, it is hoped that this research will offer a different, potentially more productive, substantive hypothesis to assist key stakeholders to solve problems related to NQNs' transition to the workplace.

1.4 Summary

This chapter, through its introduction and context sections, provided an overview of the different standards of nursing education, the nursing transition phenomenon and the context where the study was conducted. It included a discussion of the issues associated with the nursing transition, and a report of the geopolitical, demographic and socioeconomic characteristics of Saudi. It also presented an overview of the development of the Saudi economy and society. A detailed discussion of the healthcare system and the profession of nursing in Saudi provides the reader with a general understanding of healthcare services in the region. Moreover, nursing education and the national education system in general were also discussed to highlight some of the major differences between national and international nursing education standards. Finally, this chapter concluded with the focus of this project which reflects my interest in the transition experience of NQNs and how it warrants further exploration.

Chapter Two: Literature review

A scoping review was conducted to obtain a broad overview of the literature pertinent to the transition of newly qualified nurses (NQNs) from a student to qualified nurse role. The review identified theoretical papers and empirical studies about the transitional experiences of NQNs graduating from nursing schools and joining the professional workforce. Firstly, this chapter provides a discussion of the role of a literature review in grounded theory studies. Secondly, it offers a rationale for conducting a scoping review as part of a grounded theory research project. This chapter also touches on the methodology of grounded theory and how it informed the choice of a scoping review. Thirdly, the review design and search methods are explained. Finally, the findings of the review and an overall quality assessment of the current evidence are discussed. This chapter has been the basis of a publication, (Aldosari et al., 2021), which I included in Appendix 1.

2.1 Literature reviews in grounded theory

A literature review helps identify gaps in the existing knowledge about a research area, and can therefore provide a rationale for the intended research questions (Creswell, 2014). It also provides the reader with a critical summary of the current knowledge. This research project followed a grounded theory (GT) methodology, which initially uses an inductive approach to generate a theory from empirical data gathered in the field. Researchers using GT are generally recommended to delay full engagement with the relevant literature (Glaser and Strauss, 1967). Creswell, (2014) states that it is not uncommon in GT approaches for the literature to instead be used as an aid, at the end of the research, to refining the emerging theory.

This research study is part of a PhD degree, and research students are typically required to carry out a literature review as part of their research training in order to satisfy institutional requirements. By conducting a literature review, students can prove that they have the knowledge and ability to produce robust research, justify their proposals and identify current gaps in the literature to ensure they can make an original contribution to the research field

(Dunne, 2011). Furthermore, by conducting a review they can demonstrate that they will be able to clearly address the research problem, identify the appropriate methodology and methods, and develop an extensive understanding of related theories and applications (Randolph, 2009). A literature review helps students to know the current (research) state of play within a given area; therefore, it is usually set as the first milestone in their project timeline.

The role of the literature review within GT enquiries continues to spark debate and often leads to confusion, especially among novice grounded theorists, due to the misunderstanding of its function (Andrews, 2006). The co-founders of the GT methodology, Glaser and Strauss (1967), recommended that researchers delay a substantive literature review and enter the field with as few preconceptions as possible to avoid "theoretical contamination". This strategy was believed to assist researchers to maintain "openness" and discover what is really in the data, rather than being derailed by preconceived ideas (Glaser, 1992; 1998).

Since GT was originally conceived, multiple approaches have been developed that have different views about when and how to review the literature within a grounded theory study. For example, Strauss and Corbin (1990) and Charmaz (2006) developed different versions of grounded theory and thought that reviewing the literature before data collection did not necessarily hinder the development of the theory. They recognised that researchers will bring their own experience and knowledge to the research, and suggested that their role will be evident during the analysis, so that there was no need to delay reading the literature until the very end of the study. Indeed Strauss and Corbin (1990) advised engaging with the literature in "all phases of the research". With their pragmatic background, they seemed to hold less restrictive views on when to review the literature, which was deemed helpful in developing the research questions and generating a theory. Furthermore, they claimed that engaging with the literature made the researcher more theoretically sensitive and aware of what was important to the emerging theory (Hickey, 1997). Meanwhile, Glaser (1998) continued to hold the view that reading relevant literature and substantive theories prior to commencing the study is likely to impose onto the developing theory preconceived concepts that have no basis in the data.

Although the three schools of thought in GT acknowledge that the researcher cannot enter the substantive area free from ideas, they have different perspectives on the role of the literature review (Heath and Cowley, 2004). Glaser advices reading the literature but in areas that are different from the research (Glaser, 1978). He has remained cautious that early reviewing of relevant literature might impede the generation of grounded theory, expressing the fear that a literature review may lead to preconceptions that are irrelevant to the substantive area, and/or produce work that echoes what is in the literature not what is emerging from the data. To clarify Glaser's stance on literature reviews, he categorises the literature into three types: non-professional, professional but unrelated to the topic of interest, and professional and focused on the area to be studied (Glaser, 1992). Although Glaser opposed prior engagement with focused literature, he encouraged very wide reading to maintain theoretical sensitivity and improve the researcher's knowledge of theoretical codes (Glaser, 1978). Thus, a preliminary review of the literature is totally consistent with the principals of the methodology (Andrews, 2006).

There are some circumstances where reviewing the literature before data collection is a requirement, for instance: researchers who are applying for grants, or PhD students who are obliged to satisfy their institutional requirements. Those individuals who are required to conduct a literature review prior to data collection can still carry out their studies and generate grounded theory; for example, as suggested by Glaser (1998), by turning their review into a data collection exercise to be constantly compared with the emerging theory. In cases where the researcher is knowledgeable about their field and the existing literature, he or she could publish a paper that states the assumptions they had absorbed from reviewing the literature and use it as additional piece of data to be constantly compared with empirical data (Hickey, 1997;Glaser, 1998).

Conducting a literature review and having it published prior to going to the field (to collect data) better suited this study's circumstances. I (the researcher) had worked for few years in the substantive area and was largely aware of the related literature, and had already built up assumptions about the field. This option (publishing a review) was thought to help the research to stay within GT principles and simultaneously satisfy the University's requirements for PhD students. Therefore, the ideas and assumptions that I developed through professional experience

and existing literature, which I published in the *International Journal of Nursing Studies* (IJNS), will be utilised to minimise the influence of my preconceptions on the emerging concepts. A copy of the publication, (Aldosari et al., 2021), is displayed in Appendix 1. Moreover, Glaser (1998) argues that the use of the constant comparative method should counter any preconceptions derived from personal knowledge or from reviewing the literature.

As a literature review prior to data collection is still considered an integral part of research training, and as classic GT recommends wider theoretical reading, a broad exploration of the literature rather than a more focused review of the literature was needed. Thus, for this PhD project, a scoping review approach was deemed appropriate for two reasons. First, scoping reviews provide a wide theoretical overview of the area under study (in my case, nursing transition) and increase awareness of any existing ideas related to that area. A Second, more pragmatic reason was that completion of any sort of literature review was a progression criterion at the University of Manchester and would help me prepare ethics by demonstrating comprehensive and up-to-date knowledge of the key issues in the area.

2.2 Rationale for scoping review

Scoping reviews have recently gained popularity in health research as they can be useful to synthesise relevant literature, particularly in areas with rapid evolving evidence that makes conducting systematic reviews difficult (Levac et al., 2010). The main purpose of conducting scoping reviews is to provide a broad overview of an area of interest (Pham et al., 2014; Peterson et al., 2017). They aim to map current knowledge of a topic through systematic assessment of the extent, nature, and characteristics of the relevant literature (Arksey and O'Malley, 2005; Munn et al., 2018). Moreover, evidence suggests that scoping reviews are beneficial in areas that are considered complex in nature or which have not yet been thoroughly reviewed (Peters et al., 2015). This is particularly relevant to a complex phenomenon like NQN transitions, where several stakeholders such as academics, clinicians, nurses and managers are involved.

Systematic and scoping reviews share some processes as they both tend to rely on systematic and transparent techniques to produce rigorous findings (Pham et al., 2014). This methodological

strength is often lacking in other types of literature reviews e.g. narrative reviews (Collins and Fauser, 2005). A systematic review, however, differs in that it tends to summarise the best available literature in order to answer a focused question (Higgins and Green, 2011), whereas a scoping review tries to generally map the existing literature onto a topic of interest (Arksey and O'Malley, 2005). Furthermore, a systematic review often includes fewer studies, while a scoping review involves searching a wider body of literature in order to provide a general overview of the topic under study.

The type of quality assessment of included studies required is another difference between scoping reviews and systematic reviews. A scoping review attempts to provide a methodological discussion of the reviewed articles, and performing a formal quality assessment is often considered unnecessary (Levac et al., 2010; Peterson et al., 2017). Conversely, authors of systematic reviews are required to formally critically appraise the quality of the reviewed studies in order to assess the validity of their findings, and also to produce a synthesis of these studies (Higgins and Green, 2011; Pham et al., 2014). Due to the lack of formal quality assessment of the included studies, the findings of scoping reviews can be challenging to interpret and might be considered less rigorous or biased (Grant and Booth, 2009; Brien et al., 2010). To minimise these limitations and improve rigour, the Arksey and O'Malley (2005) framework was thought appropriate as it provides explicit steps for conducting scoping reviews.

2.3 Scoping review design

The approach of Arksey and O'Malley (2005) consists of five steps: identifying the research question, identifying the studies that are relevant, developing eligibility criteria for study selection, charting the extracted data, and collating, summarising and reporting the results. There is an additional, but optional, sixth step: consulting key informants as they may provide extra references or insights that have been overlooked in the literature or have emerged recently. In this study, the literature search and selection and sorting of the studies were carried out systematically, while the findings were presented through themes that were repeatedly

discussed in the reviewed articles (Arksey and O'Malley, 2005). In addition, the methodological issues identified in the included articles were discussed in this review.

For this study, the scoping review seemed to be an appropriate tool as it has the potential to rapidly map a wide range of literature and chart the main concepts identified in an area of interest. This helps to emphasise what previous studies have covered and identify the areas where there is a lack of knowledge (Arksey and O'Malley, 2005; Armstrong et al., 2011). In addition, compared to a systematic review, a scoping review allows for the wider and more theoretical reading of the literature, which grounded theorists are urged to do (Glaser, 1978). Thus a scoping review was perceived as a suitable method to provide an overview of the nursing transition phenomenon, the key informants' experiences and perspectives, and current policies and practices related to the transition of NQNs from nursing school to the workplace. The design of the scoping review is detailed in the following section.

2.3.1 Identifying the review question

Review questions form a starting point for the search process and guide the scope of the review (Levac et al., 2010). Developing a research question that is broad in nature is thought to facilitate comprehensive coverage of literature related to the topic of interest (Arksey and O'Malley, 2005). The development of the review question was discussed with the study supervisors to reflect the clinical and research expertise of all the research team members. The scoping review question was developed as:

How do student nurses transition to qualified nurses during the first year of practice?

This broad question was thought to encourage searching a wide range of literature regarding nurses' transition; however, it could have led to an unmanageable number of articles being found. To delimit the focus of the study and make the search process more efficient, Levac et al. (2010) recommend defining the concept, the target population, and the intended outcomes of

interest within the research question. A further discussion with the supervisory team to refine the scope of the review led to the development of additional questions, as follows:

- What research has been conducted in regard to the transition of NQNs from student to qualified nurse within their first year of practice?
- What are the experiences and perceptions of the strategies that have been developed/implemented to facilitate NQNs' transition?
- What are the theoretical perspectives that underpin current practices to support NQNs during the transition?
- What are the associations between the quality of pre-registration nursing education and the process of transition of NQNs?

The scoping review was carried out to map rapidly the existing literature regarding the nursing transition, clarify related key concepts, and identify knowledge gaps, if any. It included reviewing papers and policies related to NQNs' transition process and experiences, and the perspectives of the key informants on the provision of transition support programmes. This review was expected to produce a thematic overview of the literature in relation to NQNs' transition and highlight the areas that may require further investigation.

2.3.2 Identifying relevant literature

The potential to explore a wide range of literature is considered to be one of the advantages of scoping reviews (Davis et al., 2009). Nevertheless, developing eligibility criteria was thought essential to balance the breadth and comprehensiveness of the literature search (Arksey and O'Malley, 2005). The eligibility criteria were developed and were intended to assist in covering areas that are of relevance to the nursing transition and exclude less relevant papers, hence saving time and resources. The eligibility criteria for the review study are defined in the next section.

Another advantage of scoping reviews is the possibility of making post hoc changes to the eligibility criteria during the review process. This feature can be helpful, for instance, to better

address the review question or modify any of the keywords or search terms. During the scoping review process, post hoc decisions were made following suggestions from five independent reviewers from the IJNS. This included a suggestion to either focus on experiences and perceptions of the transition process or the nursing residency programmes. Thus, I revised the review supplementary questions to focus on the experiences and perceptions during role transition.

2.3.3 Developing eligibility criteria for study selection

Each paper identified had to meet at least one of the following criteria to be included in the review:

- Papers that explored the experiences and perceptions of NQNs' transition during their first year after qualification.
- Papers that investigated the development of NQNs' theoretical and clinical skills when transitioning from school to workplace.
- Papers that explored the impact of current practices to facilitate NQNs' transition to becoming professional nurses.
- Papers that discussed the outcomes of nursing residency programmes designated to facilitate transition.

Studies were excluded if they fell into one of these categories:

- Papers that included student nurses, as they are not yet considered qualified nurses.
- Papers focused on pre-registration nursing curricula.
- Papers that included graduates from disciplines other than nursing, such as midwifery graduates. (Post hoc).
- Papers that studied the experiences and perceptions of NQNs following the first 12-months in employment. (Post hoc).
- Papers that focused on preceptors' development. (Post hoc).
- Papers that were published in languages other than English or Arabic due to a lack of resources for translation.

- Search strategy

Following development of the review question, I used the mnemonic "PICo" to split the question into three components: population, interest and context. PICo also helps identify related keywords and search terms (Stern. et al., 2014). The keywords are presented in Table 4 below.

	Inclusion criteria	**Exclusion criteria**	**Derived search terms**
P "Population"	Newly qualified nurses within the first 12 months of practice.	Student nurses, registered nurses with more than 12 months of clinical experience, specialties other than nursing (e.g. midwifery graduates).	"New* graduate nurse" OR "new* qualified nurs*" OR "novice nurs*" OR "neophyte nurs*" OR "nurs* educator" OR "preceptor" OR "nurs* manager"
			AND
I "Interest"	Experiences and perceptions of the transition process.	Experience and perceptions prior to qualification	"Nurs* transition" OR "nurs* residency" OR "preceptorship" OR "transition* support program*"
Co "Context"	All healthcare settings.	Non-healthcare settings.	---

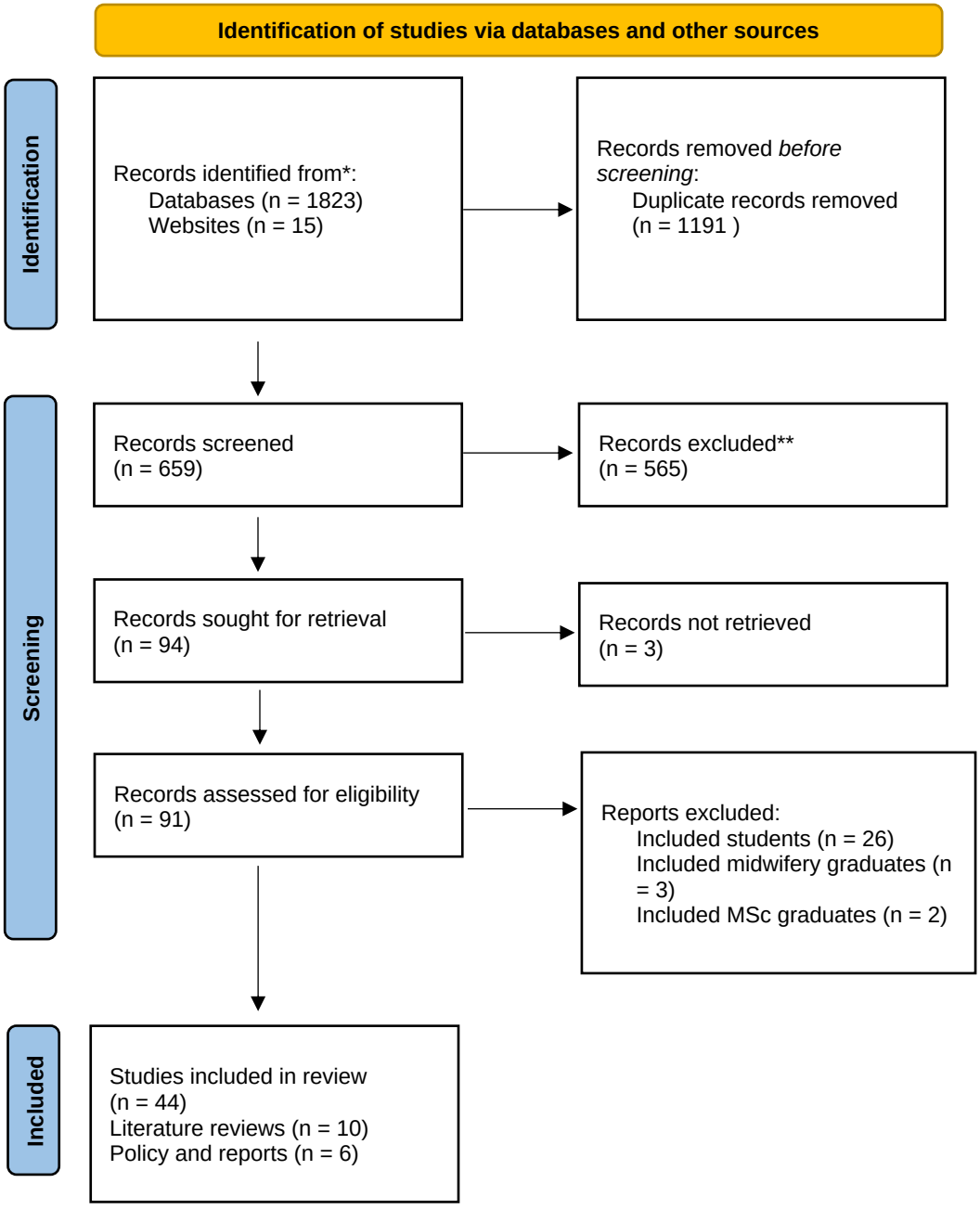
Table 4: Search Terms

- Databases searched

Initially, the Cumulative Index to Nursing and Allied Health Literature (CINAHL) database was searched, as it was the most relevant international database. The British Nursing Index (BNI) database was also searched for relevant studies that might not be available in CINAHL. An additional search was conducted through alternative databases namely PubMed, ERIC and PsycINFO as they also include literature that is related to nursing and nursing education. Papers that were not immediately accessible were obtained through the University of Manchester Library's document supply service. At a later stage, several nursing-related websites, such as the UK Nursing and Midwifery Council (NMC), the American Association of Colleges of Nursing (AACN) and the Australian Nursing & Midwifery Accreditation Council (ANMAC) were searched for policies or reports regarding nursing transition and support programmes.

The initial search of the literature retrieved a relatively large number of articles (n= 1,823). Searching the reference lists of the identified articles and grey literature resulted in an additional 27 articles. After removing the duplicates, 659 papers were returned from the search. The papers were then screened by title to determine their relevance, which resulted in 455 studies being excluded as not relevant. The remaining 204 articles were screened by title and abstract to ensure that they met the inclusion criteria. The title/abstract screening led to the further exclusion of 113 articles as they met one or more of the exclusion criteria (e.g. included midwifery graduates). As a result, 91 articles remained for a full-text review. The full-text review process led to a list of 50 studies that met the inclusion criteria. The 41 excluded studies were thought to be irrelevant due to the studies' scope of interest or population. The decisions to either include or exclude the studies were made independently by myself and one of my supervisors, with the other supervisor resolving any disagreements. An additional 10 papers were added following checking of the references of the retrieved studies, and from grey literature, making the final number of included papers 60. The following diagram (Figure 5) shows the process from retrieving the initial studies to reaching the final list.

Figure 5: Flow chart of literature search process (PRISMA 2020)



From: Page MJ, McKenzie JE, Bossuyt PM, Boutron I, Hoffmann TC, Mulrow CD, et al. The PRISMA 2020 statement: an updated guideline for reporting systematic reviews. BMJ 2021;372:n71. doi: 10.1136/bmj.n71

For more information, visit: http://www.prisma-statement.org/

2.3.4 Charting the data

A table was created using Microsoft Word to chart the relevant data from each article. This included names of authors, year of publication, country, study sample, methodology and methods, and findings. This technique was deemed useful to assist the reviewer in identifying recurring issues and themes, and potentially finding the knowledge gaps (Arksey and O'Malley, 2005). Although this technique helped in organising the details of selected articles, charting the data was a challenge due to doubts about the nature and extent of data that should be extracted. Levac et al. (2010) suggest that two authors or more should work collaboratively to create a charting form and determine which information is to be extracted from the selected papers. As this review was part of a PhD thesis, the data charted and the themes I developed from the reviewed literature were discussed with my supervisors for advices and verification. The following table (Table 5) presents the selected articles and extracted data. Due to its relatively large size (12 pages), I moved the data extraction table to the appendices (See appendix 2).

Table 5: data extraction table.

2.3.5 Collating, summarising and reporting findings

- Characteristics of included articles

The 60 papers included in the review originated from different parts of the world. Most of the empirical studies included in the review were carried out in the United States (n=24) followed by the United Kingdom (n=16), and a large number of countries were the site of only one study. The following chart (Figure 6) presents the included articles based on their geographical location.

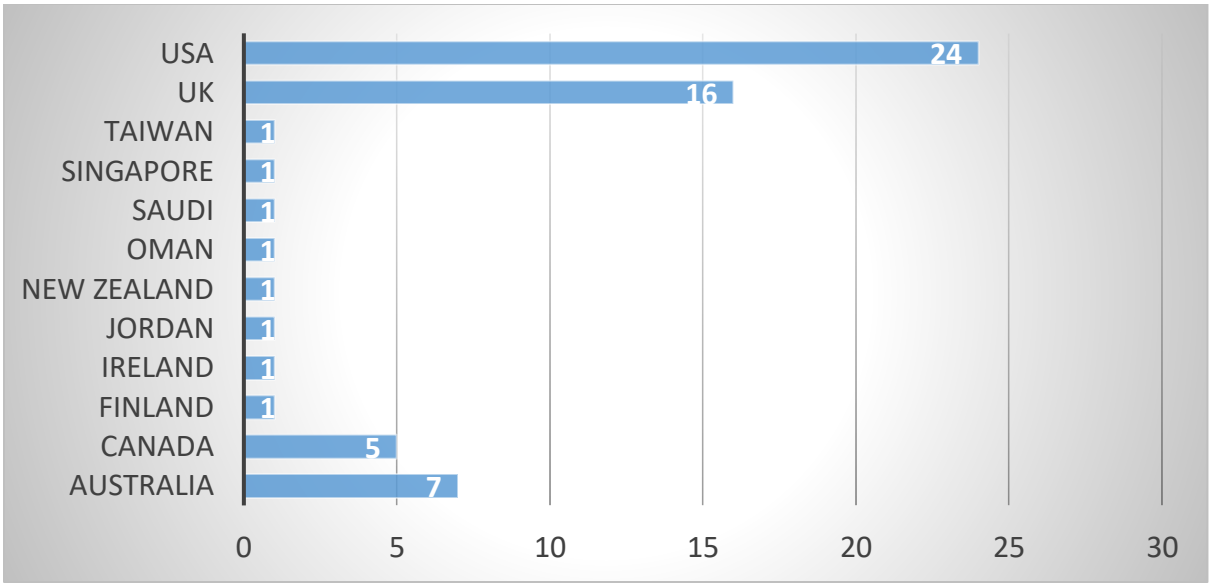


Figure 6: Included articles by geographical location.

The authors of the 44 included studies employed various methodologies, with quantitative designs (descriptive and experimental) being the most frequently used (18 studies). The review also included 16 qualitative studies, 10 mixed methods studies, 10 literature reviews and 6 policy papers and reports from the grey literature. The following figure (Figure 7) presents the articles by their methodological characteristics.

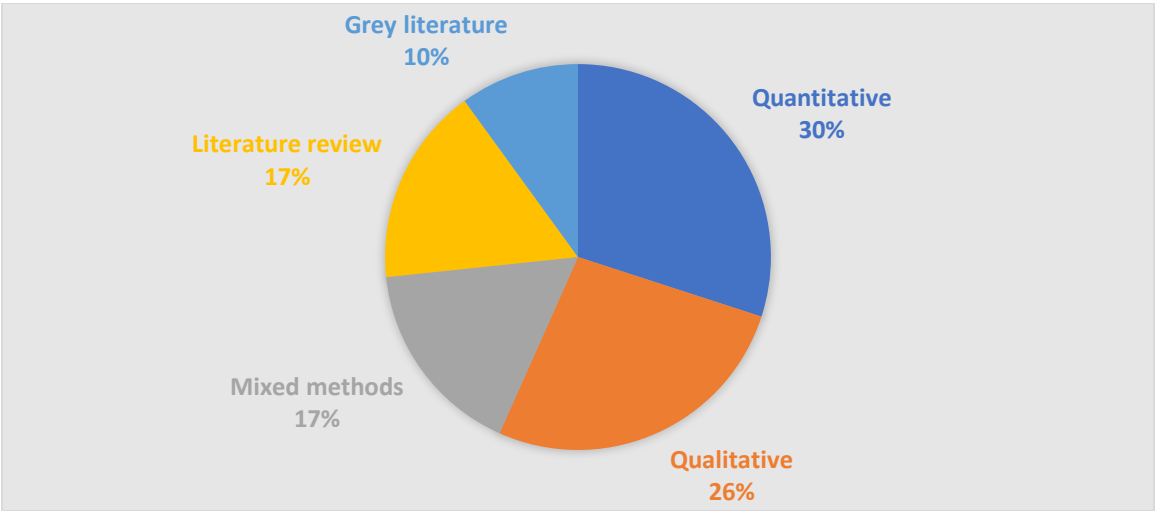


Figure 7: Methodological characteristics of the articles

- Nursing residency programmes

Almost all of the included documents made reference to nursing residency programmes (NRPs). However, authors used various terms to describe these programmes. Moreover, it was noted that NRPs varied significantly in terms of length, ranging from 6 to 18 months. All articles that discussed the NRPs reported that the rationale underpinning the implementation of such programmes was to support NQNs during transition from nursing school to workplace, yet none of them provided theoretical justification for the length of their support programmes. This signalled that, with regard to the research questions of this scoping review, the time required for NQNs to transition from student to qualified nurse role was largely assumed, and no attempts were made to clarify the reason for the length of the transition period. My decision to focus on studies that were conducted within the first 12 months of practice was a post hoc decision. Studies after the first 12 months of practice tended to specifically focus on longer term outcomes of nursing transition programmes, which were beyond the aim of this review (experiences and perceptions).

The following table (Table 6) demonstrates the variability in terminology used in these programmes, along with their length and content.

Terminology	Authors	Country	Duration	Content included
Nursing Residency Programme	Slate et al. (2018)	US	12 months	12-week unit orientation, 1:1 preceptorship, and biweekly progress meetings
	Spiva et al. (2013), Bérubé et al. (2012)	Canada	12 months	1:1 preceptorship, monthly educational sessions. and clinical rotations
	Figueroa et al. (2013)	US	18 weeks	Educational sessions, 1:1 supervision, self-care, and debriefing session
	Setter et al. (2011), Cline et al. (2017)	US	12 months	Educational sessions, regular progress meetings, and writing clinical narratives
	Kramer et al. (2012), Wierzbinski-Cross et al. (2015)	US	12 months	Stress-reduction seminars, didactic classes, and 1:1 preceptorship

	Linus et al. (2014)	US	12 months	Monthly support interactive sessions, and required completion of EBP project.
	Hopkins and Bromley (2016), Goode et al. (2013), Friday et al. (2015)	US	12 months	Unclear.
	Bratt and Felzer (2011), Olson-Sitki et al. (2012)	US	12 months	Monthly educational sessions and mentoring
	Aldossary et al. (2016)	Saudi Arabia	6-12 months	Orientation and educational classes
Preceptorship	Forde-Johnston (2017)	UK	12 months	Study days, simulation training, and regular support meetings
	Allan et al. (2018), Edwards et al. (2015), Irwin et al. (2018)	UK	Unclear	Group preceptor support, onward mentoring, and monthly support meetings
	Lewis and McGowan (2015), Monaghan (2015), Marks-Maran et al. (2013), Muir et al. (2013), Whitehead et al. (2016)	UK	Unclear	Supervised shifts and regular progress meetings
Graduate Internship	Glynn and Silva (2013)	US	6 months	4-hour weekly educational classes, 1:1 preceptorship, peer support sessions
	Al Awaisi et al. (2015)	Oman	6 months	Ward rotation and 1:1 preceptorship
Graduate Nurse Transition Programme	Henderson et al. (2015), Bakon et al. (2018), Lima et al. (2016), Lea and Cruickshank (2005)	AU	12 months	4-day orientation, 2-week supernumerary period, and bimonthly study days
	Cubit and Ryan (2011)	AU	12 months	12-day supernumerary period, 6 day study days, 1:1 preceptor, and team building exercises (e.g. snow skiing)
	Rush et al. (2014)	Canada	12 months	Orientation, 96-144 hours of supernumerary and educational sessions, and 1:1 mentor
Transitional Support Programme	Hussein et al. (2017)	AU	12 months	Orientation, 2-3 ward rotations, 4-5 study days, and formal and informal clinical supervision.
	D'Addona et al. (2015)	Canada	12 months	4-6-week unit orientation and seminars every 6 weeks

New Graduate Guarantee Orientation	Guay et al. (2016)	Canada	12 months	1:1 preceptorship
Orientation	Pasila et al. (2017)	Finland	Vary	Ward rotations, educational days, and clinical supervision.
Transition to Practice	Ankers et al. (2018), Silvestre et al. (2017)	AU	12 months	Ward rotation and theoretical and clinical components
Nursing Entry to Practice Programme	McKillop et al. (2016)	NZ	12 months	Accredited postgraduate academic course and 1:1 preceptorship
Novice Nurse Leadership Institute	Dyess and Parker (2012)	US	12	Peer support, educational sessions, and 3 courses that each provided one university credit.
Nurse Foundation Programme	Jones et al. (2014)	UK	12 months	13 study days and 1:1 preceptorship

Table 6: NRPs by terms used, length, and content.

2.4 Thematic analysis

A thematic analysis approach helps to determine common themes or topics that appear repeatedly in data and can be adapted for use in reviews of literature (Braun and Clarke, 2006). Thus, thematic analysis was employed to identify the common issues in the included documents. Thomas and Harden (2008) explain that the process generally involves three stages: line-by-line coding, grouping similar and different codes and generating categories that capture the meaning of initial codes, and then developing analytical themes.

The interchangeable use of terms to refer to programmes aimed at supporting NQNs during role transition, (Table 6), can be confusing. For clarification purposes, in this study, "internship" is used to mean a prolonged period of practice-based training that prepares students for role transition *prior to qualification*, whereas "nursing residency programmes" (NRPs) is a generic term used to refer to any programme that supports students following qualification within the first year of employment. NRPs may include preceptorship, teaching sessions and practice in simulation labs. "Preceptorship" here refers to pairing a newly qualified nurse with a senior nurse "preceptor".

The thematic analysis resulted in the emergence of two overarching themes, and each covered a number of subthemes (See Table 7).

Theme	Subtheme	No. of articles	Authors
The transition experience	Reality shock Perceived readiness of NQNs Competence Confidence	20	Ankers et al. (2018), Abualrub and Abu Alhaija'a, (2018), Al Awaisi et al. (2015), Clark and Holmes (2007), Duchscher (2008), Edwards et al. (2015), Glynn and Silva (2013), Guay et al. (2016), Henderson et al. (2015), HEE (2015), Hussein et al. (2017), Irwin et al. (2018), Jones et al. (2014), Kumaran and Carney (2014), Lea and Cruickshank (2005), Muir et al. (2013), Monaghan (2015), Nour and Williams (2018), Slate et al. (2018), Spiva et al. (2013).
The perceived benefits of nursing residency programmes	Benefits for NQNs Organisational benefits Managerial challenges within NTPs	40	Allan et al. (2018), Aldossary et al. (2016), Bakon et al. (2018), Berkow et al. (2008), Bérubé et al. (2012), Blegen et al. (2015), Bratt and Felzer (2011), Cline et al. (2017), Cubit and Ryan (2011), Cochran (2017), D'Addona et al. (2015), Dyess and Parker (2012), Eckerson (2018), Figueroa et al. (2013), Forde-Johnston (2017), Friday et al. (2015), Goode et al. (2013), Hillman and Foster (2011), Hopkins and Bromley (2016), IOM (2010), Ke et al. (2017), Kramer et al. (2012), Lewis and McGowan (2015), Linus et al. (2014), Lima et al. (2016), Marks-Maran et al. (2013), McKillop et al. (2016), Morton et al. (2017), Olson-Sitki et al. (2012), Pasila et al. (2017), Pittman et al. (2013) , Quek and Shorey (2018), RCN (2017), Rush et al. (2014), Setter et al. (2011), Silvestre et al. (2017), Snow (2013), Whitehead et al. (2016), Whitehead et al. (2013), Wierzbinski-Cross et al. (2015).

Table 7: Themes and subthemes identified in the literature

Theme one: The transition experience

- Reality / transition shock

The initial reaction of NQNs when entering professional practice was described as "reality shock" by Kramer (1974) and three decades later as "transition shock" by Duchscher (2008). The shock-like feeling during transition from nursing school to professional workplace continues to be a challenge even for contemporary NQNs (Nour and Williams, 2018). This feeling stems largely from developing unrealistic and idealistic expectations while studying nursing, which are later found to be far from reality (Duchscher, 2008). A significant point in Duchscher's study was that the majority of participants (NQNs) were hired for a float position (i.e. shared between more than two units); this is thought to add to NQNs' anxiety and delay their adjustment to the new working environment (Guay et al., 2016).

Recent studies have argued that transition shock is a result of encountering clinical scenarios that varied significantly from what was expected and/or an overwhelming increase in responsibilities associated with the new role (Al Awaisi et al., 2015; Whitehead et al., 2013). This stressful experience can consequently cause a significant attenuation of NQNs' self-esteem (Kramer et al., 2012). Moreover, the fast-paced work, particularly in critical care settings, and the complexity of patients' conditions, gives little room for NQNs to consolidate their previous learning (Clark and Holmes, 2007). This can make NQNs distrust their abilities and feel afraid of executing any procedure for fear of making mistakes (Kumaran and Carney, 2014). Additional factors contributing to reality shock include insufficient orientation to the workplace and an unwelcoming work culture (Figueroa et al., 2013; Ankers et al., 2018).

As a result of the ever-increasing workload experienced by health professionals and the high acuity of patients, NQNs entering the field are prone to physical and emotional burdens that could potentially trigger intentions of leaving the profession early (Hillman and Foster, 2011; Edwards et al., 2015) Stressful initial experiences could delay the transition of NQNs to becoming autonomous professionals and might have unfavourable consequences at both individual (nurses) and organisational (institutions) levels. There are several factors associated with the

increased turnover of NQNs, however: the literature indicates that the quality of support, workload, and pressure have been the major causes of NQNs intending to leave their jobs (Wierzbinski-Cross et al., 2015; ICN, 2020).

As explained in the *Introduction* chapter, most nursing programmes equip students with the theoretical knowledge and clinical skills required to meet standards of professional practice. However, lack of support during their first days in professional practice can make NQNs, according to some experienced nurses, prone to making basic mistakes (Glynn and Silva, 2013), leading to questions about the preparation of NQNs.

- Perceived readiness of NQNs

The readiness of NQNs to meet standards of professional practice and work independently following qualification is a recurrent debate. In a quantitative study Berkow et al. (2008) evaluated the proficiency levels of NQNs by surveying 5,700 nurse leaders; two thirds were not fully satisfied with NQNs' clinical and non-clinical skills. This is a perspective that many educators do not seem to share, as they argue that NQNs hold the appropriate knowledge and skills, but the lack of support during role transition undermines their self-confidence and may consequently lead to poor performance (Kumaran and Carney, 2014).

The diverging viewpoints of these two groups (managers and academics) remain "opinions", and neither viewpoint may necessarily reflect the actual proficiency level of NQNs. In a qualitative study, Nour and Williams (2018) explored the experiences of NQNs while working in critical care centres and found that the majority of them felt unprepared to work autonomously. Many NQNs attributed their feelings of unpreparedness to the limited clinical training they received during their pre-registration courses, and said they wished they had been offered more opportunities for clinical practice (Al Awaisi et al., 2015; Cochran, 2017). The combination of the complexity of patients' conditions, the strain entailed in interdisciplinary work, and the new role responsibilities contributed to NQNs feeling subjected to significant pressure, and also to their loss of confidence

(Kumaran and Carney, 2014). Collectively, these pressures may have catalysed the feelings of burnout during their first days in professional practice (Nour and Williams, 2018).

These results have led to calls for health organisations to consider developing new initiatives to improve NQNs' experience of transition into the professional workplace (Duchscher, 2008). These recent calls drew attention to the necessity for internships, which were first suggested in the 1990s (Whitehead et al., 2013). Indeed, there have been reviews, such as the *Shape of Caring Review* in the UK, that suggested investigating the feasibility of incorporating internships into the pre-registration nursing curriculum (HEE, 2015). This strategy has already been implemented in some US organisations, where undergraduates can electively attend one to three months of internship (Friday et al., 2015). Other countries, such as Saudi, have taken a further step and added a 12-month internship as a core element in their pre-registration nursing programme. This one-year internship was designed to prepare students for the role transition and make them practice-ready upon qualification (Aboshaiqah and Qasim, 2018). Yet some studies argue that Saudi graduates still need additional clinical training and support during their first year in practice (AL-Dossary et al., 2016).

- *Competence*

The level of competence that can be reasonably required of NQNs upon qualification has been extensively discussed in the literature, yet a general consensus seems to be lacking. Clark and Holmes (2007) interviewed 5 nurse managers and 105 nurses; the majority of both managers and nurses felt that NQNs were not ready for autonomous practice. The authors argued that expecting an NQN to work independently immediately after qualifying is unrealistic. However, it has been documented that many NQNs struggle with impractical expectations of their clinical skills on the part of nurse managers (Hussein et al., 2017; Pasila et al., 2017). On the other hand, Marks-Maran et al. (2013) explain that NQNs in the UK are expected to demonstrate a certain level of competence or proficiency upon qualification. Thus, the level of clinical competence required of NQNs remains unclear, subjective and dependent on the clinical setting, amount of practice-based training and level of qualification. As discussed in the *Introduction* chapter, pre-

registration nursing programmes and the ratio of theoretical to practice-based learning may vary from one educational institution to another and from one country to another.

Berkow et al. (2008) assessed NQNs' level of competence from the point of view of their managers, and found that the majority of nursing managers were dissatisfied. It was noted that the authors included NQNs with different qualifications (diploma, Associate, BSN, and MSc); however, they failed to distinguish between the levels of competence expected of each group. The role, responsibilities and expected clinical competence level of BSN graduates generally differ from those of diploma or associate nurses; therefore, graduates who have studied to different academic levels cannot be assessed as one group.

Lima et al. (2016) studied the competence development of 47 NQNs, at four separate points, while attending a one-year NRP. The findings showed a significant improvement in the first six months compared to the subsequent six months. This corroborated the findings of Duchscher (2008) and Clark and Holmes (2007) that NQNs need six months of practice to develop competence. It was not clear, however, whether this development could be attributed to participation in an NRP. Moreover, more than 20% of the participants in Lima et al.'s study had previous clinical experience in nursing, which may have distorted the findings.

Using a longitudinal randomised study, Blegen et al. (2015) examined the impacts of a 12-month NRP on NQNs' competence, at three separate points, in 82 hospitals. The hospitals were divided into two groups based on the level of support provided to NQNs: high-support or low-support. All NQNs improved their competence, and there was no significant difference between the high-support and low-support hospitals. This may suggests that any kind of support provided during transition can be helpful to NQNs' professional growth (Edwards et al., 2015).

The transition literature often discusses the terms "competence" and "confidence", but rarely defines them. Irwin et al. (2018) reviewed the literature to determine the impact of preceptorships on competence and confidence levels, and stated that none of the reviewed studies (n=14) offered a definition of either competence or confidence. A clear definition of the

two terms is thought useful to better understand the competence and confidence levels of NQNs and how they progress over time.

- Confidence

An inadequate orientation experience may increase NQNs' sense of insecurity, resulting in undesirable consequences. Henderson et al. (2015) explained that poor introductory transition to professional practice could undermine confidence levels and escalate feelings of isolation. These negative consequences would intensify the transition experience, potentially leading to a rise in NQN turnover rates and financial cost to employers (Figueroa et al., 2013).

NQNs' lack of confidence in their clinical skills during the transition period has been reported by several studies (Olson-Sitki et al., 2012; Kumaran and Carney, 2014; Al Awaisi et al., 2015; Monaghan, 2015). This feeling of having little or no confidence may have worsened when NQNs met with negative expectations of clinical skills on the part of nurse managers, insufficient orientation, or assignment to critically ill patients (Clark and Holmes, 2007; Ankers et al., 2018). Thus, Duchscher (2008) suggested that NQNs should not be assigned to complex patients during the first half of the transition year. This is to allow sufficient time for NQNs to develop confidence, which is consistent with the literature that showed they need six months to be confident that they can function independently as professional nurses (Olson-Sitki et al., 2012; Goode et al., 2013; Whitehead et al., 2013).

Several studies investigated confidence levels among NQNs, yet the validity of the measurement tools used is questionable. In a systematic review, Edwards et al. (2015) reported that many studies relied on weak designs and most employed unvalidated methods to measure confidence. This finding raises two questions about a) the robustness of the evaluation methods being applied, and b) the key factors that either boost or hinder development of confidence during the first year in practice.

The long-reported transition shock, lack of confidence and uncertainty regarding level of competence have been the main challenges for NQNs, contributing to them undergoing stressful and sometimes appalling transition experiences (Clark and Holmes, 2007; Duchscher, 2008; Kumaran and Carney, 2014; Hussein et al., 2017). In an attempt to resolve these issues, several initiatives, most notably nursing residency programmes and internships, have been implemented to streamline the transition process and improve NQNs' experience of work, with the potential retain them in the workforce for longer. However, internships are not considered in this review as they concern pre-registration students.

- Nursing residency programmes

Several strategies have been applied in attempts to mitigate NQNs' daunting experiences during role transition. Nursing residency programmes (NRPs) are one of these approaches. As shown in Table 6, they have been termed variously in the international literature, including "preceptorship" (Figueroa et al., 2013; Marks-Maran et al., 2013; Lewis and McGowan, 2015; Allan et al., 2018), "nursing residency" (Setter et al., 2011; Pittman et al., 2013; Spiva et al., 2013; AL-Dossary et al., 2016; Hickerson et al., 2016; Slate et al., 2018), "transition support" (D'Addona et al., 2015; Hussein et al., 2017), "internship" (Glynn and Silva, 2013; Al Awaisi et al., 2015), "orientation" (Guay et al., 2016), and "transition to professional practice programmes" (Ankers et al., 2018). Despite the variety of terms, these programmes share an overall aim which is to facilitate the NQNs' transition by means of formal support and to encourage personal and professional growth in a safe environment (Kramer et al., 2012; Whitehead et al., 2016; Cochran, 2017).

Post registration nursing residency programmes (NRPs) differ from ordinary orientation programmes as they are more structured and of longer duration. Orientation introduces a new employee to an organisation's policies and procedures, the locations of the different units within the setting, and regulations in regard to staff rostering and leave (Kramer et al., 2012), while NRPs commonly add one-to-one preceptors, clinical simulation sessions, didactic classes, reflection, and/or stress-reduction seminars (Figueroa et al., 2013; Marks-Maran et al., 2013). These

programmes are often designed for the local context and delivered to meet the organisation's specific needs. Thus, NRPs also vary in terms of structure, content, regulations, and individuals involved in the programme (Edwards et al., 2015). Most studies identified in the literature rationalise the introduction of NRPs as enhancing NQNs' knowledge and clinical skills, building confidence, and easing their immersion into the working environment. However, other healthcare agencies have adopted this strategy for different motives: to attract more new nurses and retain the existing ones (Snow, 2013; Slate et al., 2018).

NRPs have been increasingly acknowledged and adopted worldwide (Goode et al., 2013; Pittman et al., 2013). Some of these programmes have been reported as being able to meet the intended outcomes on implementation, while others needed some enhancement. The following section will report on the perceived benefits of NRPs.

Theme two: The perceived benefits of NRPs

- *Benefits for NQNs*

Studies reported that NRPs and similar initiatives were perceived as beneficial in smoothing the transition process of NQNs to the professional workplace (Goode et al., 2013; Jones et al., 2014; Henderson et al., 2015; Eckerson, 2018). Linus et al. (2014) interviewed 39 nurse managers, finding that the NRP seemed to accelerate NQNs' engagement in their working unit and their "enculturation" progressed faster. The study, however, was limited to the perceptions of nurse managers, which might have differed from those of NQNs. Although these studies reported improvements in NQNs' personal and professional skills, the nature of the link between participating in an NRP and development of skills is unclear.

Improving NQNs' clinical nursing skills was another reported benefit of the provision of NRPs (Dyess and Parker, 2012; Glynn and Silva, 2013; Marks-Maran et al., 2013). Bratt and Felzer (2011) surveyed 464 NQNs to determine their progress in professional competence using the Clinical Decision Making in Nursing Scale (CDMNS) and the Modified 6-D Scale of Nursing Performance. The results showed significant improvements in clinical decision-making skills and quality of

performance. However, the use of self-report methods may have led to response bias: specifically, social desirability bias. This type of bias can put the internal validity of the results at risk unless sufficient measures are taken to minimise it. In addition, the high attrition rate of participants (>50%) could have affected the external validity and reliability of the study's findings.

In a cross-sectional study, Aldossary et al. (2016) examined the effects of different NRPs on NQNs' clinical leadership skills. The study was conducted in three hospitals that offered different NRPs: a 12-month NRP, 6-month NRP, and an ordinary two-week orientation. The results showed that NQNs who participated in the 12- or 6-month NRPs scored higher on the Clinical Leadership Survey (CLS), suggesting either of these NRPs is better than the two-week orientation. However, the failure to provide a baseline score for all participants was a threat to the internal validity of the study, making it unclear whether the development of leadership skills was influenced by the NRP or by other variables. Another disadvantage was that CLS tool used to measure leadership skills of NQNs was not tested for validity.

The boosting of confidence among NQNs during their first days in practice was also one of the reported benefits of NRPs (Olson-Sitki et al., 2012; Spiva et al., 2013; Lewis and McGowan, 2015). D'Addona et al. (2015) explored the perceived benefits of an NRP by interviewing 12 senior nurses, including nurse managers, managers' assistants and clinical nurse educators. The seniors believed that, as the NRP progressed, NQNs developed their confidence levels and better mastered their technical skills. None of the aforementioned studies, however, showed a causal relation between attending an NRP and increased confidence.

Nursing leaders noted that NQNs became more confident and were able to better master their technical skills as the programme progressed (D'Addona et al., 2015). The NQNs perceived the seminars which were added to the programme as an effective way to develop a rapport between the new and experienced nurses, identify concerns and discuss suitable strategies to resolve them (Henderson et al., 2015). However, in the study by Henderson et al. (2015), the NQNs' opinions were collected in the presence of their preceptorship leads, which could affect the validity of the study's findings.

Using a phenomenology approach, Ankers et al. (2018) explored the experiences of seven NQNs while participating in a one-year NRP, finding that they all felt more confident by the end of the programme. However, in an Australian teaching hospital, Hussein et al. (2017) surveyed 87 NQNs to measure their confidence levels at baseline and on completion of a one-year NRP, finding that there was no significant change between the two points. The latter findings were corroborated by a review of literature which concluded that concrete evidence that supports the usefulness of NRPs in improving confidence levels is lacking (Irwin et al., 2018). In addition to the perceived benefits of NRPs for NQNs, positive outcomes for employers have also been reported.

- Organisational benefits

- *Recruitment and retention*

Work pressure and inadequate support from management have been largely responsible for early, high attrition of NQNs, i.e. within a year, according to Cochran (2017). Thus, one aim of initiating NRPs has been to counter decreasing retention rates and improve staffing levels in nursing, particularly in respect of NQNs (Blegen et al., 2015; Cochran, 2017; Slate et al., 2018). Well-organised and well-delivered NRPs were perceived to help healthcare employers improve recruitment and retain both fresh graduates and experienced nurses (Whitehead et al., 2016).

In an evaluative enquiry, Bérubé et al. (2012) surveyed and interviewed NQNs and senior nurses, and suggested that an NRP was an effective marketing strategy for attracting NQNs. The enquiry, however, had encountered some methodological flaws: the sample size and sampling methods were not reported; the survey instrument used was not tested for validity; and it was not clear how the data was analysed. Collectively, these flaws are likely to have affected the validity and reliability of the study results, leading to a weak conclusion. Whitehead et al. (2013) claimed that the provision of NRPs or similar initiatives helped improve recruitment of NQNs; however, there was no evidence of their usefulness in increasing their retention rates.

In a systematic review of the value of NRPs, Edwards et al. (2015) stated that the target of reducing attrition rates amongst NQNs was achieved in several studies. This supported the results of a study by Setter et al. (2011), where the implementation of an NRP resulted in significant improvements in NQN retention percentage (94% compared to national rate of 73%). The study's positive outcomes could, however, be linked to extraneous variables such as the US economic recession at that time. This is corroborated by another systematic review conducted in Taiwan (Ke et al., 2017), which found that the link between the delivery of NRPs and decreased attrition among NQNs was unclear.

Although several studies have claimed the effectiveness of NRPs in reducing NQN attrition rates, this effect was limited to one year following employment (Bérubé et al., 2012; Goode et al., 2013; Blegen et al., 2015). In a longitudinal quantitative study, Friday et al. (2015) investigated the impact of NRPs on NQN retention rates, finding that the 30-month retention rate dropped to 68%, which is similar to average rates without NRPs. In another study, Setter et al. (2011) surveyed 100 NQNs and found that their retention rate dropped to 60% three years after completing an NRP. Moreover, this study claimed that NRPs had little or no influence on the participants' decision to remain in the same job. The sudden sharp increase in NQNs leaving the profession after two years suggested that some might have been contractually obliged to remain with their employer for that period after joining an NRP. This policy was noted in several healthcare organisations in the US which required NQNs to sign a prior commitment to work for two years following the completion of the programme, with financial penalties should they wish to leave their job sooner. This highlighted questions as to whether the NQNs remained voluntarily or experienced financial coercion, and whether or not NRPs contributed to long-term staff retention. A further comprehensive examination of NRPs is necessary to determine their long-term impact on retention rates.

Besides the perceived advantages of NRPs for recruitment and retention, employers might also benefit financially.

- *Financial investment*

Some researchers have claimed that initiatives such as NRPs could offer financial savings through reducing costs associated with NQN attrition (Goode et al., 2013; Slate et al., 2018). In a cross-sectional comparative study, Silvestre et al. (2017) employed a randomised controlled design to evaluate the return on investment, suggesting that the gains from NRPs compare favourably to their costs. It should be emphasised, however, that the literature advocating for NRPs as a cost-effective investment strategy to reduce attrition-related costs relied on one-year retention rates following completion. Long-term research to determine the impact on retention is lacking, and whether NRPs are a suitable strategic plan for improving retention remains ambiguous.

Abualrub and Abu Alhaija'a (2018) and Pittman et al. (2013) explored the challenges associated with the implementation of NRPs, suggesting the costs were the biggest challenge. The former interviewed 36 senior nurses and stakeholders, while the latter surveyed 219 nurse leaders online. In another study, Hopkins and Bromley (2016) reported that the hospital where the study was conducted cancelled their NRP due to the financial cost. In addition, NRPs were argued to have no long-term influence on NQNs' commitment to the organisation (Bratt and Felzer, 2011), and only moderate impact on job satisfaction (Eckerson, 2018). Since the impact of NRPs on attrition/retention rates is unclear, it was difficult to draw a conclusion about whether they offer positive financial return on investment for employers.

The literature reviewed paid little attention to the financial status of NQNs during their first year in employment or during the transition period. A single study by Bratt and Felzer (2011) mentioned that participants (NQNs) were paid while on their programme. The study, however, failed to provide sufficient details about the remuneration and whether it was equal to entry-level nurses' pay. Benner et al. (2009) advised that NQNs' remuneration should be reduced while attending an NRP to offset the cost of implementation. This advice may be a suitable solution for employers; however, it may place financial stress on NQNs, triggering intentions to seek better-paid jobs. Benner et al.'s idea may, therefore, be counter-productive in view of the main goal of providing support and reducing stress during NQNs' initial experience in professional practice.

In summary, NRPs have been argued to improve recruitment of NQNs and temporarily reduce their attrition rates. From a financial aspect, NRPs are costly and their long-term return on costs warrants further examination.

- Managerial challenges within NRPs

- Content variation

Although there is no general consensus on the content and structure of NRPs, they have often included didactic classes and supernumerary shifts (Kramer et al., 2012; Figueroa et al., 2013; Friday et al., 2015; Ankers et al., 2018). Scheduling educational sessions for NQNs during their transition year has been seen as "sufficient" and "essential" to enable them to successfully transition to their new professional role (Hussein et al., 2017) (Glynn and Silva, 2013). These sessions are intended to provide a general understanding of the units, type of patients, and cases/diseases that are commonly encountered (Bratt and Felzer, 2011). These sessions, however, were not necessarily viewed favourably as there has been doubt about their value (Spiva et al., 2013). A possible explanation for this might be that the topics discussed were basic or were a repetition of those raised at university. Thus, the classes might be seen as more useful if they focused on more advanced knowledge and skills.

Faster development in NQN competence and confidence levels has been attributed to supernumerary shifts (Glynn and Silva, 2013; AL-Dossary et al., 2016). The duration of these shifts, however, varied significantly during NRPs. Lewis and McGowan (2015) and Ankers et al. (2018) interviewed NQNs who were attending an NRP, finding that some of them had worked under supervision for three weeks, while others had only had one shift as a supernumerary before being left working alone. This inconsistency increased uncertainty and confusion, and was attributed to either failure to develop a clear and consistent programme or senior nurses' lack of understanding (Cubit and Ryan, 2011).

Several studies have suggested the use of simulation within NRPs to reduce NQN's stress and improve their professional skills (Bérubé et al., 2012; Friday et al., 2015; Monaghan, 2015). Using

individual and group interviews, Kramer et al. (2012) interviewed 907 nurses, suggesting that simulation was seen as effective for developing and mastering technical skills in a protective and supportive working atmosphere. Additional components that have been delivered within NRPs and seen as helpful included peer support (Whitehead et al., 2013), regular review meetings with preceptors (Forde-Johnston, 2017), debriefing sessions (Cubit and Ryan, 2011), and stress reduction seminars (Kramer et al., 2012). Rotation between wards while attending an NRP was also evident in other contexts (Al Awaisi et al., 2015).

The impact of ward rotations on the transition experience is another issue that remains unresolved amongst proponents of NRPs. Through exposure to various clinical scenarios in different work environments, NQNs are able to enhance their knowledge, clinical skills, and interprofessional communication (Pasila et al., 2017). However, frequent moves between wards and constantly meeting new colleagues and patients can also be problematic. NQNs could re-experience shock every time they are introduced to a new ward, and they could have less time to develop bonds with patients (Glynn and Silva, 2013; Ankers et al., 2018). This is in line with the view that familiarity with the work culture and patients could accelerate the transition process, unlike frequent ward rotations (Guay et al. 2016). During transition, NQNs may have different needs and preferences; thus the length and frequency of rotation could be better tailored to the individuals. This view is supported by Spiva et al. (2013) who suggested individualising NRPs to better respond to each NQN's individual needs and preferences.

In terms of the length of NRPs, Bakon et al. (2018) reviewed 30 studies, finding that it differed significantly from one setting to another, spanning periods of from three to twelve months. The majority of reviewed papers in this study, however, indicated that they used a 12-month NRP (Setter et al., 2011; Pittman et al., 2013; Spiva et al., 2013; AL-Dossary et al., 2016; Hopkins and Bromley, 2016; Hussein et al., 2017; Slate et al., 2018). Most NQNs were able to notably develop their confidence and clinical and professional skills by the end of their one-year residency programme. Therefore, 12-month NRPs were perceived as the most effective for a successful transition from a student to a registered nurse role, and compared favourably to shorter programmes (Pasila et al., 2017).

The significant variations between NRPs, in terms of content, supernumerary days, rotation, and length, made it difficult to robustly determine NRPs' effects on either individual nurses or organisations. To better organise these programmes, Slate et al. (2018) suggested standardising the content and length of NRPs, which could enable researchers to determine clearly their impact on the transition experience. This is thought to alleviate associated concerns and encourage reluctant employers to introduce NRPs into their organisations (Abualrub and Abu Alhaija'a, 2018).

- *Facilitators within NRPs*

Some of the managerial challenges reported within NRPs include role ambiguity and role conflict between individuals involved in the delivery of the programmes (Marks-Maran et al., 2013; Bakon et al., 2018), increased workloads for ward-nurses and preceptors (Blegen et al., 2015; Quek and Shorey, 2018), and the varying personal characteristics of preceptors (Cubit and Ryan, 2011; Snow, 2013; Al Awaisi et al., 2015).

Preceptors expressed concerns over role ambiguity and inadequate training, which were the common reasons for their hesitancy to participate in the delivery of NRPs (Whitehead et al., 2013). D'Addona et al. (2015) explored the perceptions of 12 nurse managers, finding that role ambiguity and inconsistency between preceptors and other senior nurses may have led to NQNs being given conflicting instructions, making them feel confused. Moreover, several preceptors experienced higher levels of stress and worry due to role conflict, particularly the challenges of balancing their roles as clinicians and preceptors (Marks-Maran et al., 2013). Thus, a better definition of the role of NRP facilitators and a clear explanation of NQNs' needs should encourage preceptors to overcome their reluctance and efficiently participate in NRPs (Snow, 2013).

Although working as a preceptor was regarded as beneficial for enhancing the preceptor's own knowledge and skills (Muir et al., 2013), the associated workload was found to be stressful (Bakon et al., 2018), and securing sufficient time to fulfil the role's responsibilities was difficult (Lewis and McGowan, 2015). Thus, Whitehead et al. (2013) argued that experienced nurses

participating in NRPs should have their clinical-related workload lightened. The benefits would have been two-fold: a reduction in stress levels among both preceptors and NQNs (Edwards et al., 2015).

With the persistent shortages of nurses and the associated heavy workloads, recruiting suitable preceptors has been reported as challenging. Al Awaisi et al. (2015) interviewed NQNs, reporting that they perceived their preceptors as unsuitable, and believed that their teaching was either wrong or out-dated. The qualifications and expertise of preceptors, however, were not presented in this study. Pairing a preceptor with an NQN with a higher level of qualification can be a source of conflict: Quek and Shorey (2018) pointed out that some NQNs perceived that their higher level of qualification posed a threat to their preceptor's status. The authors also said that NQNs feel frustrated when supervised by inexperienced preceptors. To resolve these issues, a comprehensive training course for preceptors about their roles, responsibilities and expectations could help improve the relationships between preceptors and preceptees, and potentially the quality of NRPs (Marks-Maran et al., 2013; Slate et al., 2018).

Nurse managers have also found assigning preceptors to NQNs challenging because many experienced nurses lack interest in the preceptor role (Wierzbinski-Cross et al., 2015). Most of the articles reviewed, however, failed to indicate the strategies used to make the role more attractive, or whether there was a monetary bonus. In exploring the Capital Nurse preceptorship framework, Morton et al. (2017) argued for reliance on experienced staff volunteering to fulfil the preceptor role. The authors did not, however, provide evidence to support this suggestion.

In a Canadian study, Bérubé et al. (2012) explained that there was an additional benefit (additional remuneration) for preceptors and a reduction in the patient-related workload. Whitehead et al. (2013) advised that role recognition and financial benefits/rewards could attract more preceptors and potentially enhance the quality of NRPs. However, the impact of pulling nurses away from the bedside and the financial costs for employers, compared to attrition-associated costs, still requires consideration.

- *Variation in the target population*

The target population in NRPs is known to be NQNs who are transitioning from student to professional roles. The NMC (2021) stated that these programmes are "to welcome and integrate newly registered professionals into their new team and place of work", and help them grow in confidence and competence. Yet many of the studies reviewed reported that they admitted NQNs as well as nurses with previous professional experience onto their NRP (Kramer et al., 2012; Hussein et al., 2017; Nour and Williams, 2018). They did not, however, provide an explanation for including experienced nurses in their programmes or whether these nurses had perhaps failed to meet a specific expectation, and were therefore placed on the NRP for remediation. This difference in length of experience between participants (NQNs and experienced nurses) may have affected the credibility of the studies' findings. The rationale for admitting nurses who have more than one year of professional experience onto NRPs remains unclear.

Bachelor and diploma nursing programmes vary in terms of theoretical knowledge and practical training, and graduates may have different levels of nursing knowledge, clinical competence and needs (Cochran, 2017). Despite this, degree qualified and associate nurses were often dealt with as one cohort, and placed on the same NRP (Spiva et al., 2013; D'Addona et al., 2015). These programmes failed to take account of the variation in qualifications or to distinguish the different learning needs of the two groups, which led to the criticism that they were a repetition of pre-registration programmes (Jones et al., 2014; Lewis and McGowan, 2015).

- *Voluntary or mandatory participation*

Many organisations have been offering NRPs as an option for NQNs who feel in need of support during their role transition. However, there are also growing calls to introduce NRPs as a prerequisite for all NQNs (Slate et al., 2018). This approach has been implemented in some countries, such as Scotland, where newly qualified health practitioners, including NQNs, are required to complete a post-registration 12-month NRP (known as Flying Start NHS) (NES, 2021). It can be argued that NQNs with sufficient training may not feel they need the support programme (Pittman et al., 2013), and may find it unnecessary (Jones et al., 2014; Lewis and McGowan, 2015). In this case, NRPs could be a waste of time and resources for both employers

and NQNs. Moreover, NQNs who start a job in an area that they have previously worked in during their clinical placement may find NRPs redundant (Cubit and Ryan, 2011). The studies reviewed failed to determine the rationale for the decision to introduce NRPs as a requirement; furthermore, it was not reported how the stakeholders (employers, senior nurses and NQNs) viewed that decision.

2.5 Discussion of the literature review

This review found that, for many NQNs, the experience of transitioning from student to RN continues to be stressful (Duchscher, 2008; Nour and Williams 2018). Entering professional practice is an overwhelming experience, and numerous unfavourable consequences are attributed to it, from loss of confidence to deciding not to continue in the profession. Many employers have tried to ameliorate this by developing NRPs to make the transition process easier for NQNs during their first year of employment (Goode et al., 2013; Jones et al., 2014; Henderson et al., 2015). What evidence there is to support the efficacy of NRPs, however, remains tentative. Various authors have suggested that NRPs help reduce NQN attrition rates (Bérubé et al., 2012; Goode et al., 2013; Blegen et al., 2015); however, these studies were limited to just one year after graduation, and there is no evidence as to NRPs' effectiveness in the longer term. Thus, it remains uncertain whether NRPs improve NQNs' loyalty to their employer, or indeed to the profession itself. This is supported by Whitehead et al. (2013), who found that the literature is inconclusive on the link between NRPs and reduced NQN attrition rates.

A number of studies have asserted that NQNs' increased adaptability and clinical competence during their first year as practising nurses may be due to their having participated in an NRP (Bratt and Felzer, 2011; Dyess and Parker, 2012; Aldossary et al., 2016; McKillop et al., 2016). However, NRPs cannot necessarily be deemed wholly responsible for their professional development, because other researchers have found that NQNs' competence and flexibility increased naturally over time through experiential learning (Duchscher, 2008; Ankers et al., 2018). To determine the

actual impact of NRPs on NQNs' level of competence would probably require a randomised controlled trial.

As for NQNs' levels of confidence, several studies have found that NRPs were helpful and prepared NQNs to practise autonomously (Olson-Sitki et al., 2012; Cline et al., 2017). However, validated measures of the outcomes claimed for NRPs were used in only a few studies; many researchers developed their own tools to measure what impact NRPs have, such as Olson-Sitki et al. (2012). Unfortunately, these tools tend to rely on weaker methods of assuring validity, i.e. content validity. Therefore, further work is needed to assess the reliability and validity of these measurement tools. A further issue is the difficulty of synthesising studies which rely on different measurement tools and often measure different outcomes as well. Thus, there is a need to develop reliable, valid outcome measures for the various elements of NRPs. In order for this to be possible, researchers need to reach some level of agreement about which outcomes should be measured.

This review included a relatively large number of quantitative studies which examined various ways of supporting NQNs during their transition and attempted to evaluate the outcomes of NRPs. It is unsurprising that organisations want to assess the effectiveness of NRPs, since they have invested significant resources in developing them. Unfortunately, this has led to a rush to measure the outcomes of these programmes despite there being as yet no general agreement about the purpose of these programmes. Furthermore, most of the qualitative studies included in this review did not seek to identify NQNs' main concerns, and therefore paid no attention to their impact on the transition process. As there seems to be no general agreement about what NQNs see as the most important issues during the transition period, more research using qualitative data is needed to discover the most problematic elements in transition, and how these can be ameliorated. Such research could bring a better understanding of how NQNs boost their level of confidence and become more competent. This could, in turn, lead to a better understanding of how the transition process could be managed in order to address the needs of NQNs themselves and thus improve retention.

The transition period is a make-or-break point in the professional lives of many NQNs. They might engage more fully with their chosen profession or feel unable to continue in nursing. It is a matter for concern that the social process of making the transition from student to registered nurse, and the issues associated with that challenge, may not be specifically elicited or dealt with. Even so, many employers continue developing NRPs with the aim of easing NQNs' transition. How the format, content, and length of these programmes is decided, and on what basis, however, is unclear. Whether the programmes are effective, and what impact they have on how NQNs experience transition, are similarly unclear. Moreover, the existing literature is mainly concerned with work-associated issues, such as the working environment and NQNs' confidence and competence. There might however be other factors, outside of the workplace, that could have an impact of the NQNs' transition but are yet to be discovered.

This review identified gaps in the literature, one of which was that the transition experiences of NQNs who already had role transition support built into the undergraduate nursing programme have not been explored. It also helped me shape the direction of the empirical aspect of this project in that, given there seems to be no general agreement about what NQNs see as the most important issues during the transition period. More research using qualitative data is needed to discover the most problematic elements in the transition, and how these can be ameliorated. Moreover, based on my review, there appears to be an overemphasis on the descriptive aspects of the transition experience of NQNs, instead of an understanding of the conceptual aspects. This corroborates my initial decision to choose grounded theory methodology to conceptually explore the social processes during transition from nursing school to the workplace. Exploring NQNs' transition experiences in depth could lead to a better understanding of their and their employers' needs, which potentially could help in the development of more effective nursing transition programmes.

2.6 Limitation of the review

This scoping review encountered some limitations. First, due to the lack of a formal quality assessment of included studies, bias could have been introduced during the study selection stage. This limitation, however, was minimised by the use of a dual independent review throughout the review process. Moreover, despite using multiple data sources, few articles which could have added value to the review were unavailable via open sources.

2.7 Summary

This chapter discussed the justification, design, and findings of a scoping review conducted to explore the nursing transition phenomenon and the experiences of its stakeholders. This was mainly driven by the conceptual confusion that surrounds the transition of newly qualified nurses and the clear lack of empirical research in this area. First, the rationale for carrying out a scoping review was presented, mentioning the debates around engagement with the literature within grounded theory studies. Second, the design of and procedures for a scoping review that followed the work of Arksey and O'Malley (2005) were provided. Finally, the issues discussed in the literature were mapped thematically under two overarching themes: the transition experience and the perceived benefits of nursing residency programmes. This concluded with a discussion of the literature relevant to nursing transition and the areas that require further investigation, justifying the aim of this research study.

The next chapter will discuss the theoretical perspectives that influenced this research study. It will discuss the methodological approach and methods employed to conduct this research, in addition to the ethical issues.

Chapter Three: Methodology and Methods

3.1 Introduction

This research study used a classic grounded theory methodology to investigate the transition experience of newly qualified nurses (NQNs) from school to workplace. Rather than generating a hypothesis and testing it, or developing a questionnaire of plausible items to measure the progress of NQNs' transition, or reformulating existing concepts of "role transition", this study aimed to discover the transition process from being students to becoming registered nurses. Grounded theory is seen as a method of discovery and considered to be the optimum choice when there is insufficient research about a phenomenon or a new theory is required (Glaser and Strauss, 1967). It is an inductive methodology that drives the researcher to make direct contact with the substantive population to identify their concerns, instead of preconceiving a particular research problem. The procedures of sampling, data collection, and analysis are each tailored to the needs of the emerging concepts. These procedures therefore need to be flexible to accommodate the needs of the study as it progresses (Glaser, 1978, 1992).

This chapter presents a discussion of the theoretical issues that influences my research. It also provides an overview of grounded theory methodology and its central tenets. Within the chapter the study aim and objectives are reviewed together with a description of the study context. In the *Methods* section, I explain how the study was conducted in practice, highlighting how data were collected through interviews and relevant documents, and the use of constant comparison, theoretical sampling and memoing to analyse the data collected. Finally, this chapter concludes with discussions of the ethical considerations related to this research and the quality assessment of grounded theory studies.

- Research aim

The aim of the research was to explore how newly qualified nurses experienced the role transition involved in becoming registered nurses.

3.2 Selecting an approach

The broad aim of this project was to explore the transition of NQNs into the workplace. I initially thought I would do this through the lens of nursing residency programmes (NRPs). However, as NRPs are part of a government initiative, they are not static, fixed and lasting. A PhD study normally lasts three to four years, and selecting one particular policy to investigate, in a political world where governments and policies are subject to constant change, risks losing relevance should NRPs be replaced with newer initiatives. Thus, in the light of the scoping review I conducted; I broadened the focus to include the whole of the transition experience rather than simply NQNs experience of NRPs. Exploring the transition experience more broadly raised three methodological issues, which I thought the methodology of classic grounded theory would be able to address.

The first issue which rose from analysis of the literature was a general overemphasis on description. As discussed in the introductory chapter and reinforced by the findings from my scoping review, there appears to be a great focus on description of the different transition experiences of NQNs and residency programmes. How NQNs experience the transition may completely differ from one institution to another and from one country to another. Thus, I felt there was a need to move beyond mere description to conceptualise the transition experience in order to better understand this phenomenon. To address this issue, instead of *describing,* I wished to attempt to *conceptualise* patterns of behaviour during the role transition. Therefore, other qualitative methodologies, such as the phenomenological approach, that tends to descriptively explore a topic of interest through participants' lived experiences and develop thick descriptions of their insights (Polit and Beck, 2012; Gray, 2013), were considered less appropriate for this particular study.

An ethnographic methodology could also be used for an exploratory study. In ethnography, researchers aim to study individuals in their natural environment, and evaluate and interpret the cultural meaning of a specific phenomenon from the subjects' perspectives (Hammersley and Atkinson, 2007). Through immersion in the lives of participants and close observations of multiple

events and actions, ethnographers can obtain a holistic picture of the cultural and social system in the studied area (Fetterman, 2010). However, ethnography is deemed beneficial when the link between culture and behaviours needs to be discovered (Gray, 2013). This was not the aim of my research; therefore, it was perceived less suitable than grounded theory.

I thought focusing on conceptualisations was particularly useful to this research as I was interested in the nursing transition phenomenon, rather than the context or time. The grounded theory methodology was designed to transcend accurate description of what is going on in a given area by abstractly conceptualising patterns of behaviour in that area (Glaser, 2014). The analysis of a grounded theory study, through the use of simultaneous and iterative processes of data collection and analysis, produces a conceptual theoretical framework that is not directly dependent on relevant individuals, contexts and times (Glaser, 2002a). This is methodologically important to my research study because I was not interested in the people or the context but the role transition phenomenon and how it is processed.

The second issue that influenced my choice of methodology was that, as explained in the *Introduction* (Chapter 1) and corroborated by the *scoping review* (Chapter 2), there was no clear evidence that nursing residency programmes improve the transition experience of NQNs. This may suggest that the development of these programmes was based on assumptions and perceptions of managers and experienced health professionals, which may not necessarily be similar to those of people who are actually transitioning: the social actors, i.e. NQNs. To address this issue, I decided to first speak directly to NQNs, which granted me access to the lived experiences of these individuals. Stories and perceptions collected from NQNs formed the basis of the data. By grounding the study in individuals' lived experiences, grounded theory methodology ensures the development of a theory that is relevant to and practical for the studied area.

The third issue was that I had worked in the substantive area, i.e. the area of study, for a few years, and my professional experience and knowledge of the relevant literature were more likely to have an impact on the way I approached the study. To address this issue, as well as the

previous one, I chose an inductive approach in attempt to minimise the assumptions and preconceptions that I brought to the study in order to find out what really matters to the studied individuals. Rather than asking participants to talk about the problems I perceived, I allowed participants to speak from the heart about what really mattered to them, thus highlighting the research problem themselves. If the impact of nursing residency programmes was an important concern, then that would emerge during the data analysis stage. In this way, the generated theory is not something derived from preconceived ideas but is, rather, an original and relevant substantive theory that explains what participants felt was actually going on during the role transition.

- Grounded theory methodology

Glaser and Strauss developed the methodology of grounded theory in 1967 in an attempt to improve the credibility of qualitative research in terms of generating theory. It aims to generate an inductive theory, based on the experiences and behaviours of individuals involved, that reflected the social processes within the substantive area being researched (Glaser and Strauss, 1967). In contrast to the hypothetico-deductive approach, where a logically derived hypothesis is tested against observation, grounded theory uses an inductive approach that guides researchers to inductively collect data and constantly compare them in order to first, generate concepts, and then compare the emerging concepts with new data being collected (Glaser, 1992, 1998). The two main characteristics that distinguish grounded theory are: first, the constant comparative method, which uses iterative procedures to compare data with other data to develop concepts, categories and theories; second, theoretical sampling, where the concepts emerging from the data analysis dictate what additional data are needed and where to find them (Glaser, 1978, 1998). These two tenets, as well as other fundamentals of the methodology, will be outlined later.

Since its conception in 1967, grounded theory has gained popularity and become one of the top cited research methods across various fields of study, including health science, education and psychology (Creswell, 2014; Foley and Timonen, 2015). However, similar to other methodologies,

grounded theory has evolved over time, leading to the development of different versions of the methodology: for example, Strauss and Corbin, (1990), Charmaz (2006), Gibson and Hartman (2013) to name a few . All versions of the methodology have used similar terms: coding, constant comparison and memos, and shared similar basic research processes: gathering data, coding, comparing, categorising, theoretical sampling, developing a core category and generating a theory. The differences, however, lie in how these processes are carried out. For instance, some of the differences between the classic (also termed Glaserian) and Straussian approaches include the coding procedures, the role of induction, deduction and verification, and the debate over emergence versus forcing of the data (Heath and Cowley, 2004; Walker and Myrick, 2006).

The similarities and differences between the classic approach and subsequent versions are confusing, subtle and tedious to elucidate, and are widely argued, but there is a general consensus that they are just different approaches to grounded theory (Glaser, 2014). Given my relatively limited experience in grounded theory studies, I thought engaging in the rhetorical wrestling between the different grounded theory camps would add nothing significant to the debate, and more importantly it would not add value to the current research study. Therefore, instead of engaging in the rhetorical debates of different grounded theorists, I described, in the previous section *Selecting an approach,* the rationale for my methodological choice through a discussion of three main issues; conceptualisation, speaking directly to the relevant people and inductive reasoning.

Using an inductive approach and focusing on conceptualisation were essential to address the aims of my research, and influential in choosing between different grounded theory approaches. Unlike subsequent versions of grounded theory, the classic approach of grounded theory claims to have remained consistent with the original methodology that was first presented in 1967, in terms of its emphasis on induction and conceptualisation (Heath and Cowley, 2004; Glaser, 2014). The newer versions of grounded theory were perceived by Glaser to have diverged from the novel approach, leading to the development of “remodelled” methods that served different purposes (Glaser and Holton, 2004; Walker and Myrick, 2006). This remodelling of the methodology, and the terminologies used interchangeably by different authors, have

contributed to methodological confusion, especially among novice researchers according to proponents of classic grounded theory (Holton, 2008; Evans, 2013). This is not to say (i.e. this thesis does not contend) that the classic grounded theory is superior to the newer versions, just that they are different.

Consequently, Glaser has written a series of publications aiming to clarify what he sees as the purpose of the original methodology as well as its principles and procedures. The explicit explanation of the methodology, its simple and flexible procedures, and its emphasis on generating a conceptual theory that theoretically explains, rather than describes, the social process, became a decisive factor for selecting the classic grounded theory approach as a methodology for this study. Moreover, the neutral role of the researcher during data collection in the classic approach was thought beneficial, especially for this study, to minimise the influence of my previous professional experience and preconceptions, in order to allow the participants' concerns to freely emerge (Glaser, 2012). On top of that, in the classic approach researcher bias is acknowledged as just another variable that should be woven into the process of constant comparison (Glaser, 2002b). This process will be further discussed in *Constant Comparison*. Therefore, I chose the classic approach because it maintained its focus on induction and conceptualisation, which better suited the aims of this research. The following section discusses some of the foundational tenets of the classic grounded theory approach.

3.3 Fundamentals of grounded theory

Grounded theory is a general methodology that aims to develop theory based on conceptualisation of empirical data. One of its main component is that the researcher collects, codes and analyses data concurrently (Glaser and Strauss, 1967). This simultaneous process dictates what data are collected next, in a process known as theoretical sampling (Glaser and Strauss, 1967; Glaser, 1998). This section briefly discusses four foundational tenets of grounded theory: constant comparison, coding, memoing and sorting, which will later be linked to how the study was conducted in practice; and how they should be carried out based on the classic

grounded theory approach. How I actually followed these tenets in practice will be detailed in the subsequent section *3.4 Research methods (the procedure).*

- Constant comparison

Constant comparison is an integral feature of grounded theory methodology, which involves three stages of comparison: incident to incident, concept to incident, and concept to concept (Holton, 2007). In grounded theory, the unit of analysis is not the participants themselves, but the incidents. Incidents are the parts of raw data that can be coded to indicate a concept or a category. A further explanation will be provided in *Data Analysis* section. As a first step in constant comparison, the researcher codes the empirical data and then constantly compares all these incidents. The purpose of incident comparison here, as explained by Glaser (2001), is not to describe similarities and differences, but to generate and increase the density of categories and their properties. This comparison leads to the development of multiple provisional categories based on underlying uniformities (Glaser, 1978). A category must be based on several incidents, as a single incident does not represent a pattern which could be described as a category (Glaser, 1998).

Once sufficient categories are developed, the researcher ceases incident to incident comparison and starts comparing new incidents to existing categories to be either woven in or develop new categories. This incident to concept comparison expands categories and elucidates their related properties until they are theoretically saturated. Finally, the researcher carries out concept-to-concept comparison to integrate the theory and establish theoretical propositions (or hypotheses) about the relationships between categories (Glaser and Holton, 2004). Through this constant comparison, the researcher progressively delimits the theory, generating an abstracted concept or core category - which accounts for most of the participants' main concerns and how they continuously attempt to resolve them (Glaser and Holton, 2004).

- Coding

In classic grounded theory, coding is split into two stages: substantive coding, which includes open and selective coding, and theoretical coding. Open coding starts by coding raw data (incidents). During this stage, the data are coded line by line to ensure theoretical coverage of all possibilities (Glaser, 1978). Each significant piece of data (or incident) is labelled and often given an in-vivo code that is taken from a direct quote from a participant. These codes, however, are subject to modification as the constant comparison continues to ensure they best fit the raw data from which they were derived (Glaser, 1998). Open coding continues until the emergence of a core category, which appears frequently in the data and accounts for most of the concerns in the data (Holton, 2007). As the core category emerges, open coding stops and selective coding begins, during which process the researcher tries to delimit the theory.

Selective coding is the stage where the researcher narrows their focus to concepts that are significantly related to the core category. In doing so, the analysis process moves from an inductive to a deductive approach, as further data collection and analysis become increasingly focused on the core category. This focus, however, does not mean ignoring other categories: rather, they simply become secondary to the emergent core category (Glaser, 1978). This process of delimiting further data collection and analysis serve to enrich the core category, facilitating theoretical saturation. When the core category is theoretically saturated, the researcher moves the analysis to a higher level of abstraction in order to integrate the final theory.

While substantive codes, which are the categories and the properties of the theory, reflect the area under study, theoretical codes implicitly conceptualise how the substantive codes relate to each other (Glaser, 1998). Thus, theoretical coding aims to determine the inter-relationships between the emergent core category, its properties and its related categories in the service of providing models or hypotheses for theory generation (Holton, 2007). To put it more simply, theoretical coding is like looking at the substantive area using a bird's eye view. It is an elevated level of abstraction, where the researcher weaves the fractured pieces of categories and properties into one whole picture. During open and selective coding, several substantive codes

are generated, and the researcher explores the relationships between these codes through memo writing, or "memoing". In memos, the researcher presents their analytical thoughts about the substantives codes to help conceptualise the relationships between them and to show where each thought fits within the theoretical framework.

- Memoing

Writing memos is essential to the method of constant comparison and should be carried out simultaneously throughout the research process. Memos are written, as explained by Glaser (1998), to capture conceptual ideas as they arise and preserve them to ensure that they are not lost. Most importantly, there is no pre-defined form for a memo: it can be in writing, drawing or even audio notes; it can be anything, as long as it captures the moment as the conceptualised idea emerges. The fundamental aim of memo writing is to develop ideas, which may be as short as a single sentence or as long as a few paragraphs. These memos can help by elevating the level of conceptualisation of the data, generating properties, and introducing hypotheses about relationships between categories and properties. Moreover, they give the analyst freedom to simply get thoughts out, regardless of their construction, presentation or value. I explain later how memoing in Arabic helped me during the analysis process. Memoing also helps accumulate a collection of thoughts that presents an overview of theoretical ideas and connections to facilitate the integration stage of writing the final theory.

- Theoretical sorting

Theoretical sorting of memos is an important step to integrating the theory, facilitating the transition from open and selective coding to theoretical coding and moving the conceptual level up from descriptive to explanatory (Holton, 2007). Memo writing, as explained earlier, occurs at every stage of the research process, and by the end of the analysis stage, often there will be a large number of memos. They are an accumulation of the conceptual ideas of several months spent collecting and analysing data, but in a "messy", unordered state. For me, it was like solving a jigsaw puzzle, where I threw all the memos (sticky notes and A4-size papers) on the floor and

tried to find out how they related to each other. To provide a base for the final theory development, Glaser (1998) suggests sorting these memos theoretically: comparing memos and exploring the interrelationships between them. As comparison continues, memos seem to integrate themselves and become like a single blueprint that lays out the framework of the theory. Not all the memos will necessarily find their place in the final theory box as the feature of "best fit" will prioritise some memos that are more relevant to the core category and others will be put aside. The developed theoretical framework then sets the scene for writing up the final theory (Holton, 2007).

3.4 Research Methods (the procedure)

The previous section (*Methodology*) presented the theoretical issues that influenced my methodological choice for this research, along with an overview of classic grounded theory and its central tenets. In this section, I describe how the study was actually carried out in the field. I started with presenting the broad aim of the research project and its objectives. Then, I discuss the steps undertaken to conduct the study within the relevant tenets of classic grounded theory, adding my own reflections, and notes of any difficulties that I experienced while going through the stages of data collection and analysis. Within this section, the study aims are reviewed. I also present an overview of the study site and how access to the study site was approved, as well as the ethical implications of the study. I explain the data collection process, which included interviews and document analysis, and how the data were analysed through the use of coding, constant comparison and theoretical sampling.

- *Research question:*

How do Saudi newly qualified nurses experience the role transition to registered nurses?

- Research objectives:

The aim of the research was conceptualised as a question, which in turn led to the development of a number of objectives that outline how the research aim would be met. The research objectives generally remained consistent throughout the study as they were broad in nature. However, analysis of first few interviews led to the development of a new objective (the fourth objective), which became a central issue in this research. The objectives were:

- To explore the interaction of newly qualified nurses with each other and with other experienced professionals in the whole process of becoming autonomous registered nurses.
- To explore the techniques and strategies newly qualified nurses use to facilitate role transition from a student to a registered nurse.
- To explore the role of other stakeholders (experienced nurses) in the transition process.
- How do newly qualified nurses feel about their roles as nurses and their future career plans?

3.4.1 Research Setting

The study setting for this research is a large, not-for-profit, tertiary hospital, with a capacity of 1,500 beds and more than 3,000 employees. The hospital is located in the Western province of Saudi, which is considered one of the most international provinces in the world during the Hajj season (the Hajj is an annual Islamic pilgrimage). It is a relatively new healthcare facility, which was established in 2009, yet it has gained popularity due to its advanced, high-tech services and has become the third largest referral hospital in the country, providing integrated and comprehensive healthcare services. The hospital has been accredited by a US based organisation, the Joint Commission International (JCI, 2020), and the Saudi Central Board for Accreditation of Healthcare Institutions (CBAHI) for health care quality of care and patient safety (MOH, 2021). However, based on internal information, the hospital is still in the process of gaining Magnet accreditation, which, according to the American Nurses Association (ANA), is a US based system of accreditation that focuses on quality patient care, nursing excellence and innovations in professional nursing practice. The hospital is a tertiary referral centre that provides advanced clinical care and thus provision of healthcare services is limited to patients referred from other

secondary hospitals, as well as employees and their dependents. However, during the Hajj season, healthcare services are provided to all pilgrims regardless of the severity of the case and at no cost.

In addition to health services, the hospital hosts separate centres for academic training (the academy) and research (the research centre). It has been accredited by the Royal College of Physicians and Surgeons (Canada) as an academic institution, and is recognised as a training centre for Residency Programmes in different specialties, including Internal Medicine and Oncology. Moreover, they offer several postgraduate courses that are accredited by the Saudi Commission for Health Specialties (SCFHS), such as Nursing Diploma for Intensive Care, Nursing Diploma for Cardiovascular Care, Nursing Diploma for Oncology Care, and Higher Nursing Diploma in Wound and Tissue Treatment.

- Nursing in the setting

In compliance with the Saudi Ministry of Health (MOH) regulations, the hospital requires a BSN degree as the entry point for Saudi nurses, and for foreign nurses a BSN plus three years' clinical experience. Based on unpublished internal documents, there are 994 nurses currently working in the hospital, who are from a variety of different countries. The majority of the nurses come from the Philippines (30%), followed by India (23%), and Egypt (17%), while the percentage of Saudi nurses is 16%. The rest of nurses (14%) come from other countries such as US, Malaysia and Jordan. The proportion of Saudi nurses in the hospital has been increasing yearly, from less than 5% in 2010 to nearly 16% in 2021, yet they remain in a minority.

Shortage of nurses has been a recurrent issue since the establishment of the hospital. This is partly because, as discussed in the introductory chapter, there is a shortage of national nurses, and partly because of the attrition rates of nurses. Based on an informal discussion with one from the nursing office that 7% of expatriates and 11% of national nurses left the hospital in 2021. Another significant issue that affects the recruitment of nurses, as well as other professionals, is that recruitment at the hospital is restricted to Muslim professionals only. The hospital is situated

within a sacred site that is restricted to Muslims, and non-Muslims may not enter this area, according to Islamic teachings. The extent of the area covered by this ban, however, has been argued amongst many Muslim scholars, whether it relates to just the sacred mosque or to the whole city. Legally, the government agrees with the opinion that no non-Muslims may enter the sacred boundary of the city, which includes the hospital site. Thus, the hospital is legally restricted to recruiting Muslim employees.

Unlike foreign nurses, who are required to have at least three years' experience to work at the hospital, many national nurses are hired as freshly qualified graduates. Therefore, the nursing office has implemented a mandatory one-year Nursing Residency Programme (NRP) for all newly qualified nurses (NQNs) with less than one year of clinical experience, in order to enhance their clinical skills and adaptation to the new working environment. These NQNs get a full pay but are hired on a conditional contract: they have to successfully complete the NRP by the end of their first year in order to secure a permanent position. Failure to complete the NRP may result in dismissal from their nursing job.

- The Nursing Residency Programme

The Nursing residency programme (NRP) spans 12 months, and is split into three phases. The first three months (Phase 1, also termed preceptorship), are designed to give a general orientation to the hospital and its departments, general competencies, documentation, and the roles and responsibilities of staff nurses. NQNs may be introduced to direct patient care, but with close supervision from a senior nurse. Hence why it is called preceptorship. During this phase, NQNs rotate between three different departments of their choice, and by the end of Phase 1, they choose one "home area" to work in for the rest of the programme. From the fourth to the sixth month (Phase 2), NQNs are asked to complete specific unit competencies, and begin to handle patients independently under intermittent supervision. During this phase, NQNs are expected to attend relevant educational sessions within the hospital to enhance their communication, leadership and critical thinking skills. During the last six months (Phase 3), NQNs are assigned to patients and are expected to work independently and take full responsibility for the care they

provide. NQNs are assessed and evaluated through monthly meetings to ensure their progress through the three phases. Also, there is a two-weekly competency assessment that needs to be completed by NQNs. In addition to the regular assessments, there is a final evaluation assessment at the end of the programme. NQNs who successfully pass the end-of-year evaluation are granted a permanent position.

The team facilitating the residency programme includes head nurses, clinical resource nurses (CRNs) and preceptors and is led by a master's prepared nurse. Head nurses of departments work regular hours (8 am – 5 pm / five days a week) and are generally involved in managerial work, e.g. evaluating and assessing the department's needs and overseeing the performance of other nursing staff. They are also involved in the evaluation of NQNs' progress while attending the NRP. Head nurses do not often get involved in direct patient care, unless it is an emergency or if there is an unexpected shortage of staff. Key roles of CRNs are promoting and maintaining quality care and supporting the educational needs of other staff nurses. CRNs also have responsibility for introducing all new nurses, including NQNs, to their departments, assessing and evaluating their nursing competencies, and organising short periods of educational leave for them so that they can attend seminars or workshops.

Some of the staff nurses, often those with greater experience and better communication skills, are selected to be preceptors in addition to their regular roles. The preceptor's role includes working with NQNs on a daily basis, guiding, educating and supporting their adaptation to the working environment and to their new role as staff nurses. The selection of preceptors is often based on a friendly and informal agreement with the head nurse of the department, and there is no extra remuneration for this additional role. This probably explains the difficulties in recruiting preceptors in many departments as it involves additional work with no financial benefits. As a result, the NRP has been run in only a limited number of departments.

When I started my data collection, in November 2019, there were 24 NQNs attending the Nursing Residency Programme. NQNs had been in the programme between four to six months, and two of them had already resigned. They were distributed to different departments based on the availability of preceptors. According to an informal discussion with the programme lead, the NRP

operates in departments that have a relatively better nurse-to-patient ratio and have a sufficient number of preceptors. Departments such as Accident and Emergency and the Operating Room are excluded from the programme due to staff shortages and shortages of preceptors.

3.4.2 Access

The study was conducted in a healthcare facility that includes a tertiary hospital and a separate academy and research centre. To access the study population, I needed permission from both the hospital (nursing office) and the academy, as they cooperatively run the Nursing Residency Programme (NRP) and are responsible for NQNs' performance and professional development. Because I was based in the UK and the study setting was in a different country (Saudi), initially I arranged a virtual meeting with the NRP manager via Zoom to discuss my research and ways of gaining access to the target population (NQNs). The NRP manager was very welcoming and supportive, and after checking my ethical approvals, he gave me access to a list of all NQNs' details enrolled in the NRP. However, he advised that I needed to obtain permission from the nursing office to gain access to the NQNs and their respective departments. Initially I was sceptical about meeting the managers for the first time using electronic means, but this saved me significant time. Early negotiations with the gatekeepers, as suggested by Gelling (2015), expedited the access process and helped me overcome the time constraints imposed by the immigration laws in the two countries.

When I physically arrived at the hospital, most of the head nurses were aware of my study and were expecting me. Some of the head nurses had gone the extra mile and posted my study advertisement letter (see Appendix 3) in their respective nursing stations. Some head nurses, however, were apprehensive about the purpose of the study and whether it would have negative consequences for their departments. They asked to review all the study papers, including the interview guide – i.e. the questions to be asked in interviews. Being asked about the interview guide was particularly challenging for me. Researchers conducting grounded theory studies are encouraged to avoid using an interview guide as this may lead to preconception of the problem (Andrews et al., 2017). Thus, I developed a loosely structured topic guide that included general

and non-controversial questions such as “How’s your life as an NQN?” (See appendix 4). In practice, this actually made those head nurses even more apprehensive, as they underestimated the potential value of my study. As a result, I had to explain the interviewing procedures used in grounded theory studies and how interviews should be conducted, and, eventually - luckily - I was able to convince them to let me approach the potential study participants. It was quite understandable, since grounded theory seemed to be a research methodology that was new to many in the hospital.

In general, the process of gaining access to study subjects at the hospital was relatively smooth, thanks to the early online negotiations with the gatekeepers. Next, I will detail the sampling process.

3.4.3 Sampling

Classic grounded theory is characterised by its theoretical sampling technique. According to the methodology, any sort of data that has the potential to facilitate the emergence of the theory is acceptable (Glaser, 2001). Researchers are not restricted to particular methods when collecting their data and they must not determine the data sources at the outset of the study. Instead, they are allowed to use any source of data that is perceived as relevant to the emerging theory, following the leads that appear in the data and choosing data collection methods that are best suited to the emerging questions. Data sources can be interviews, observations, reports, books, documents, comments, or any other relevant sources that the researchers may find in their substantive areas (Glaser, 1998). However, researchers should select a starting point (e.g., a purposive sample) to gather initial data and analyse them, and progress from there.

- Purposive Sampling

Although the sample of a grounded theory study cannot be identified at the outset, choosing a group of participants to begin with is inevitable. The researcher will typically start with a small group of participants and, following initial data collection and analysis, will then recruit more participants that allow for theoretical comparison. As a starting point for this research, I

purposefully recruited five newly qualified nurses, who were experiencing the role transition, i.e. admitted into the residency programme. The initial analysis of the data collected yielded concepts that either needed further elaboration or required the recruitment of a different group participants. Glaser (1978) suggested that participants are chosen as they are needed rather than predetermined prior to data collection. Although purposive sampling allows the researcher to choose the location and cohort of participants, there is a risk that the sample might not have sufficient relevant information. In theoretical sampling, however, this limitation is minimised, as relevance is assured by tailoring the progress of data collection to the emerging concepts (Glaser and Strauss, 1967).

- Theoretical Sampling

The first few interviews with NQNs provided a good point of departure, and the analysis of these interviews resulted in the development of concepts that shaped a provisional theoretical framework. Subsequent to the analysis of initial interviews, I recruited more participants from the same group (NQNs) and from other groups (experienced nurses including preceptors, clinical resource nurses and head nurses), which provided the opportunity to refine and develop new categories. Sampling in grounded theory is theoretically oriented; the aim of theoretical sampling is not to select a representative sample of the population, but rather to selectively identify information-rich sources that generate new relevant insights within the researched area (Breckenridge and Jones, 2009). Therefore, the theoretical sample was chosen to saturate the emerging concepts from earlier interviews e.g. “ambiguous support” was an emerging concept from initial interviews, therefore, I had to elaborate by asking those who are responsible for supporting NQNs. Although experienced nurses worked within the same setting, delivering the same residency programme, they provided more varied data. Furthermore, theoretical sampling led to the review of documents related to the residency programme to compare or clarify some of the codes generated from interviews. This will be further discussed in *Document Analysis*. Constant comparison of different data from various groups did not only result in weaving more codes into existing categories, but also yielded new categories to enhance the emerging theoretical framework.

Theoretical sampling in other hospitals would have been beneficial to increase the scope and density of the emerging theory; however, was not possible for several reasons. First, as this research was part of a PhD study, there was a limited timeframe and thus further theoretical sampling was not advisable. It was difficult to secure ethical approvals from different sites owing to the constrained timeframe. Second, the geographical distance between the educational institution from which the study was conducted (in England) and the study setting (in Saudi), and the travel restrictions during the COVID-19 pandemic made it more difficult to continue theoretical sampling. However, as explained by Glaser (2001), the purpose of theoretical sampling is not full coverage of data, but to develop categories via constant comparison of empirical data. Therefore, it is not necessary that the researcher covers all the concepts as long as the data collection is systematically delimited to facilitate the emergence of a parsimonious theory i.e. simple theory but with a great explanatory power. Following initial data collection and analysis, and as categories become dense and the theory is increasingly delimited, the amount of data needed decreases. Data collection, then, becomes more focused on specific categories in order to increase the density of the core category. Once the core category, relevant categories and properties become saturated, the process of theoretical sampling is stopped.

3.4.4 Sample size

In grounded theory studies, the sample size is dictated by the concept of "theoretical saturation" (Glaser and Strauss, 1967). The researcher continues collecting and analysing data until the analysis leads to no new concepts or categories, or the same concepts continually emerge (Simmons, 2009). This indicates that saturation is reached. Regardless of the size, sampling stops when emerging concepts and categories are sufficiently saturated (Thomson, 2010). In this study, I initially began with a relatively small sample of NQNs as transition was an inherent aspect of being an NQN. Subsequently, I started theoretical sampling with other significant individuals based on the leads and concepts emerging from earlier interviews. In total, I interviewed 33 participants, who were a mixture of NQNs (n=19), preceptors (n=4), clinical resource nurses (n=3), head nurses (n=5), and managers (n=2). The study participants were of different

nationalities and had various educational levels, professional backgrounds, subspecialties and positions, which I think facilitated a greater understanding of the transition phenomenon. There were 19 Saudi NQNs and 14 experienced nurses from the Philippine, Jordan, India, Saudi, Malaysia and Egypt. All experienced nurses had more than five years of professional experience working in various areas including ICU, medical and surgical units.

3.4.5 Theoretical Saturation

Theoretical saturation is a point at which collecting further various incidents indicates the same concept (Glaser, 1998). In other words, although collecting additional data may lead to new incidents at a descriptive level, incorporating or weaving them into the emerging theory will not change the theoretical concepts. Theoretical saturation is concerned with the theoretical understanding of a concept, rather than description. Glaser and Strauss's focus on the density of categories being the trigger to cease theoretical sampling implies an understanding that theoretical saturation is not about the quantity of data and whether it covers all incidents. To help illustrate this complex concept, taking an example from this current study, many incidents in the data referred to the process of choosing nursing as a career. The category indicating this pattern of behaviour is *Constrained Choice*. At the empirical level there were many instances of participants explaining the process of their career decision-making and the influence of social, practical and economic factors, and so on, on their decision to study nursing, but all these instances indicate the same category: *Constrained Choice*. Thus, although the instances are descriptively different, conceptually they related to the same category.

When the inter-relationships between the core category, its properties and related categories have been conceptualised, the theory has become saturated. Saturation, here, indicates that the core category accounts for most of the incidents in the area under study (Glaser and Holton, 2004). It is essential to understand, however, that the core category does not necessarily cover *all* incidents, and the emergent concepts or hypotheses remain open for modification within the substantive area. Additional data from either the same area of study or from published literature will always have the potential to alter the theory. Therefore, the final substantive grounded

theory is viewed as a continuing process rather than a fixed unmodifiable object, whereby saturation is only a temporary stop in the ever-continuous process of developing a theory (Glaser and Strauss, 1967). To reiterate, saturation in grounded theory is not about verifying hypotheses or describing in detail a specific situation at a specific point in time. Rather, grounded theorists seek to generate a theory that can cope with changing situations, which is a particularly essential element due to the constant change in healthcare (Breckenridge and Jones, 2009).

3.4.6 Data Collection

As mentioned earlier, I selected interviews as the main method for data collection. Although classic grounded theory accepts the use of any method of data collection to generate a theory, interviews have been preferred by many researchers. In a survey of articles professing to use grounded theory, Ralph et al. (2014) found that interviews were the dominant method of data collection in grounded theory studies. However, theoretical sampling revealed that a review of the Nursing Residency Programme manual was essential to saturate some of the emerging concepts. Furthermore, reference was made to the residency assessment and progress forms in response to certain issues raised in the interviews.

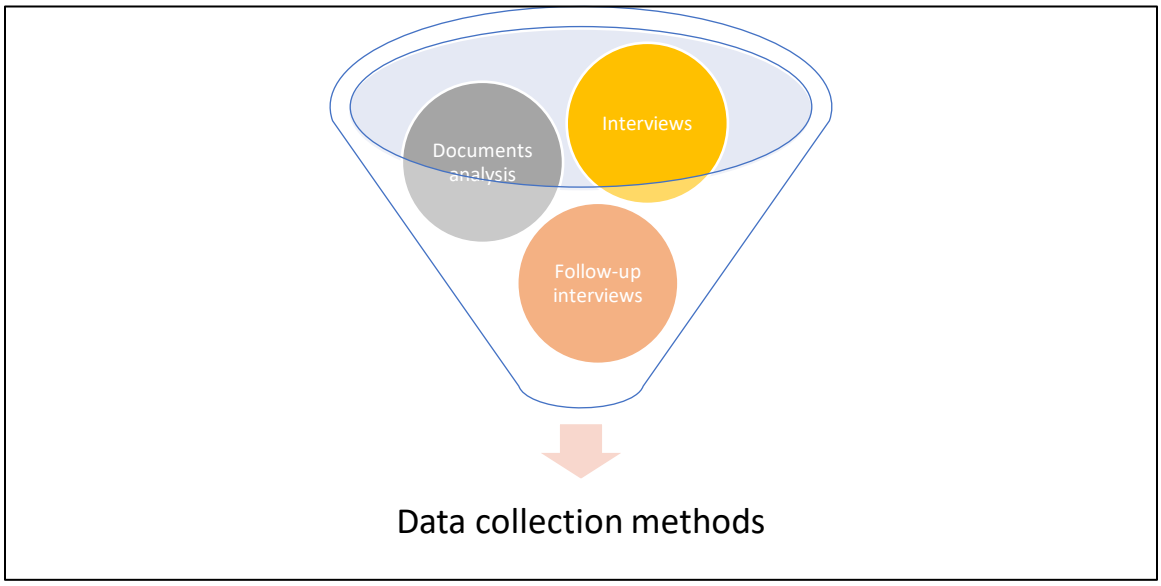


Figure 8: Methods of data collection.

- Interviewing

Speaking with participants is unquestionably important to discover their main concerns and how they continuously process them. Therefore, although I used a topic guide during interviews, the topic guide was loosely structured around the topic to allow participants to speak freely. This was compatible with the suggestion that grounded theorists begin interviews with general conversations that apply no constraints and give the interviewee the lead (Glaser and Strauss, 1967). I was increasingly flexible in the use of topic guide as the study progressed. As theoretical sampling dictates what data are to be collected and where to find them, there is no need for structured interviews since this can run counter to the process of theoretical sampling, which aims to saturate emergent concepts (Glaser, 2001). This is based on the premise that ideas emerging from interviews should shape further subsequent questions and not to be completely predetermined from the outset. Thus, I tried to prompt and probe significant incidents and to follow up issues that arose, searching for clarification and better understanding of the topic.

While early interviews with participants were more open, emerging theoretical leads progressively delimited the focus of subsequent interviews. The first few interviews resulted in the development of codes and categories, identifying various provisional leads that required further data collection. For example, some of these codes included “family role” and “social pressure” and their influence on the NQNs’ choice of career. Further interviews, although tailored to the emerging categories, were flexible and maintained openness to identify any new codes. Rather than being formal and strict, the interview environment tended to be informal, and using a conversational style allowed participants recount their stories naturally. With the participants’ permission, interviews were audio recorded and transcribed for analysis. Although it was mentioned in the Participant Information Sheet (PIS), at the end of each interview, participants were asked to reconfirm their willingness to participate in potential follow-up interviews.

As a novice researcher, using a topic guide with more fluid and open-ended questions was unnerving. It was also challenging to convince some of the gatekeepers (e.g. head nurses) that a structured interview guide can run counter to the inductive nature of the research methodology.

However, undertaking training in interviewing techniques and conducting two preliminary "practice" interviews provided a taste of how interviewing feels and increased my confidence. I started interviews with an open, non-controversial question: "Tell me, please, about yourself and how you came into nursing." This question was purposely made general and easy to answer, and was a helpful starting point to develop rapport (Gerson et al., 2020). Subsequent questions were developed based on the participants' responses, as explained in *Theoretical Sampling*, which was also useful for driving the conversation and discovering their main concerns and what really mattered to them.

Audio recording of interviews, which is not encouraged in classic grounded theory, was another initially unnerving aspect of data collection. However, it was an important tool to compensate for my lack of experience in interviewing and note-taking techniques. Glaser (1998) warns against the use of voice recording as, he argues, it delays the process of delimiting the research, slows data collection, and puts unnecessary extra work onto the researcher's shoulders. This was particularly evident as the recording, transcribing and converting into notes was significantly time consuming. However, recording interviews eliminates assumptions by interviewers, facilitates PhD supervision and avoids loss of data, as researchers can go back to the data whenever they need to (Holloway and Wheeler, 2010). This was evident from the two practice interviews I conducted; after listening to the recordings, some significant issues discussed in the interviews were found to be missing from the notes taken. Without the recordings these issues would have been lost forever. This failure, however, could be attributed to my relative lack of experience of interviewing and note-taking; more practice in the field might give the competence and confidence in future to interview participants without the need for recording and thus avoid delays in the data collection and analysis process. Although audio recording was time consuming and brought an enormous amount of data that later were found to be irrelevant, it was a necessary aid in this research study.

- Interview process

With support from a research coordinator, I was able to book a private office for most interviews at the academy building, which is on the hospital site but in a separate building. The interview location (at the academy building) and timing of interviews (2 pm – 5 pm) were convenient for both participants and myself. The academy building was considered safe as it was based on the hospital premises, and the time of interviews was thought to be relatively quiet in terms of nursing workload. For safety reasons a Distress Protocol was put in place prior to commencing the field work. This will be further discussed in *Ethical Considerations*.

Prior to each interview I made certain that all the essential equipment was available and functional, including pen, notebook and audio-recorder. I also brought two bottles of water and coffee to the interviewing room to help participants feel comfortable. To ensure the clarity of the audio-recording, I tried to minimise the background noise by placing an 'interview in process' sign on the door to avoid interruption. When interviews were conducted within the participants' departments, I encouraged them to inform their charge/head nurses where they were, and that it was acceptable to be interrupted in case of an emergency. Interviews with head nurses were generally more organised and less disrupted, compared to NQNs and preceptors, most likely because head nurses had more control over their work and had no direct patient care responsibilities.

Usually I began interviews with "Welcome and thank you for taking part in the study." Then, I introduced myself and the aims of my research project before asking participants to sign a consent form. All participants were given a participant information sheet (PIS) and enough time to think about taking part. Although most participants had given their consent (via phone) to participate before coming to the interview, I reassured them that they had the right to stop or withdraw from the interview at any time. One of the impressions that I received from the initial interviews was that my status as "an outsider" researcher encouraged participants to speak more freely and honestly. For example, one of the NQNs concluded their interview by saying that they would never have been this honest if I had been a member of their management team. This

corroborates the suggestion that participants may conceal their actual/honest opinions due to concerns related to the privacy of the research (Kelly et al., 2013). Consequently, at each subsequent interview, while introducing myself I would reemphasise my status as an "outsider" researcher and remind participants about the confidentiality measures taken, to gain their trust and facilitate honest responses. However, in some ways, I was also considered as an insider to the research, which I explain later.

Each interview started with a general question about their nursing degree, when they graduated and from which school. As all NQNs were fresh graduates they vividly recalled their experiences while studying nursing. This was a good starting point to make participants feel relaxed and assured that there were no right or wrong answers: I was just interested in their experiences and perceptions. Surprisingly, what I thought was a general and easy to answer question turned out to be a major issue for most NQNs. This will be explored later in the findings chapters. As I did use a semi structured interview guide, I was able to focus on participants' responses, jot down some notes and follow up on their answers. Although interviews with experienced nurses were more tailored to the concepts emerging from interviews with NQNs, I ensured using semi structured and open-ended questions to allow them to speak freely. Follow-up questions were developed instantly to clarify or explore issues raised during interviews. For example, some participants expressed their unhappiness with their current role, so I probed, asking: "What is it that you don't like about your role?" Also, in relation to the opportunities for professional development, I was able to explore the relationships between NQNs, head nurses and CRNs and how they negotiate and arrange continuous professional development courses for NQNs.

Discussing the challenges and issues associated with becoming a registered nurse gave participants the opportunity to "vent" and speak up about concerns that they had been dealing with for a while. This was clear when some participants said, off the record, that they felt so relieved at the end of the interview because they were able to speak freely, and they would not have done so if there had been anyone from the management team in attendance. These incidents assured me that some interviewees, NQNs in particular, enjoyed their interview and that they actually spoke about what really concerned them. Major concepts emerging from

NQNs' interviews were further elaborated in interviews with experienced nurses. Thus, Interviews with experienced nurses were tended to be more focused on emergent categories. The length of interviews ranged from 45 minutes to 70 minutes, and I allowed participants to take a break whenever they needed. At the end of each interview, I thanked the interviewee, asked if they would like to add anything, and then reminded them of the possible follow-up interview. None of the participants said at the time that they minded being contacted for a follow-up interview; however, this was not how it turned out.

The onset of the COVID-19 pandemic (March 2020) while collecting data made access to data sources even more challenging. Luckily enough, I was able to complete my first set of interviews before the coronavirus outbreak and returned to the UK in February 2020. However, follow-up interviews were essential to saturate some of the concepts and categories emerging from the analysis. In March 2020, COVID-19 was declared a pandemic and many countries, including Saudi and the UK, imposed strict regulations and banned international travelling. The restrictions imposed to control COVID-19 forced a change in the data collection mode from face-to-face to virtual interviewing. Although some participants were happy to move to Skype/Zoom interviewing, some decided to discontinue due to not feeling comfortable with online interviews, or being too busy with work. All the participants in this study were involved, to some degree, in the delivery of direct patient care and, thus, often requested to reschedule appointments, or even expressed a desire to withdraw from the study due to work pressure associated with COVID-19. For example, two participants who decided not to continue in the study explained that they were leaving the hospital (resigning). It would have been interesting to know about their working experiences especially during the pandemic and what made them decide to leave.

Although researchers in grounded theory are recommended to begin their data analysis immediately (Glaser and Strauss, 1967; Glaser, 1998), this was practically difficult. I had to compromise on this point partly because my data collection time was constrained by visa and immigration regulations, and partly because the NQNs could only make themselves available when they had time. For example, this meant conducting four interviews in one week and none in another week. I simply had to juggle my interviewing schedule based on the availability of

NQNs. Moreover, the whole process of conducting interviews, transcribing them and writing memos straight after interviews was very time consuming indeed. Consequently, I did not start data analysis until after the fourth interview.

- Transcribing process

The participants were health professionals from different parts of the world with a very good command of English. Technically, Arabic is the official language in the hospital; however, in practice English is used as the main language of communication between professionals. Thus, all the interviews were conducted in English. Despite this, participants, including non-Arabic speakers, used several Arabic phrases and idioms to express some of their views. I audio-recorded all the interviews and then transcribed them verbatim into a Word document. Due to the limited study leave I was given for data collection, I delayed transcribing some of the interviews until I returned to the UK, which allowed me collect more data and follow up concepts emerging from earlier interviews. As the study progressed, I developed my interviewing and note-taking skills.

- Document analysis

Initially I selected face-to-face interviewing to explore the transition experiences of NQNs. Analysis of the interviews, however, revealed that a review of the paperwork relating to the Nursing Residency Programme (NRP) was essential. NQNs frequently referred to different forms, documents and practices that caused a degree of conflict between them, clinical resource nurses and head nurses. For example, there was a significant variation in understanding of the aims and objectives of the NRP between NQNs, preceptors and head nurses. All parties somehow had different views about the roles and responsibilities of NQNs attending the NRP and how they should be treated. Therefore, permission was sought to investigate any form of documentation that was relevant to the NQNs, including the NRP manual, assessment forms and monthly reports. These documents were used as part of the theoretical sampling, and to clarify the participants' accounts during interviews (Mason, 2017).

Furthermore, reviewing the associated documents provided an additional slice of data to be added to the constant comparison. It helped me go beyond the participants' experiences and perceptions of the transition process. Although the manual presented the aim, objectives, strategies and intended outcomes of the programme, the reports from many NQNs and experienced nurses on the delivery of the programme were different. Moreover, when reviewing the NRP manual, I noticed that it was adapted from a nursing organisation in the United States, where nursing culture is different from that in Saudi. This could explain the criticisms questioning the value of the programme to the transition experiences of NQNs. Comparing the different roles of individuals involved in the delivery of the programme allowed me to weigh their contribution and influence on the transition process. In addition, by reviewing the manual, I was able to notice the vagueness of the descriptions of the different roles within the NRP, such as charge nurse, preceptor and clinical nurse. This could also be linked to what preceptors and head nurses said about their struggle with role conflict and responsibilities in terms of the performance and assessment of NQNs.

3.4.7 Data Analysis

As explained in *Coding*, the analysis process was split into two stages: substantive coding, which includes open and selective coding, and theoretical coding. I conducted 36 one-to-one interviews, including 3 follow up interviews with an NQN and two experienced nurses. Initially, five NQNs were purposively sampled then I used theoretical sampling to recruit more participants. I also had several informal conversations, which resulted in the production of extensive transcripts and field notes. I analysed and coded these data line by line, asking continuously, as suggested by (Glaser, 1978, 1998), "What are these data a study of?" and "What category does this incident indicate?" This is the process of open coding, where data are coded line by line to ensure theoretical coverage of all possibilities (Glaser, 1978). I coded and labelled each incident and often used an in-vivo code that was taken from a direct quote from a participant (See appendix 5 for an example of open coding). This resulted in the generation of some 120 codes and categories. These codes and categories, however, were later integrated and

modified through constant comparison to ensure they best fitted the raw data from which they were derived (Glaser, 1998). In terms of technical support in the analysis, I attended two workshops about using NVivo and MAXQDA software programmes for facilitating qualitative data analysis, as suggested by colleagues and my supervisory team. After two weeks of using these programmes, however, I decided to return to manual analysis. I thought the programmes were useful for storing and managing the large amount of data but not analysing them.

Although analysis of the initial interviews was slightly delayed for practical reasons, as explained in *Interview process*, I commenced writing memos right from the beginning (See an example of a memo in appendix 6). Memos allowed me to capture conceptual ideas as they arose and preserve them (Glaser, 1998), and I used them later to compare incidents within and between interviews, alongside document analysis, in a process referred to as constant comparison. As I am native Arabic speaker and English is a second language, I found myself writing some memos in Arabic or sometimes broken English. That did not matter as long as it preserved the idea that had arisen at that particular moment. Thus, this freedom of memoing was very useful, particularly for my study. Comparing memos with other incidents resulted in the need for additional theoretical sampling and the development of more categories and their properties. For example, "gender sensitivity or gender segregation" emerged in early interviews as an important category, which I explored further in subsequent interviews, leading to the concept of "reconciling" as a category. This category reflects how NQNs attempt to reconcile requirements from work to work with the opposite gender, while as the same time, they try to keep this intermingling to the minimum.

3.4.8 Evaluating a grounded theory study

When discussing research rigour, the terms "reliability" and "validity" often crop up; however, these concepts have been accepted mainly within quantitative research, and are rejected by many qualitative researchers. In qualitative research, there have been attempts to find some analogues; probably the most well-known are those of Lincoln and Guba (1985): credibility, transferability, dependability and confirmability. The disagreements between quantitative and qualitative researchers in terms of evaluating the quality of studies stems from their different

purposes and philosophical positions. While the former approach is generally concerned with verification and belongs to the positivistic paradigm, the latter positions itself within the interpretivist paradigm and focuses on exploring experiences and perceptions (Houghton et al., 2012). As a result, there seems to be a general consensus that there cannot be one set of criteria to evaluate the quality of studies in both approaches, but separate, discrete criteria that consider the fundamental principles of the selected approach.

Classic grounded theory was introduced as a general methodology that is distinct from the aforementioned (quantitative and qualitative) approaches, and thus comes with its own set of criteria for evaluating the quality of findings, as explained in Glaser (1978, 1998). In contrast to quantitative research, the aim of a classic grounded theory study is not to produce factual results or accurate description, but to generate plausible theoretical hypotheses that explain a pattern of social behaviour (Glaser and Strauss, 1967). The finding of a grounded theory, i.e. the emergent theory, presents an integrated plausible account that should not be judged as true or false, but instead as relevant, applicable and modifiable within the researched area. Furthermore, in contrast to qualitative studies, classic grounded theory does not aim to offer a full description or interpretation of participants' experiences and perceptions, but to conceptually abstract their perspectives (Glaser, 2004). This aspect of the classic methodology, however, can be problematic especially if the research study is going to be introduced to an international audience. Therefore, in this thesis, I intentionally provided detailed description of the study context giving that the study supervisors and potential thesis examiners are most likely to be unfamiliar with the study context.

Criteria used to judge rigour in quantitative and qualitative studies cannot be used to evaluate the quality of grounded theory studies. When judging the quality of a classic grounded theory, Glaser (1978, 1998) suggests using four criteria: fit, relevance, workability and modifiability. I will discuss these criteria below, and explain what I did in practice to ensure the generation of a "good" substantive theory.

- Fit

Fit is analogous to validity in quantitative methods, or credibility in qualitative research. It refers essentially to the credibility of the concepts presented in the theory, and whether they fit with the collected data and conceptually represent the pattern of behaviour in the area researched (Glaser, 1998). I adhered to the constant comparison technique, as detailed earlier, to ensure that I relied only on the empirical data, not perceived or received ideas, to generate concepts. Evaluating fit is similar to assessing whether the generated concepts adequately reflect/express the pattern in the data (Glaser, 1998). Constant comparison guided me to carefully check where concepts came from and refine them, if necessary, to better fit the data. I ensured this by developing an audit trail for my study supervisors to continuously check and provide feedback. This improved the chances of the grounded theory being well-integrated and clear and grounded in my actual data. I also collected data from multiple sources (e.g. nurses, preceptors and managers) to compare them, which was helpful in refining some of the generated concepts and to ensure their fit.

As an insider researcher in some ways, I was concerned that my taken-for-granted assumptions might have an influence on the generation of codes and categories during the analysis stage. I was a newly qualified nurse few years ago and had experienced the role transition myself, which makes me an insider researcher. Although the use of constant comparative analysis minimises this risk, I sought a methodological consultation from an independent grounded theory expert in addition to my study supervisors to ensure that the concepts adequately reflected what was in the data – not my personal experience or preconceptions.

- Relevance

Relevance is the extent to which the core category is important to the individuals in the researched area, that is, the "grab" of the generated theory (Glaser 1978, 1998). If the emergent theory fits the data, then it will inevitably be relevant to what is really going on that is of significance to the participants. Forcing data to fit perceived or popular concerns may lead to the generation of a theory which is less relevant to the studied area. This was particularly evident in

this project, where a common global concern, which I found in my scoping review, i.e. transition shock, was relatively small or of little concern in the substantive area. Had I relied on the existing literature and personal experience, I would have missed identifying the NQNs' main concerns and the generated core category would have been less relevant to the substantive area. Therefore, grounded theorists are urged to limit their focus to the data to generate concepts that are relevant to the participants studied.

- Workability

This criterion refers to the ability of a theory to explain what happened or is happening in a researched area (Glaser, 1998). Evaluating the quality of this theory was a continuous process focusing on whether the theory is fit, relevant, workable and modifiable. Thus, I evaluated the quality of my theory by questioning; How well the developed categories fit the data? How relevant is the theory to the behaviour of the NQNs in their area? Does the theory accurately capture the main concern of the NQNs? This ongoing process of asking questions helped me to assess the quality of the theory. Moreover, during data analysis, I shared my work with the study supervisors and a grounded theory expert who provided constructive feedback to improve the analysis procedure.

- Modifiability

Modifiability relates to the ability of a theory to be updated/edited as a result of constant comparison with new relevant data (Glaser, 1998), so that new data from different contexts can expand the scope of the core category to account for more variation of behaviour rather than refuting the original theory. To enhance the quality of the theory, in this research, I specified the scope and delimited the generality of the substantive theory to the experiences of NQNs' transition. I am only suggesting that these patterns and concepts are relevant to NQNs' experience during role transition. As explained earlier, the purpose of a grounded theory study is to produce not a static, fixed theory but an "ever developing entity" that can be altered by constant comparison (Glaser and Strauss, 1967). This feature (modifiability) allows a theory to be

applied to other substantive areas; it is an analogous to the term “transferability” in qualitative studies or “generalisability” in qualitative methods. Any new data that generate a new indicator or concept is woven in through constant comparison and modifies the theory to be better able to explain what is going on in that particular area.

I used the four criteria discussed above (fit, relevance, workability and modifiability) to continuously assess the quality of developed theory. I also, as mentioned earlier, used my study supervisors as “critical friends” to challenge my thoughts and offer constructive feedback. I attempted to explain the procedures of how the theory was developed. Although transparency is not considered essential in assessing the quality of grounded theory, I thought it was necessary in this research for multiple reasons. First, to evidence the researcher’s ability in conducting a rigorous and systematic study, which is a PhD requirement. Second, to showcase how a grounded theory is generated, especially for people who are unfamiliar with the methodology. Finally, to enhance the chance of being accepted for publication in international journals. Quality assessment criteria in classic grounded theory appear to focus on the final product or end result of the study, rather than on the process through which it was achieved. This is different from qualitative studies and could explain the tensions between grounded theorists and qualitative researchers in terms of quality assessment: they use different measures. However, I think classic grounded theory measures of rigour are congruent with more widely accepted criteria for rigour such as Lincoln and Guba’s (1985).

In addition to the different criteria used to judge rigour, there is a procedural difference between a grounded theory study and other studies. The typical procedure for conducting a classic grounded theory study does not necessarily fit neatly into the “PhD thesis box”; thus, different strategies need to be adopted so that specific institutional requirements are fulfilled. This will be exemplified in the next section, *Ethical Considération*s, which reports some of the adjustments that had to be made to satisfy both classic grounded theory and institutional (university and hospital) requirements.

3.4.9 Ethical Considerations

This chapter ends with a discussion of the ethical considerations involved in this research study. As an inductive methodology, grounded theory encourages going straight away to the field of interest, collecting and analysing data. Given the traditions in academia and modern healthcare research ethics, however, this is somewhat controversial. Classic grounded theory methodology strongly suggests beginning a study without a preconceived problem, a review of relevant literature or pre-determined sampling procedure. However, these suggestions contradict per se the common requirements of most ethics committees, including the two committees involved in sanctioning this study, to evaluate the quality and ethical integrity of the potential research study, and failure to meet these requirements could have resulted in my study being rejected. Therefore, I had to compromise on the recommendation to avoid reading related literature at the outset of the study. However, as explained in the *Scoping review* (Chapter Two), I purposely selected a type of review that aimed to provide a broad overview of the nursing transition, and not to investigate a particular problem. Moreover, as suggested by Glaser (1998), I published my scoping review in order to document the assumptions I had absorbed from the literature and my clinical experience and not to mix them with the empirical data.

Other requirements from the two research ethics committees were filled with anticipated information. For example, in the aim of the study and based on the review of literature I conducted, I wrote that the *Transition Shock* is most likely to be a major issue for newly qualified nurses and required further investigation, which I later found to be of little relevance to what the participants were saying. This finding suggests that hypotheses derived from reading the literature do not necessarily force or contaminate the generation of theory, if openness is properly maintained. To ensure openness to discovery, and as explained previously, I developed a loosely structured interview guide to not restrict the conversation with the participants and allow them to speak freely. Therefore, I start interviews with general questions such as how is work going? or how did come into nursing? These simple but powerful questions generated concepts that I did not come across during my reading of the literature.

As this study was conducted under the auspices of The University of Manchester, ethical approval was sought from and granted by the University research ethics committee (UREC) as a first step in the process of gaining access to data sources. Afterwards, as an international PhD student and in compliance with the UK visa and immigration rules, I sought permission from the Home Office and the Saudi Arabian Cultural Bureau in London (SACB) to leave the UK for the purpose of field work. To access the study setting, and thus the study participants, ethical approval was also sought from and granted by the institutional review board (IRB) at the hospital. The hospital approval was linked the University approval. As a nurse educator, I was also bound by the ethical code of conduct defined by the local professional body, the Saudi Commission for Health Specialties (SCFHS). The two ethical approvals from the University and the hospital, under the numbers UREC: 2019-5141-9284 and IRB: 18-488 respectively, are displayed in Appendices 7 and 8. As part of the ethical approval procedure, a participant information sheet (PIS) and informed consent form were also developed; copies of these forms are available at Appendices 9 and 10.

As the two institutions were based in different countries (UK and Saudi), it was essential to fulfil additional requirements such as travel permissions and data transfer rules. As a result, the process of obtaining the two ethical approvals spanned over a year, from initiating the first request to actually starting data collection. Comparing the two institutions, the University ethics process was significantly longer and more bureaucratic than that of the hospital – twelve weeks vs three weeks. On reflection, to accelerate the ethics approval process, several very similar ethical approval forms could have been combined or cancelled, and the number of required signatures could be reduced. Moreover, ethics committees could be more aware of different types of research methodologies and the associated time needed for data collection. In this study, the hospital research committee permitted only a limited period of three months for data collection, assuming that would be sufficient. As this study involved travelling between two countries and followed the principles of grounded theory, where data collection and analysis should be carried out concurrently, I found that permission for only three months was inadequate. This led me to apply for a study extension and visa extension, which were rather bureaucratic and time-consuming applications.

The three key areas to ensure research is conducted ethically are informed consent, data management (including confidentiality and anonymity) and participant and researcher safety. These three elements will be discussed below.

- Informed consent

Informed consent is defined as the process of making a voluntary decision to participate in a study based on a full understanding of the possible consequences (World Medical Association, 2013). A comprehensive explanation of the research study and the potential benefits and risks of participating ensures the autonomy of participants to make an informed decision. As a fundamental principle of research ethics, I provided all potential participants with a detailed participant information sheet (PIS) and ensured that there was no time limit to decide whether to consent to participate. However, as the gatekeepers who granted access to potential participants hold higher positions (e.g. nursing director), there was a risk of coercion (McDonnell et al., 2000). Potential participants may have felt pressured to participate as they saw their managers had approved the study. To minimise this risk, I did not involve the gatekeepers in the recruitment process nor inform them of potential participants' final decisions about participation. In addition, I informed NQNs that neither their participation nor non-participation would have an impact on their end-of-year performance assessments.

Before approaching potential participants in their departments, I talked to them by telephone about participating in the study. Those who initially agreed to participate were met in person in their respective departments and were given a PIS, and any concerns which arose from that were addressed. Everyone I contacted agreed to participate in the research apart from three NQNs who did not respond to my calls and emails. Prior to each interview, the participant was given sufficient time to discuss any issues that might be of concern, and written consent was obtained. I emphasised to participants that they were free to withdraw their consent at any time. Some of the participants asked about the audio-recording of the interviews and who was going to listen to them. I assured them that access to audio-recordings and transcripts would be limited to me – the researcher. Other than that, participants did not seek further clarification about the details provided in information sheet.

The detailed PIS provided to participants prior to the interviews, however, posed a dilemma. In grounded theory, researchers should not start with a preconceived focus, but the PIS provided led participants to develop assumptions about the interview content and act accordingly. For instance, because the study title included the term "Transition", some NQNs began the interviews by discussing their experience of role transition and the differences between school and hospital. A similar experience was also reported by Morse (2008), arguing that fully informing potential participants actually interferes with collecting data inductively. Given that the informed consent process somehow contradicts the inductive nature of grounded theory, but is inevitable, I used a strategy to minimise this threat. Rather than allowing participants to speak about the assumptions they had developed, I took the lead and nudged the discussion from "transition" to "tell me about your nursing degree?" Starting the interview with a broad question, about the interviewee's experience of choosing/studying nursing, brought up some concerns that they considered more important than the transition experience.

- Confidentiality

Confidentiality refers to the expectation that the information collected during a study will not be disclosed to a third party without the consent of the relevant participant (Kaiser, 2012). Assuring confidentiality is vital to protecting the privacy of participants and building trust, particularly in this study as it involves relatively long and in-depth interviews where personal and sensitive information may be divulged. I endeavoured to assure the participants of confidentiality by building and maintaining good relationships with all participants throughout the study process, expecting that rapport with participants would encourage openness, which was essential in my study to explore participants' significant concerns.

Furthermore, following the University of Manchester's data management guidelines and to protect the confidentiality of participants, I used an encrypted audio-recorder while recording interviews. Hard copies information, including demographic information and informed consent forms, were stored securely in a locked location during the study process. Electronic copies, such as coded transcripts and the coding key, were separately saved in different locations in password

encrypted files to protect against unauthorised access to these files. In addition, these files were copied and saved in three different secure cloud storage locations (my university's personal P-drive, Dropbox and OneDrive) to minimise the chances of them being damaged or lost. Finally, in line with the University's data storage regulations, the data stored will be permanently deleted five years after the completion of the study. The audio-recordings of interviews were overwritten immediately after transcription to ensure their complete disposal.

- *Anonymity*

Anonymity refers to ensuring that the shared or published information from a study does not contain identifiable personal information about the study sample or settings (Jones et al., 2013). In qualitative research, achieving anonymity is often complicated due to the detailed information about participants which is necessary to situate the study's claims, and the relatively small sample size (Goodwin, 2006). Although in-depth descriptions of the study sample or setting in grounded theory studies are unnecessary due to the nature of the methodology, I had to provide a detailed description in consideration of the international audience who might be unfamiliar with the study context. To ensure that the information provided did not contain identifiable personal data, I coded all the interviews.

In terms of participants' privacy, I ensured their anonymity by creating a code for each interview throughout the research. At the same time, I created a coding key, as explained in *Confidentiality*, that contained their contact details, to be used exclusively for follow-up interviews in this study. The study supervisors' access was limited to the coded data, which had no identifiable information. Moreover, through the informed consent, I sought permission to quote participants verbatim to illustrate some of the concepts, with the proviso that no quotations would include personal or identifiable information.

- *Safety*

A Distress Protocol, as displayed in Appendix 11, was developed and put in place as a safety measure to protect both participants and researcher during the course of interviews. The

protocol indicated that if a participant reported or showed signs of distress or feeling uncomfortable while being interviewed, I (the researcher) would switch off the recorder, reassure them and end the meeting, if necessary. Moreover, the protocol indicated that the participant had the right to ask for a short break or cancel the interview altogether at any time.

3.5 The inbetweener-researcher role

I was considered an insider to the research in some ways and an outsider in other ways throughout the study process. As a nurse with a number of years in clinical practice, I was considered an insider to the research. Participants and I shared a common ground in the nursing culture, and they accepted me as one of their group members. Dwyer and Buckle (2009) suggest that participants might speak more freely when talking to an insider: it is the feeling that we are one group and it is "us versus them". This was apparent in the participants' frequent use of phrases such as "you know what I mean" or "you know how it feels" when discussing workloads in nursing or interactions between nurses and doctors. Had I been an outsider, I would have needed more time to understand these issues. Moreover, as a Saudi nurse, NQNs tended to be more open to talking about their experiences confronting *our* culture's (Saudi culture's) low perception of nursing and the relationships between Saudi and non-Saudi nurses. I think the commonality between *us* (researcher and NQNs) made me theoretically sensitive and encouraged NQNs to be more willing to talk about their experiences and perceptions and what really matters to them. A potential limitation, however, could have been the fact that I was a male researcher interviewing largely female sample. Discussing issues around gender and working in mixed-gender workplaces could have been affected by me, being from a different gender. Female participants might have said something different if the interviewer was from the same gender.

Although being an insider can be beneficial to the research, it can also pose a risk. Bonner and Tolhurst (2002) discussed how over-familiarisation with the study area can lead researchers to develop assumptions about certain actions without seeking clarification, and become a non-

observing participant. To minimise this threat, I kept reminding myself and the participants, from time to time, of my role as an outsider who had never worked in the same hospital, and that nursing practice differed slightly where I come from (another city). Maintaining my role as an outsider allowed me to ask naïve questions about all actions instead of making assumptions, and encouraged participants to explain in detail what they did, how they did it and why they did it. Moreover, being an outsider and the fact of my stay being temporary somehow contributed to my status of not being a threat to any participant. NQNs shared sensitive information and criticisms of their employer and management team that, according to some participants, they would not have discussed if I had been an employee from the same hospital. Discussing such sensitive issues necessitates that the information collected be treated confidentially. I assured the participants that their responses, perceptions and future plans would not be divulged to their colleagues or to the management team. In general, being viewed simultaneously as an insider and outsider to the research facilitated collecting in-depth and relatively honest responses from the study participants.

3.6 Summary

This chapter has started with highlighting the overall aim of the project and what methodological approach was thought most appropriate for this research. It then presented an overview of grounded theory methodology and a discussion of the central tenets of the classic grounded theory such as theoretical sampling, constant comparison and coding. This was followed by a report of the practical steps undertaken to conduct the study and an explanation of the particular criteria used to evaluate the quality of a grounded theory study, setting the stage for the reader to judge the quality of the emergent grounded theory presented in the following chapters. Finally, this chapter concluded with a discussion of the ethical considerations, highlighting some of the challenges involved in using a grounded theory approach while adhering to common institutional review boards' policies.

The next three chapters will present the findings of this research, discussing in particular the social process underpinning NQNs' transition, which I described as *Forward Escaping*.

Chapter Four: Acquiescence

In this and the subsequent two chapters (5 and 6), I intend to present the basic social process of *Forward Escaping* that accounts for the patterns of behaviour in which newly qualified nurses (NQNs) continuously engage to try to resolve their main concern: the perceived threat to their status associated with working at the patient's bedside, which I termed the "bedside nurse role". The term "bedside nurse role" here is defined as a nurse who provides direct, hands-on patient care.

The analysis of data through coding, constant comparison, theoretical sampling, and memoing resulted in the emergence of this social process as the core category in this study. This core category stemmed from three subsidiary categories and the relationship between them. These were acquiescence, reconciling and perseverance. These three subsidiary categories, will each be explained separately, with a chapter devoted to each one. These three categories were interconnected and reflected the social process as experienced by NQNs during their transition to becoming qualified nurses. The stories of NQNs tended to reflect on three different periods of time: 1) getting into nursing, 2) studying and practising nursing and 3) surviving nursing, which I later conceptualised as 1) acquiescence, 2) reconciling and 3) perseverance. To start, I will briefly introduce the core category of *Forward Escaping* and then discuss the first subsidiary category, "acquiescence". The second and third subsidiary categories – "reconciling" and "perseverance" – are discussed in chapters 5 and 6 respectively.

4.1 The core category: *Forward Escaping*

There were three main obstacles that newly qualified nurses (NQNs) dealt with on their path to becoming nurses: acceptance of nursing as a career, reconciling work and personal life, and persistence in the face of perceived challenges at work in order to reach their long-term goal – a position with a higher social status. Although NQNs reluctantly accepted their career choice, they did not embrace their roles as bedside nurses due to the association they made between bedside

nursing and a poor social status. To resolve this perceived issue, they sought opportunities for professional growth which would allow them to escape their role at the patient bedside. Their eagerness for professional progression was seen as a way of compensating for their uniformed or constrained choice of nursing as a career and was a way to overcome their negative feelings that their choice of nursing meant that they could not achieve the status they wanted to achieve. Attempts to advance professionally generally involved either pursuing the natural process of advancement and promotion through their employer, or through obtaining an advanced degree. I conceptualise this process of an overtly ambitious search for professional growth as *Forward Escaping* strategy that the NQNs used to deal with the perceived low status of nurses that concerned them the most. This emerged from the data as a core category with three subsidiary categories, each with their own categories and properties. Figure 9 provides a summary of the coding process.

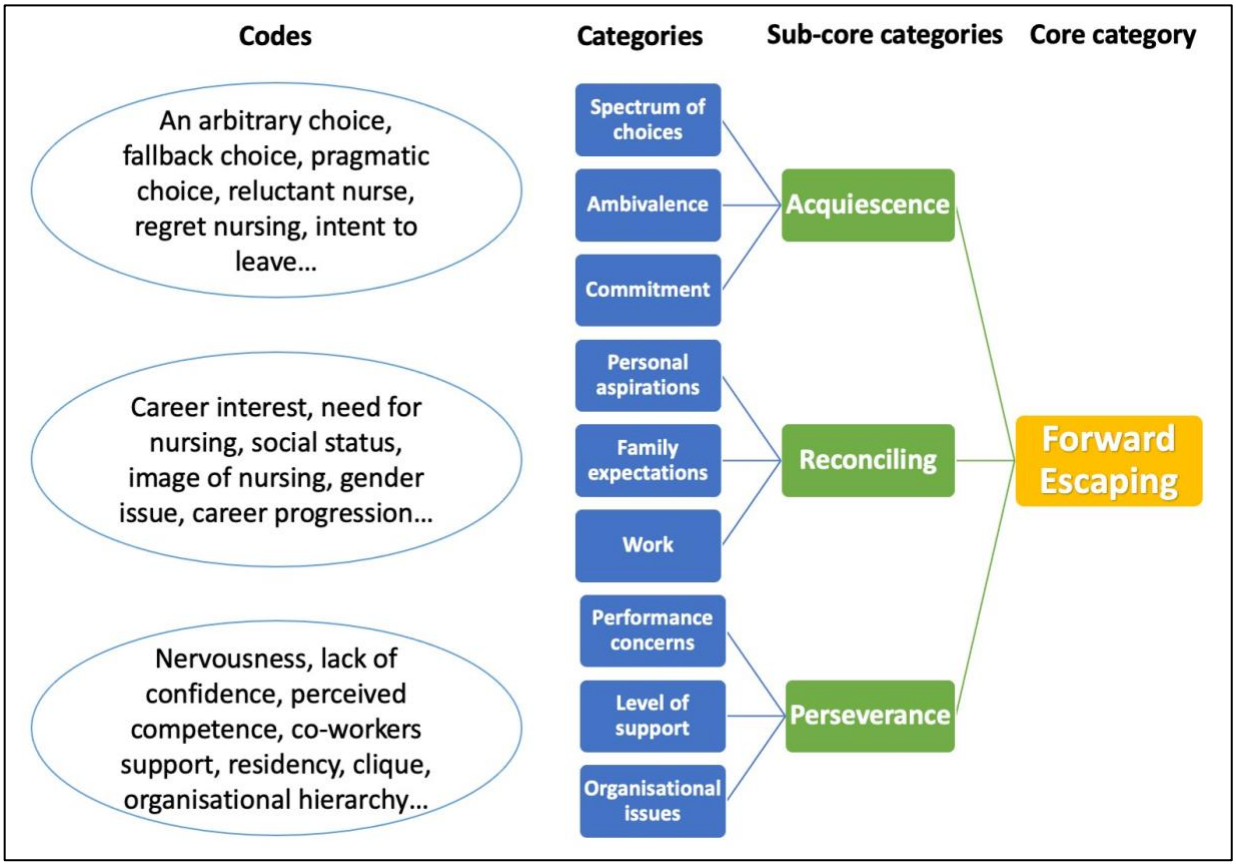


Figure 9: The coding process.

I generated conceptual codes to detail the categories, as suggested by Glaser (1978). By asking questions of the data, I sought to discover meaning rather than facts, which is consistent with the methodology of grounded theory (Glaser, 1978). I used verbatim quotes from the participants to articulate the properties of the concepts that emerged. All quotations are presented in Italics and have not been modified in any way other than grammatical editing (NQN= newly qualified nurse, P= preceptor, CRN= clinical resource nurse, HN= head nurse and M= manager).

4.2 Acquiescence

As explained, *Acquiescence* is a subsidiary category of the basic social process of *Forward Escaping*. It presents the process in which NQNs engaged to try to choose their career path, the practical challenges they confronted and how they dealt with them, and the associated consequences. Following their graduation from high school, NQNs faced a spectrum of choices which contributed to varying degrees of ambivalence and commitment to the nursing profession. NQNs reluctantly and conditionally accepted their career choice as they progressed to become registered nurses. These processes will be presented in a temporal sequence.

4.2.1 Spectrum of choices

From the participants' narratives, there appeared to be a connection between students' performance at school/college and the expectations that arose. Most NQNs reported that their perceived high grades at high school raised their expectations, as well as those of their social circle, about future career plans. They saw themselves as high achievers who had achieved a high school GPA and achieved success by securing a place on a university foundation year (health track). As explained in Section 1.2.5 *The education system in Saudi*, a health-track foundation year prepares students to study one of the health-related subjects, e.g., medicine, dentistry or nursing. For most NQNs, securing a place on the health-track foundation year seemed a significant milestone towards achieving their goal of being selected to study medicine, which was their preferred choice. This choice seemed to be in line with the expectations of their families and significant others, and appeared to be in part influenced by the perceived prestige of the profession.

> *My grades [in high school] were very high compared to my friends'… All my teachers and friends were expecting me to be a doctor, or at least a dentist. Even my family were suggesting studying medicine or engineering… Old friends and teachers were shocked when they knew that I had entered nursing. - NQN4*

On the other hand, some NQNs were expected to join nursing, following in the footsteps of their siblings. Another reason for this expectation could be the student's relatively low grades.

> *My sister is a nurse and she is happy with her job so the whole family was expecting me to copy my sister's path… My grades [high school GPA] were below 90% … It didn't qualify me to enter the [health-track] preparatory year at [university]… I studied both HR [human resources] and nursing at [private college] - NQN16*

Nursing, for the vast majority of the NQNs, was not a first choice and their career decision-making was influenced by various factors such as grades, family and distance between home and college. I categorised their choices into two sections: constrained choices and first choice.

A) Constrained choices:

Based on the narratives of NQNs, I further characterised constrained choices into arbitrary choice, fallback choice, pragmatic choice, and choice based on proximity, in addition to choice overload and family-influenced choice.

- An arbitrary choice

Since the establishment of Saudi Arabia as a unified independent state in 1932, jobs in the healthcare sector, including nursing, have been largely dominated by expatriates (See *1.2.4 The healthcare system in Saudi*). This prolonged dominance has created a culture where nursing is not usually considered as a career path for a native-born Saudi. Therefore, it was not surprising for NQNs in this study to demonstrate a general lack of understanding of the nursing field upon leaving high school. Some NQNs indicated that they had "randomly" selected nursing as their

major when applying to university programmes. Despite the element of chance, some students discovered that they enjoyed the practicum aspects of nursing and their clinical experiences:

> *I can't say why I chose nursing; it was by chance. To be honest, I started liking nursing from my second year at university. The simulation lab and clinical practice at hospitals were my favourite. I think the role of helping others is probably the main role that made me like my job as a nurse - NQN17*

On the other hand, the arbitrary choice turned out to be not so successful for some NQNs. Among other reasons, these participants were unhappy about the way nurses were perceived within the hospital, compared to other health professionals.

> *I randomly chose nursing; don't ask me why because I don't really know [laughs]. In college, I wasn't really interested in nursing and picked the lenient hospital [less workload and less supervision] to do my clinical training… At [hospital name] nurses were ignored and not listened to. Doctors would eat their dinner and nurses would have leftovers [idiom]… That first impression told me that nursing is not a respected profession compared to, let's say, medicine or even pharmacists. I had that bit of feeling that my choice of nursing wasn't right… Even when I graduated, I was not excited about getting a job; my dad found me this [current] job. - NQN14*

The clinical experience of "real-life" nursing practice was an eye-opener for many NQNs. In contrast to NQN14's experience, for other NQNs the clinical training was a reason to embrace nursing. The combination of a positive first hands-on experience, an opportunity to apply their skills and knowledge, and feeling like an active participant in a patient care team affirmed nursing as a true calling, as opposed to a "random" choice.

> *Honestly, I had no clue about nursing whatsoever when I first joined… I remember when [friend's name] asked me to pick nursing so that we could be together in class and use the same bus to go to school [laughs]… I wasn't sure in Semester 1, but I started clinical training in Semester 2, I liked it and became more interested in developing my nursing skills… - NQN11*

Prior to graduation from high school, few NQNs had ever considered nursing as a possible future career and did not learn about it until their university induction programme (following

acceptance on the health-track foundation year). Some NQNs explained that the induction programme was influential in raising their understanding of nursing and its vital role in the provision of healthcare. Moreover, the induction course was reported to stress the potential for professional development within nursing and the variety of disciplines in which they could specialise. Some NQNs discussed how the induction course "played a role" in convincing them to consider nursing as a potential career choice. However, it did not seem convincing enough for them to select nursing as a first career choice. Despite the reported influence of the induction course on their subject choice, most NQNs appeared to have made an uninformed choice.

> *First I was going for nutrition, then laboratory, but then I changed my mind and chose nursing… I don't know how I chose nursing; I decided very quickly without actually thinking about it... I think the induction week played a role in driving me to nursing…. things like… the joy of helping others, the important role of nurses, lots of job opportunities, etc… - NQN6*
>
> *It [nursing] was not my first preference… I don't know why I put nursing as second preference… it was random and quick decision… Maybe because it is close to the speciality that I wanted, which was medicine. I had never thought about becoming a nurse…Possibly hearing about the opportunities available in nursing during the induction days drew me to nursing… - NQN9*

It is apparent that most participants, when they graduated from high school, lacked knowledge about the nursing profession, and did not view it as a potential career option. The majority of NQNs who stated that they arbitrarily chose nursing as a career eventually found it rewarding for its altruistic nature and the possibilities of further specialising in a selected area. A few participants (about 30%), however, expressed regret over selecting nursing upon experiencing the status of nurses within their organisations, and what they perceived as inequity in treatment compared to other professionals.

- A fallback choice

The information provided to potential students during university induction days was reported to convey the message that nursing is, to some degree, similar to medicine; thus, nursing is valued, respected, and now one of the careers for which there is great demand. This was influential in

catching students' attention and sparking an interest in studying nursing, as well as convincing others to make nursing one of their top three choices on their subject preference list. Commonly, nursing was placed third after medicine and dentistry. As explained in the introduction chapter, students on the health-track foundation year are required to list a few subjects of interest, and the university assigns students to different courses based on certain criteria such as a student's high school and foundation year GPA. As result, selecting nursing as a fallback choice became common practice. Many NQNs had come to university with plans to study either medicine or dentistry, and ultimately studied nursing as an alternative. The notion of selecting nursing as a fallback choice, however, led some NQNs to assume negatively that students chose nursing only as a back-up plan and were actually not interested in becoming nurses.

> *I have never met a student who, from the beginning, wanted to do nursing. Studying nursing is normally a plan B or even C for everyone… Those who couldn't get accepted for any of their preferred subjects, they would just do nursing. - NQN1*

The campaign to promote nursing which NQNs experienced during the induction days led to some over-inflated expectations amongst prospective students, who later felt disappointed. Those who had very limited knowledge about nursing believed that nursing and medicine courses were identical, and the only difference between them was the length of the course of study – five years for nursing and seven years for medicine. This misconception over-elevated students' expectations, leading some with an interest in healthcare to add nursing as an alternative to their preferred subject:

> *When I was in high school, I had the idea that doctors and nurses were the same as they all wore medical uniforms and gave injections to patients etc… and the nursing campaign during the foundation [year] made me think that the two courses were similar… My preference list was medicine, nursing,… radiology… can't remember the rest… It was four or five subjects. - NQN10*

"Selling" nursing as similar or equal to medicine seemed to have been effective in attracting more students to put nursing as a second choice. However, those who had been convinced to study nursing, equating it to medicine, would soon discover that the two professions differed in many

aspects, particularly social status, a disappointing fact for some, leading them to consider dropping out. This is explored further in *Perseverance*, Chapter 6.

> *I only learnt about nursing and how they work when we started our clinical training… I think it was in Year 2. I did not like it. In practice, nurses were not respected compared to doctors and will only follow doctors' orders… I didn't like that… I always wanted to be a leader, not a follower. I thought about changing subject to something that I would like but I was already half way through… I didn't want to lose two years of my time and start all over again. - NQN1*

A few students indicated that they "arbitrarily" chose nursing as their second option because they believed that if they could not secure a place on their preferred programme, they were willing to study any other course, and thought nursing was equally acceptable compared to other second choices:

> *I wanted to study medicine, but I couldn't … It was fated… Then the university chose nursing for me. Saraha [to be frank with you], since I lost my chance in medicine, other courses seemed equal for me… The university put my name on the nursing course, and I didn't mind. - NQN13*

> *I remember I came to university with only one goal, which was to enter medicine… but that didn't happen… Based on my grades [at foundation] they suggested I study either nursing, pharma, or lab. I chose nursing… I don't know why… - NQN9*

Promoting the perception that nursing was a good fallback choice, or encouraging students who failed to achieve their first choice of programme to consider nursing, could be seen as a good short-term recruitment technique. This strategy may have been helpful in increasing the number of students entering nursing. However, in the long term, it may not contribute to developing inspired, compassionate nurses who are dedicated to their roles, and may lead to early attrition. This phenomenon is examined further in Section 4.2, *Ambivalence and Commitment*.

In addition to nurses who arbitrarily chose to study nursing and those who entered nursing as a backup plan, others may have had more than one reason, such as availability of work and good pay.

- A pragmatic choice

As explained in Chapter 1 (*Nursing education*), the local government has been promoting the nursing profession by introducing measures to make it more attractive to Saudi nationals in particular. This includes promoting the role of nurses, increasing nurses' remuneration and offering more professional development opportunities for all nurses. High employability already exists in nursing due to the country's current shortage of nurses, which is also a serious global concern. Therefore, finding a job in nursing is relatively easy, compared to other careers. Securing a nursing job with good compensation, however, can be an issue for new nurses.

The pay scale for nurses has improved over the past two decades to allow hospitals to compete in the competitive regional (GCC countries) job market. This increase, in turn, has resulted in an increase in the number of students choosing nursing as their field of study:

> *For long time, I have always wanted to be a dentist and placed it at the top of preference list. But because of the huge competitiveness in admissions to dentistry college, I had to put a second preference in case I didn't get a place as a dentistry student. I put nursing as second choice because of the job opportunities… I liked pharmacology, but when we think about job availability, nurses have more chances compared to pharmacists. For instance, in a small hospital, they may advertise 20 jobs for pharmacists and more than 100 jobs for nurses. - NQN5*

It should be noted that choosing to study nursing for pragmatic reasons was not the same as choosing to study nursing as a second choice after their preferred subject. In fact, some students left their preferred field of study for nursing when they realised that finding a job in their preferred field might not be easy. Though there may have been other motivations influencing their decisions, these students favoured job security over personal preference:

> *I studied a human resources course at a [private] college… but in Year 2 I thought finding a job in this field would be quite difficult… I heard classmates talking about their friends who had graduated two years ago and couldn't find good jobs… My sister is a nurse and she was given a job offer even before completing her internship, and a nice salary as well… So, I dropped out from HR and went to [college] to study nursing. - NQN16*

High employment rates in nursing not only convinced some students studying other subjects to change courses, but also attracted graduates from other disciplines to pursue nursing as a second degree in order to find a job. Spending years job hunting with limited success was discouraging to these graduates. After a certain length of time, some graduates turned their focus to obtaining qualifications that are more likely to secure a job, rather than what they were interested in. For these people, nursing became a viable option, because it is currently one of most in-demand careers in the market, with some student nurses even receiving job offers prior to graduation (e.g., the previous quote from NQN16). This experience is perfectly encapsulated by this quote from an NQN:

> *I loved chemistry and still do… I actually have a degree in chemistry and was planning to continue in that field… but I wasted one and half… or almost two years looking for jobs with no success… One day I saw an ad about a bridge course to nursing for graduates from different subjects; it was like a safety jacket… Then, I decided to study nursing knowing that finding a job in nursing wouldn't be as difficult [as in chemistry] ... I got a job offer straight away - NQN2*

Some NQNs, despite disliking nursing after their initial clinical experience, faced a dilemma: to drop out, or to continue. They struggled between feelings of dissatisfaction and a desire to remain, for fear of losing the time already invested in nursing. Another influential factor appeared to be uncertainty about whether dropping out would result in successfully finding a better option, particularly with the current limited availability of university places (See *Tertiary education in Saudi* in Chapter 1). Thus, some students decided to wait until they had first completed their degree in nursing. Although they were discontented about this decision, their fear of losing time and their university place outweighed their displeasure. The following quote exemplifies the feelings of making a pragmatic choice to continue in nursing, despite a lack of interest:

> *I didn't like nursing when I was in college…. But when I discovered that, it was already too late; I was in my third year. I sent a request to transfer to the pharma course but it was rejected…. I had no option but to continue in nursing…. I could've dropped out but what if I didn't get accepted on another course? You know, finding a place in university is really difficult – a bird in the hand is better than ten on the tree [proverb]… true. - NQN1*

The association between choosing nursing as a pragmatic choice and NQNs' commitment to nursing and intentions to leave, compared to those who chose nursing as a first choice, will be discussed further in *4.2 Ambivalence and commitment*.

In addition to the choice of a nursing career path being either random or pragmatic, the location of nursing schools and their proximity to students' homes seemed to strongly influence students' choices.

- Choice based on proximity

In this study, the distance between a student's home and a university appeared to play an instrumental role in deciding their future career. Generally, NQNs, including both males and females, tended to target universities closer to their homes, and then search their catalogues for a major subject of interest. Many were drawn to those with potential career options available within their home towns. Considerations also included social/cultural restrictions on students' freedom to leave the family home, which could eventually restrict their career choices (*see Women* in Chapter 1). This issue seemed particularly relevant to female NQNs. Therefore, many NQNs, particularly females, reported that they had only considered courses available in their home towns. The impact of Saudi culture and societal norms on career decision-making will be further discussed in the next chapter, Chapter 5.

The size of a village, town or city and the resources available there were reported to limit career options for high school graduates. As a result, residents of smaller towns, unable to move to a large city to study in the field of their choice, might select another subject by default, as a result of the limited offerings at their local institution:

> *I'm from [a small city] and there was only one college, which was a branch of […] university, that only teaches health science subjects. I was 17 years old at that time and was afraid of moving to Jeddah by myself. I chose the best available subjects… medicine first, nursing second, then laboratories… I got accepted into nursing. The nursing college was close to my home; this could be*

> *a reason for accepting the nursing offer… If there were other colleges in my town, I might have chosen a subject outside the medical field… If I'd had the chance, I would have studied politics or public relations. - NQN3*

Students who felt restricted by the courses provided in their home towns cited living away from family and friends as the main barrier to moving to a larger city with more opportunity to study in their preferred field. With limited options, they became more pragmatic about the available degree choices:

> *I was interested in fashion design but it was only available in very few universities… and obviously it wasn't available in [hometown], and we didn't have many choices… so I picked nursing… There are many new nursing schools now. I compared the available courses, and found out that nursing was the best choice available… I didn't want to leave [hometown] and there is high demand for nurses too. If time goes back, I would've chosen fashion design – but that doesn't mean I dislike nursing (laughs). - NQN7*

Remaining connected to family and friends tended to be a strong determining factor for NQNs considering applying for a degree or job. Many never entertained the idea of moving away from home. A preference for remaining at home was the most frequently cited reason for accepting a career that may not have been their first choice. Other factors that may have influenced their decisions included social or financial concerns.

> *I got three offers from three different universities… the offer from [university name] in Riyadh was the best because it was training with a guaranteed job… If the job in Riyadh would give me double the salary, I wouldn't take it… It's either a job in [home city] or just stay at home and help Umi [my mother] … I think having a job is important but it is not something that I would die for… for me family is more important… I'm planning to work temporarily till I get married, then I will resign and stay at home - NQN11*

The increased awareness of nursing and the increased number of nursing programmes have encouraged many high school graduates to consider nursing as a future career. Additionally, the flexibility in admission paths for nursing courses (e.g. nursing accelerated courses for degree holders) has improved the flow of students into the nursing field. These accelerated courses offer

the opportunity for degree holders from other disciplines to transfer credits, and study further for three years instead of five to meet the minimum requirements to qualify as a nurse. Thus, they seem to be a suitable solution for those students with reservations about starting a new degree course:

> *I was really confused and desperate… I couldn't find a job with my chemistry degree… I couldn't continue my study in laboratories because there were no master's degree courses in Jeddah. When I read about the bridging course to nursing…. I was like… Alhamdulillah [thank God]! This is it. Instead of studying for five years, I studied for three years and then graduated. - NQN2*

The situation of a school close to home appeared to be one of the top priorities for the participants when choosing a degree, regardless of the field. The recent proliferation of nursing programmes, especially in smaller communities, allowed students to seek a secure career that could easily be found within their home towns. Furthermore, living with or close to family was a high priority for the majority of students, despite the fact that this meant passing up the potential for better opportunities away from home.

- Choice overload

As discussed in *Tertiary education in Saudi* (Chapter 1), when high school graduates are accepted to study at a university, they are normally required to complete a foundation year and generate a subject preference list stating order of preference (4-6 courses). Upon completion of the foundation year and evaluation of the student's high school and foundation year GPAs, subject preference list, and programme vacancies, students are admitted to one of their selected programmes.

The requirement to provide a preference list of four to six courses created dilemmas for many NQNs, as they normally had at most one or two subjects which they preferred. As a result, NQNs, after choosing their preferred subject/s, sometimes described picking any available course simply to satisfy the requirement to provide a list of several programmes, despite their lack of interest in the lower ranked subjects:

> *Nursing was at the bottom of my preference list… I didn't like nursing, and I wasn't convinced at all… I added nursing and health administration to complete the subject preference list… It [nursing] was the sixth in my list. - NQN8*

Some NQNs felt that they were coerced in their choice rather than having the freedom to choose the courses they felt drawn to. They had a perception that universities tried to fill gaps in their degree programmes while paying less attention to students' area of interest. NQN1, for example, felt they were coerced into studying nursing:

> *Nursing was at the bottom of my list… I cannot say that I chose nursing… I think the university tries to push more students into nursing…. It is either nursing or the door fits a camel [Idiom: like it or lump it] … They [universities] usually do this with less popular courses…[like]… nursing, nutrition and health administration. - NQN1*

Frequent reports of NQNs being placed onto programmes that were very low on their preference list had cultivated negative emotions towards university administrations among some participants. The participants perceived that their interests and needs were ignored, which created feelings of dissatisfaction and disappointment. The notion that schools put their institutions' interests ahead of their students' interest was commonly expressed by participants and, as a result, many described how they did not trust administrators' motivations or willingness to accommodate their needs. This is clearly expressed in a statement from NQN15:

> *I was interested in biochemistry.... I was confident in getting a place there because it's not one of the popular subjects; it's not medicine. And I met all the requirements… My GPA was way above the minimum requirement… but at the end they put me in nursing! I was really upset… nursing was fourth on my preference list… I'm not saying nursing is bad, but it was not my top interest when I finished high school. - NQN15*

Ultimately, most NQNs felt that that they had little or no freedom of choice, and the assignment to the nursing course was a *fait accompli*. This was compounded by the reports that many NQNs experienced external pressure from their families and social circles to select a specific career path within their home towns that did not necessarily match their own interest or career plans.

- Family influence

For most NQNs, family was a vital source of emotional and occasionally financial support, when making decisions about university subjects and future careers. Familial, particularly parental, interference in personal decisions such as choosing a career path can sometimes be problematic, as noted in some narratives. If the two parties (often child vs parents) cannot achieve a compromise, the differing perceptions and preferences of students and their parents regarding the choice of university subject could leave both parties unhappy and anxious about the child's future.

> *To be honest, I don't like it [nursing]… I wanted to be like my aunt [physician], but my dad was saying that I needed to try something different… There are five doctors in my family… but my dad had other ideas. So, I listened to dad and entered nursing… I shouldn't have. Now he has offered to pay the tuition fees to take a bridge course to medicine… I think he saw that I'm not happy with my job and he realised that his decision was wrong… It's like compensation… but it's too late. - NQN4*

On the other hand, some NQNs reported having different study/work plans from those of their families, and had felt empowered to challenge them, and to follow what they, the NQNs, predicted to be best for their future. In the following quotes, NQN9 had decided to study nursing as a suitable alternative to their preferred subject, which was not welcomed by their family. Rationales for rejecting nursing as a career path varied, and will be discussed further in the next chapter, Chapter 5.

> *Most of my family rejected it [nursing]…. They didn't force me to change my subject, but they were not happy at all with my choice… As I said, I was planning to study medicine and my family were excited about that… but that didn't happen… so entering nursing was big disappointment for them. I was disappointed too, but what could I do? I had to accept the reality. Up to this day, they are not happy with my job, but I do not really care; it is my future and my life. - NQN9*

Familial interference could be influential not only in choice of a future career, but also in choosing a job location. As members of a family-oriented culture, NQNs were generally expected to remain

in close proximity to their family home, with fewer restrictions on males compared to females. Finding a subject that would offer a career within the same community/area was perceived as a top priority for many NQNs, including both males and females. Despite the frequency of this preference (to remain in the home town), some NQNs had decided to break with familial culture norms, make their own way, and become more independent or goal-focused individuals:

> *I grew up in a big family and they wanted me to follow their steps… study and find a job within the same town. I didn't like it. I believed that in cities like Makkah or Jeddah there would be hundreds of opportunities to learn and develop. So, I made my decision to move to [city]. I think because I was clear and firm about my plans, they [parents] accepted it… Nearly 20 years ago, no girl would ever think of leaving our town alone… It was haram [forbidden]… (laughs). - NQN12*

The impact of family voices on NQNs' decisions regarding their educational and professional lives was clear. Although some students acquiesced to their family's advice, others (such as NQN12's stories) decided to subvert traditional paradigms to gain independence and self-reliance. The latter normally had clearer goals and manifested greater eagerness to achieve those goals.

B) First choice:

According to NQNs' narratives, it was uncommon for nursing to be a first-choice subject. The vast majority of students cited nursing as a second, fallback, arbitrary, or pragmatic choice. However, one participant (NQN12) stated that they had planned to study nursing before applying to university. Their strong desire to become a nurse and passion for the profession were palpable as they recalled their experience and the difficulties they overcame to achieve their goal to become a nurse:

> *I studied hard to enter nursing. It was one of my dreams: I wanted to be a nurse. In [town] there was no nursing college. I had to leave my town to study nursing. Living in a campus and away from home and family was really difficult... It took me long time to convince my parents to let me live on a campus. It is uncommon in our community, especially for girls. But, luckily, my parents were not strict about these things... My two brothers were not happy but I didn't care as long as I got the approval from my mum and dad. - NQN12*

The commitment to follow her own dreams and reject unsuitable or unfair family advice had a pivotal role in helping NQN12 overcome the social and geographical challenges she faced. Moreover, having a clear goal and passion for nursing gave the participant confidence in her choice, with no sign of ambivalence, which was a major issue for many participants.

4.2.2 Ambivalence

Although it had been more than five years since the NQNs had chosen to study nursing, their narratives still showed a high level of ambivalence. Many NQNs were still unable to decide whether nursing was right for them. This inability to choose whether to remain or leave nursing hindered the ability of these NQNs to adapt well to their new working environment. Most were reluctant, showing contradictory feelings towards nursing, saying they liked it, but simultaneously lacking excitement about it, or saying that they barely fulfilled their responsibilities:

> *There is a war inside me: "Is nursing for me?" … Something inside me keeps saying, "Nooo, this is not the right job for you." … You know… when I graduated, I didn't feel really excited, I wasn't looking forward to applying for jobs… you know… If you don't have the will and motivation to do something, like me, you just do what's required...Yanee [you know], you won't go the extra mile. - NQN1*

This high level of ambivalence could be attributed to the NQNs' experience while choosing a major at university. Some, including NQN1, believed they were given a choiceless choice, and were admitted into nursing despite it being one of their lower-ranked choices. Feeling pressured to study nursing created feelings of dissatisfaction and resentment amongst student nurses, and led to multiple requests to transfer out of the nursing programme.

> *I tried to change my specialty [course] to something that I like… but couldn't. - NQN1*
>
> *I did have a chance to change my subject [course], but my dad did not approve it. - NQN4*

Some NQNs who had voluntarily chosen to study nursing also struggled with a high level of reluctance to remain rather than drop out, especially those who had made a pragmatic choice. They often had a subject they would have preferred over nursing, as well as unfulfilled plans to study and work in the field they loved. The lack of job opportunities or poor compensation in their non-nursing field drove them to consider more lucrative opportunities. Despite choosing nursing, which essentially guarantees a well-paid job upon graduation, some NQNs had regretted not being able to pursue their previous interests, and did not see studying and working as a nurse as satisfying, so regretted their decision:

> *It [studying nursing] was a tough decision because I had to leave one of my dreams [chemistry]… If there was a chemistry master's course in [city]… I think you would not see me in nursing… I still feel attached to chemistry [laughs]. - NQN2*

Additionally, for some NQNs the interference of families in their choice of career led to contradictory attitudes towards nursing. Their inability to challenge or reject parental suggestions or advice put students in a vulnerable position, increasing their uncertainty as to whether to adhere to their parents' suggestions, or challenge them and follow their own preferences:

> *I didn't decide [to study nursing]; it was my dad's decision… I am doing something that I am not convinced of and I don't really like. I always ask myself, why am I doing nursing?... I had a feeling [after graduation] that I could have done something better than nursing. I could have studied business and got a better job… It is more complicated, now, to change my path. I feel disappointed… very disappointed; It is like doing something that you don't like. - NQN4*

NQNs for whom nursing was a constrained choice felt ambivalent, and continued to struggle to decide whether to continue or withdraw from the field. Conflicting sentiments about nursing arose from the perception that students were admitted to nursing despite their lack of interest, chose nursing solely to secure a suitable job, or had to acquiesce to parental advice. As a result, many NQNs still could not make up their minds whether nursing was the right job for them.

Almost all the NQNs felt some ambivalence in relation to their choice of nursing as a career. The level of ambivalence varied from one participant to another, and had a direct impact on their degree of commitment to nursing.

4.2.3 Commitment

The majority of NQNs echoed, to some degree, the same sentiment that "nursing was not my first choice." Because of this perception these NQNs found it harder to accept their new roles and had varying levels of commitment to nursing, leading to intentions to leave their jobs. Thus, four different subcategories of commitment emerged, based on the stories of the NQNs interviewed. They were: committed to nursing and their *current* job; committed to nursing, but not to their *current* job; committed to their *current* job, but not nursing as a whole; and committed to neither nursing nor their current job.

I. Committed to nursing and the current job:

This group of NQNs (a minority) had managed to develop supportive professional relationships and found their feet in a new working environment. Moreover, they liked their new roles as nurses and had plans to continue in their current posts at the same organisation:

> *After nearly 15 months [as a school nurse] I felt that I was losing my nursing skills. So, I thought I would search for a nursing job at a hospital, and got accepted here at [study setting]. I am enjoying it [current job] now, and I do not feel that it is that difficult… To be honest, the other nurses are treating me really nicely. I'm really happy now at the [working unit] … When I think of the nice treatment [that] I get from the head nurse and other staff, I feel I won't find a better working team… - NQN6*

Moreover, these nurses showed that they were able to reconcile work and different social pressures well, while focusing on professional development with the same employer. They also believed that there was room to develop within the current working culture, particularly for nurses:

It was a bit difficult to get used to the shift work, but it is fine now. My husband is a policeman and does shifts too. We try to take our off days at the same time... (laughs)… One of the reasons I chose [current employer] is that it is a new hospital and there are more opportunities for younger nurses to develop… I've applied for a diploma in quality control... - NQN17

For the same group of NQNs, work had become a second home, and they tended to dismiss other opportunities outside the hospital where they were currently employed, and some planned to retire within the same organisation. The formation of successful bonds with colleagues and the short distance between work and home were the foundation on which NQNs based their decision to remain loyal to their employer.

I received two job offers: one in Jeddah and one in Makkah. My family lives here in [home city], so why would I choose a job away from home? Also, the working team here is fantastic and supportive; they are real professionals… If I like my job, my colleagues, and the hospital is just ten minutes' drive from home, why would I think of changing my job…? You might see me here when I'm 60 years old [laughs]. - NQN10

II. Committed to nursing, but not to the current job:

This group comprises the vast majority of NQNs who were similar to the previous group in their commitment to nursing, but, given the chance, would leave their current job for better options within nursing. They expressed some satisfaction with their career choice, but not with their current role as bedside nurses. They were generally able to maintain the balance between work and life responsibilities, and paid great attention to personal and professional development to try to escape the perceived low social status associated with the bedside nursing role. They seemed to be willing to compromise aspects of their social lives for the sake of flourishing at work and becoming better nurses:

I like and don't like my job… (laughs). I mean, I like my job, but I don't like my work as a bedside nurse… You know what I mean?... cleaning patients, etc… I want to develop and be an important person: charge or head nurse…- NQN14

I loved working in the OR [Operating Room] during my internship… I want to improve myself in it, see new procedures, deal with different cases and

machines… I prefer working in OR, but they put me in Oncology; I don't like it. I feel that they will not move me to the department that I like, so I'm thinking of moving somewhere else… I found a diploma course in OR in one of the big hospitals in [city] and applied, but still haven't received the approval…- NQN7

Settling into a new job and enjoying a current role did not necessarily demonstrate an intention to remain in the same job. These NQNs showed a high degree of commitment to their profession, but a lower degree to their employer. They were open to new ventures and willing to explore different available opportunities. Moreover, they tended to be more independent and focused on personal, rather than organisational, goals:

Nursing was one of my dreams: I had to fight for it. If the clock was turned back to choosing a subject, I would choose nursing again… Getting a job here was a big success; I rejected many offers to be here at [study setting] … I think [study setting] is one of the most popular hospitals… Everyone tries to get a job here because of its excellent reputation and high standards… but to be fair, if I find another job that would improve my skills and give me a better promotion, position, I would leave here… I'm like a footballer seeking better contracts. - NQN12

III. Acquiescent to the job, but not to nursing:

Just as there were perceived reasons to leave a post, according to some NQNs, there were also factors that justified their acquiescence to staying in a job that they felt was poorly suited to them. This group of NQNs was the smallest. They tended to accept their job temporarily and perceived financial security as a major advantage of being in a job, regardless of their career interest. Some of them reported dissatisfaction with their career choice and high intentions to leave, but the fear of finding a better alternative made them reluctant to resign. This is exemplified in the following quotes, where the participant had little to no interest in their job, struggled to manage work/life commitments, acquiesced to work demands, and had low motivation for professional development:

I'm planning to work temporarily till I get married, then I will resign and stay at home… - NQN11

> *Nursing, what is nursing? [contempt expression] … I chose nursing because of their high salaries and dead easy to find a job… It's my first year and I'm already dragging myself to work: there must be something wrong… My friends come in the morning excited and with happy faces… I don't have those feelings… I'm ok with the [job] as long as there is good payment... - NQN16*

Some NQNs were inclined to be more pragmatic about the extrinsic rewards of a having a job rather than the intrinsic factors associated with job satisfaction, such as advancement and recognition.

IV. Uncommitted to nursing or the current job:

Nursing practice and the role of nurses were quite vague for many NQNs prior to commencing their nursing degree. The majority of NQNs stated they only discovered what nursing was after beginning clinical practice in healthcare settings. After discovering what nursing was really like, some NQNs embraced the profession due to the perceived altruistic nature of the job, and the perceived importance of nurses' role in delivering healthcare services and promoting people's health and wellbeing. Other NQNs, however, did not like what nursing turned out to be for a variety of reasons, including a perceived lack of respect or because they were not interested in bedside nursing. This phenomenon (disliking the bedside nurse role) will be explored further in the next two chapters, Chapters 5 and 6. These nurses found it difficult to accept their roles and constantly sought opportunities for a change. Thus, they were already planning an exit from their current job, and in some cases from the profession altogether, if possible:

> *I think I discovered real nursing when I started my internship… I still have feelings of regret …. I should have done another course, not nursing… I would've been happier... I mean, I'm not accepting the idea that I'm going to be a nurse for the rest of my life, picking up vomit and emptying urine bags… I don't talk about these things with my cousins or friends, it's embarrassing. - NQN1*

The experience of being a nurse in real nursing practice corroborated, for some NQNs, the preconception that nursing is a less respected career. Their perceptions of initial negative first-hand experiences with other professionals (e.g., physicians) created the impression that nursing suffered from a lack of autonomy, as well as systemic disrespect. Therefore, these NQNs became

even more convinced that nursing, particularly the bedside nurse role, was not a suitable career choice for them.

> *To be honest, I don't like it [nursing]… Nurses only follow doctors' orders, and deal with grumpy doctors… The doctors' behaviours are also a major problem… I try to avoid interacting with them… If I stay on the bedside, I would burn myself out…I will not continue on the bedside… I might even leave the profession all together. I'm always thinking of finding a way out of nursing. - NQN4*

In addition to a work culture that they perceived as promoting hierarchical relationships between physicians and nurses, these NQNs thought that the public was also prejudiced against nurses. They also felt that nursing as a career is often seen as undesirable, and the effort of nurses is underestimated. The perceived public perception of nursing will be further discussed in the next chapter (Chapter 6). For NQNs who previously had no idea about the status of and respect for nurses within and outside work, the reality was felt to be both outrageous and unendurable, leading them to consider moving to different careers:

> *Yes, I moved to nursing because of the pay and job availability, but the status of nurses in our department is so bad… In practice, nurses are always blamed and shouted at by managers and relatives of patients... Dealing with doctors is stressful; they wanted us to be their secretaries… I have a plan to leave here and study medicine. I want to be in a well-respected speciality. - NQN16*

The link between the three previous quotes (NQN1,4 and 16) and their desire to leave nursing is that they disliked the perceived low status of bedside nurses. Therefore, as explained by a head nurse, the thought of resigning always cropped up when NQNs encountered any difficulties in the workplace.

> *I think those who love the field would keep going despite any struggles. Those who don't really like nursing would leave us from the first problem… They [NQNs] always talk about moving to other departments to avoid direct contact with patients – I think they are ashamed of things like changing diapers. From what I noticed, Saudis always want to be in clean, prestige jobs [laughs]... - HN01*

The issues that confirmed the NQNs' low preconception of nursing included the actual content of bedside nurses' role, what they perceived as a degrading work culture, and the perceived poor public perception of nurses. These experiences had a profound impact on many NQNs, causing them to resent their new jobs, and, as a result, compromised their commitment to both the profession and their current role.

4.2.4 Integrating choice, ambivalence, and commitment

The NQNs had different experiences with regard to choosing what profession to pursue. The majority of NQNs felt they had either a constrained choice that led them to study nursing or made a uniformed career choice. A constrained choice implied that NQNs' choice of career was a fallback, or pragmatic choice, or was largely influenced by proximity. While NQNs who were offered too many less preferable choices or had to acquiesce to family advice perceived themselves as having little or no choice in their career decision-making. It was apparent that the perceived level of freedom when deciding a career path had a significant impact on NQNs' feelings throughout their education and beyond. The greater the freedom of subject choice, the greater the NQNs' confidence and certainty about their course of study and future career plans. In contrast, when NQNs believed they had had less freedom of subject choice, they struggled with higher levels of ambivalence about their choice of subject and uncertainty about future professional plans.

Moreover, a link between the NQNs' freedom of career choice and degree of commitment to their profession was apparent. NQNs who had greater freedom of subject choice demonstrated a higher degree of commitment to the profession that they had selected. Conversely, NQNs who felt their choice of subject was constrained, were less committed to their profession. Although students whose choice of subject was constrained struggled with higher levels of doubt, many of them eventually acquiesced to their career. Those who felt their choice of subject had been restricted or coerced by school or family were the least committed to their profession, and were actively searching for an alternative career. Commitment to the profession did not necessarily imply commitment to their current job or employer; some nurses showed commitment to

nursing, but also sought better or different nursing opportunities. Those nurses who showed commitment to nursing but not to their current employer focused on the importance of professional growth, and revealed their plans for further education as a strategy for advancement. On the other hand, NQNs who showed acquiescence to their current job but not to the profession cited financial security as a main reason for staying in their jobs.

There was general consensus amongst NQNs that the bedside nursing role was associated with an unimpressive social status, within and outside work, and thus was difficult to endure for longer periods of time. As a result, all the NQNs, regardless of their experience with choice of career, their ambivalence and their commitment to nursing, agreed that they had no intention of remaining as bedside nurses for more than three to five years.

4.3 Summary

This chapter has reported on how NQNs entered a professional career that was not their first preference, and how they dealt with it. I conceptualised this as “acquiescence” to nursing, and have explored its categories and their properties. Most NQNs reluctantly and temporarily accepted their jobs, while actively seeking opportunities for professional development to compensate for their loss of becoming what they originally wanted to be. To summarise the relationships between career choice and level of commitment, it can be suggested that higher freedom of career choice was linked to lower levels of ambivalence and greater commitment to nursing, while less freedom of career choice seemed to contribute to higher levels of ambivalence and reduced commitment to the profession. In the next chapter, I will discuss the perceived public perception of nursing and nurses, how nurses perceive themselves, and the recent attempts to rebrand the image of nursing, as well as the process that NQNs engage in to deal with the public perception of nursing.

Chapter Five: Reconciling

The previous chapter discussed how newly qualified nurses (NQNs) entered nursing, their feelings about their choice of career and their loyalty to the profession. The majority of NQNs had not chosen nursing as their most favoured field for various reasons related to their prior perceptions of nursing as a career. Therefore, many of them were planning to escape their current roles and seek better opportunities, within or outside nursing. This chapter will report the NQNs' perceptions of nursing, their views of the public perception of nursing and nurses, and their attempts to reconcile conflicting views of nursing as a career. It will also describe the perceived transformation of NQNs' perceptions about nursing and nurses, and how they viewed the recent initiatives to improve the status of nursing. The narratives of participants will be organised temporally, i.e. before and after becoming a nurse, while considering key issues such as status, social barriers and working conditions.

5.1 Getting into nursing: studying nursing

From the NQNs' quotes reported in chapter 4, a future career in nursing had been considered undesirable, thus, most NQNs had never included nursing in their future career plans. The factors that turned NQNs away from nursing and made it an unattractive career are unclear so far. Hence, exploring how nursing was generally perceived through the eyes of these NQNs and other key informants (experienced nurses and managers), could help explain why a job in nursing was still viewed as unattractive by many nationals.

A few participants reported that their local community perceived nursing as a low-class job and that a nurse's work was normally equated to that of a housemaid. This low perception of nursing seemed to negatively influence students' career decision-making and deter them from exploring or even thinking of a career in nursing. Some of the NQNs had grown up in communities that perceived nursing as a working-class occupation; consequently, it was no surprise that these NQNs would not consider nursing to be an ideal job.

My mum and brother were OK… I think they didn't like it [the decision to study nursing] but didn't want to let me down. Papa [father] thinks nursing is a low-class job, and asked me more than once to find a better job… - NQN3

Oh, all of my family didn't approve of it… He [father] was constantly asking me to study another subject… - NQN5

Most of my family rejected it…. They didn't force me to change my subject, but they were not happy at all with my choice… - NQN9

None of my family agreed with that [studying nursing] because they think it's a low-class … - NQN14

The emphasis on just one part of a nurse's work, namely basic nursing care, showed a misconception that nursing work is limited only to the more menial care tasks. This eventually played a role in making nursing a less popular choice amongst NQNs.

People used to say things like "Nurses work like maids, and do nothing but clean patients" … I think bed making and bathing duties make people link nurses with maids… Maybe that's why our community still considers nursing a low-class job…. I'm not sure but I think this is one of the main reasons. - NQN2

Dad was making fun of me all the time… "Oh, you're just going to be a Shaghallah [maid]… You'll just clean and wash patients" … My mum, dad and sisters did not like nursing… sometimes they called me Shaghallah… They think it's funny… but it hurts me a lot… - NQN14

The low public perception of nursing made it more difficult for many NQNs to gain support from their families to study nursing. Their communities ranked nursing as one of the undesirable jobs. Indeed, some NQNs reported that their families were quite hostile to the idea. Therefore, parents were reported to be displeased to see their children taking a place on a nursing course. Having parental approval, as discussed previously in *Family* – Chapter 1*,* was perceived as essential to students in order to be emotionally and sometimes financially supported in their choice of subject or career.

In Saudi, nursing is not seen as a nice job… Socially of course… Parents would be proud of their children being doctors or engineers, but not nurses… Sometimes when people ask my mum about my job, she'd say "[NQN3] works

in a hospital." … She wouldn't say "a nurse" … People assume that I'm a doctor… I hate it when mum says that. - NQN3

Similar to the public, many NQNs reported that, prior to stepping into the field, they had very limited knowledge about nursing, and some held a negative perception of the profession. Some of these participants had had the chance to see at first hand the interprofessional relations between physicians and nurses, which was a negative experience. This unpleasant experience corroborated the apparent public perception that nursing was not an ideal career to aspire to.

When I was little, I used to go with my aunt [a physician] to her clinic…I heard that nursing was not a good choice… Nurses do what you're [they're] asked to do… They're also supposed to clean vomit, change bed sheets… - NQN4

I had the view that nurses' job is only to carry out doctors' orders… Before entering nursing, my view of nursing was narrow, with some underestimation that they only carry out doctors' orders without thinking or judging whether the order is right… - NQN9

Although the quote from NQN4 reflects only the work relations between the aunt and her colleagues, it matched the general understanding of nursing reported by many NQNs: that it was a low-class and less desirable career. On top of being perceived as a "maid" job, nursing was also perceived as a subordination to the medical profession. This appeared to be a factor contributing to the reported parents' refusal of nursing as a career for their children.

The perceived inferior status of nurses also appeared to contribute to the low prestige of nursing. The role of nurses was perceived to be very limited, and normally about executing others' orders. The view that nurses were inferior to physicians had probably hindered some ambitious parents from accepting their children's back up plans to become nurses.

My parents rejected it [nursing] because of society's view of nursing… They think nurses' role is about doing what you are told to do… When a doctor asks you to give medicine you do… and when a patient asks you to change a bed sheet you do…. - NQN9

Nurses are doctors' assistants; this was my thought before I became a nurse. I thought doctors did all the work and nurses only helped them… I thought nurses blindly adhered to the commands of the doctors… - NQN13

In contrast to the frequent reports from NQNs that their families rejected nursing, some NQNs reported that their families were supportive or neutral in regard to their decision to pursue a career in nursing. Other families were thought to lack sufficient information about nursing and tertiary education in general, so they put their trust in their child's judgment and ability to make the right decision about their future job. These families tended to be more permissive and allowed their children to choose the subject they wanted without imposing any restrictions.

I wasn't sure when I chose nursing, but my mum was supportive of that choice. She was happy, actually, because I was the first child to enter the medical field… - NQN11

My family were 50:50, or to be more accurate, the majority did not like it [decision to study nursing], but in the end, they all agreed that it's my future and I'm responsible for making the final decision… Actually, their support made me more confident about choosing nursing… - NQN15

I was the eldest, I was the first child to go to university… My parents didn't know much about higher education… When I told them that I had picked nursing they were happy and told me to do whatever I like… - NQN6

Although being a child of a physician was expected to add more pressure onto the child to study medicine, an NQN felt that they had the full support of their parents and other family members to pursue a degree in nursing.

In our culture, they always expect us to follow our parents' path... that's not me!... I chose nursing and I'm happy with my choice… Everyone was supportive of me studying nursing… Most of the family are in the medical field… Father [a physician] supported me choosing nursing for reasons like different subspecialities, more opportunities for further studies… - NQN18

Contrary to the aforementioned experiences where NQNs often struggled to gain approval from their families to study nursing, there were also examples where it was the other way around. The family took the lead and suggested studying nursing, while their child was interested in

something else. However, eventually, the participant accepted their families' advice and went into nursing.

> *My sisters and mum convinced me to drop out from HR [Human Resources] and move to nursing… After spending a year on that course… I thought nursing would be a better choice… - NQN16*

Some NQNs said that they were concerned about gaining parental permission or approval. As explained in Chapter 1, the Saudi culture tends to be strongly family-oriented and children are often expected to gain approval from their parents prior to making any major decision, such as choosing a career. Thus, these NQNs thought they had already developed their plans to study nursing but were waiting for the green light from parents to go ahead.

> *When I decided to choose nursing, I was worried that my family would reject it… I discussed it with my family, and they gave me the green light…. Honestly, the whole family were with me… - NQN7*

> *As I said, nursing was one of my dreams… Permission to leave our town and move to [city] was the only thing that I needed… Alhamdulillah [thank God] I was allowed to do so… - NQN12*

Parental permission to study nursing was sometimes given upon certain conditions. One NQN explained that their parents accepted nursing as a career but with a restriction on the job location. Thus, their job search was limited to within their home city.

> *My mum said that if I can't find a job in [home city] then ["Soak your certificate and drink its water" – Arabic idiom which is similar to "It's not worth the paper it's printed on"] stay at home and help with the cooking (laughs)… - NQN15*

Having a family member in nursing was thought to ease the discussion with parents regarding the choice of studying nursing. Some NQNs said that having a relative in the field made it a more acceptable career choice.

> *One of my cousins is a nurse, and he is successful in his job… Maybe that's why my family accepted my decision to study nursing… - NQN7*

> *My sister is a nurse… I remember when she became a nurse my parents were not really happy, but they have accepted it now… So when I told them that I'm going to study nursing they didn't refuse… - NQN13*

Similar to outsiders (e.g. parents of NQNs), insiders (nurses) were also reported to have conflicting perceptions of the suitability of nursing as a career. Participants who had asked about whether a nursing course was a good choice had been advised by some relatives to find a better subject. An NQN consulted a relative who used to be a nurse, and the answer was that nurses' compensation was low compared to their workload, and it was not worth it.

> *Khalti [aunt] was a nurse and she advised me not to choose nursing… saying it's a really difficult job, long working hours, no weekends, and the salary is low compared to the work pressure… - NQN6*

To summarise, the majority of NQNs described having had some difficulty convincing their families about their "choice" of career. The divergence of perceptions between NQNs and their families emerged from the public image of nursing, the nature of nurses' work, which includes some perceived "dirty" tasks, and the perceived inferior status of nurses. In spite of this, some positive experiences in regard to career decision-making were also reported: some NQNs felt supported and were given the green light to decide their professional future. Yet, socially, the gender mixing in the nursing workplace appeared to be a major concern for many NQNs.

5.2 Gender sensitivities

As explained in the Chapter 1, the culture in Saudi has been largely influenced by a religious and cultural view that prohibits the mixing of male and female workers in one workplace unless it is unavoidable. This view was reported to influence how NQNs and their families developed their future career plans. As a result, NQNs were inclined to select jobs based on their gender. Jobs that require working in a mixed-gender environment were often regarded unfavourably. The nature of nurses' work involves working with staff and patients of both genders, and this is one

of the major factors that made NQNs perceive nursing as an undesirable job. This perception of nursing is clearly reflected in these two quotations from participants:

> *While I was doing some research about different majors and jobs, I heard that nursing was not suitable for females because of the high workload, working with men, etc. That's why fashion design was my preferred subject… (laughs)… In fashion we would have very limited interactions with males… [while] in nursing we would work with males everyday… male nurses and male doctors… - NQN7*

> *They [some family and friends] said nursing is not an ideal job for women for reasons like long working hours and working with men…I think if I became a doctor [first preference] I would face the same things… long working hours and having to work with males…I would prefer to work in a female-only job but it's almost impossible these days… - NQN10*

Other participants explained that their families rejected the decision to study nursing based on a cultural perception that women should seek jobs that offer women-only workplaces.

> *Oh, none of them [family] accepted it… They either remained silent or advised me to think of other subjects. Aboi [father] was constantly asking me to study another subject. I think his main point was about Ikhtilat [mixing of men and women] in workplace. - NQN5*

> *Most of my family rejected it [decision to study nursing] because of the low view of nursing, working with men, etc. They didn't force me to change my subject, but they were not happy with my choice. - NQN9*

The inclination to one-gender careers seemed a common factor that made many families disfavour the idea of working in a mixed-gender workplace. The NQNs reported that their parents held the cautious view that the nature of nurses' work could be risky for their children. One of these risks was the perceived higher chance of sexual harassment in the nursing workplace. Thus, parents often refused to accept nursing as a career for protective reasons.

> *Papa [father] didn't like that I'm going to be a nurse… He didn't want me to work in a mixed-gender area. I didn't understand his point at that time. But after working here, I can see why he was apprehensive. I think he wanted to protect me from strangers and from sexual harassment at work… I think I still*

feel uncomfortable when I'm surrounded by my male colleagues. It is weird... you are a male so you won't understand that… (laughs) - NQN3

Surprisingly, the cultural values of family members that led them to reject nursing due to the requirements to work in mixed-gender areas did not seem to apply to higher status jobs, such as medicine. The same participant (NQN5), replying to a probing question, explained that her father's reaction would have been different if she had decided to study medicine.

The situation is different when we talk about medicine… I think if I were a doctor, they would be happy and wouldn't mention anything about working with males or females… it's funny! - NQN5

It was not explicit as to why cultural gender sensitivity would crop up when students are planning to study nursing but melts away when the discussion is about becoming a physician. The different social status between the two careers could explain the public's rejection of nursing yet acceptance of medicine. I will discuss this topic further in the discussion chapter, Chapter 7.

Gender sensitivities seemed to be a recurrent issue with all NQNs, particularly females, while attempting to reconcile the conflicting views of nursing as a career. Female NQNs appeared to struggle with the social expectations that they should seek a job in a women-only workplace. However, the local culture appeared to apply less restricted boundaries to males in regard to their choice of career. The following quote corroborates what has been discussed in the Chapter 1 about the local culture.

In our culture, we tend to be more protective of women… As a man I can do any job I want and take the risk, and no one would ask me why… But when we talk about girls it's different. Parents are more selective about the jobs that their daughters do… - NQN18

I think teaching is the most popular job that women like to do…. Girls-only schools and regular duties from 7 till 2… it suits our society - NQN19

On a personal level, some female NQNs themselves had their own preferences: they favoured working in female-only wards. In contrast, male nurses had no preference but were culturally aware that female patients would normally prefer to be taken care of by a female nurse.

> *Saudi female nurses, for different reasons, prefer working with female patients… We accommodate that as much as we can but not always… - CRN03*
>
> *I have no problem treating a patient from the female ward, but I also understand that patients wouldn't like it, especially if it's not an emergency. - NQN18*

In terms of patients' preferences, they reflected similar gender sensitivities. According to an experienced nurse, female patients preferred to be cared for by nurses of the same gender, while male patients were happy to be treated by either gender.

> *Culture and religious views here are quite complicated… I think girls [female nurses] are more accepted and they can cover on male or female wards… Sometimes, we get to see women who refuse to be treated by male nurses, but we never have the same issue with female nurses…. - P03*

Both male and female NQNs shared similar perceptions i.e. that patients' preferences are a priority and should be considered at all times. However, in critical care areas, e.g. ICUs, it is not always possible due to either shortage of staff or the criticality of a case that requires immediate intervention.

> *Most of our patients are unconscious and on machines [ventilators]… I don't think their families would really care who helps them… The point is that they want to get their lives back. - NQN19*
>
> *From my experience, patients and relatives are quite relaxed about the male/female thing [gender sensitivities], especially when the patient is in a serious condition. - HN02*

In summary, one of the major factors that drove many NQNs' continuing ambivalence about their profession (whether they entered it by deliberate choice or not) is how nursing and nurses are perceived by the public. They felt that the public holds a low view of nursing as a profession and

that nurses are perceived as low-status in comparison to other professionals, particularly doctors. The main factors that shaped the public's low perception of nursing included; the nature of nurses' work, which normally includes some menial tasks, and the perceived inability of nurses to make independent decisions that have a direct impact on patients' treatment plans. Moreover, nursing was considered to be an undesirable job because of the requirement that female nurses might have to provide care for male patients, and work regularly with male professionals, which is not culturally favoured. The NQNs' perceptions generally reflected traditional views about gender mixing. Therefore, many of the NQNs' families were hostile, sceptical or apprehensive about their children becoming nurses. The prior perceptions of NQNs towards their "chosen" career and the social barriers associated with it have been discussed. Next, I will report their experiences in clinical practice and how those had influenced their perceptions of the profession.

5.3 Practising nursing: experiences of NQNs

As discussed in *Nursing in Saudi* in Chapter 1, the majority of nursing jobs in Saudi have been dominated by expatriates for decades, to the point that seeing a Saudi nurse has become unusual. The public perception that view nursing as an expatriate's job seemed to still exist. Some NQNs reported that being a nurse brought assumptions about their nationality.

> *My friends sometimes call me "Filipino" because I chose nursing and I'm hard-working… they all went into teaching, apart from me… it's typical – a nurse means a Filipino - NQN7*

> *Some patients and their relatives have been calling me "Filipino" because I'm a nurse… people always link nursing to Filipinos… - NQN8*

The opinion that nurses were merely followers of doctors' orders was corroborated by the clinical experience of some participants. These participants expressed their unhappiness regarding the status of nurses in their workplaces.

> *I've been told that nurses only follow doctors' orders, and deal with grumpy doctors all the time… and I can say that it's absolutely right. Nurses here have*

no voice and work at the mercy of doctors… If he [a doctor] likes you, it's a good day. If he hates you, it's a disastrous day… - NQN4

Other NQNs had experienced what they thought was disrespect for or an undervaluing of nurses' work.

People think we spend most of our shifts sitting and chatting; that is not right…. When they see us laughing or making jokes, they think, "Ooh, you have nothing important to worry about" … We are not machines, we are humans! - NQN5

Some patients' families are very demanding and rude sometimes… They think we are slaves… If they don't get what they want, they will start shouting…. Once, I was asked by patients' relatives to clean the floor and remove the garbage bin! ... This is how they look at us. They [the public] think we're housemaids but educated… They think we should do everything. - NQN16

Another participant explained how some patients behave differently when someone with a higher status (e.g. a manager) is present. Patients were seen to behave aggressively or disrespectfully when dealing with nurses.

It's obvious that we are not as respected as, let's say, managers or doctors… I can see that in the tone of voice the patient uses…. Patients – of course not all of them – use a louder and more aggressive voice when they deal with us… but when a doctor turns up the tone goes down and the patients become more gentle… It's strange! - NQN18

The following table (Table 8) illustrates how some NQNs' negative preconceived views of nursing were confirmed following their clinical experience. Indeed, some participants' views were changed from reasonably positive to negative.

	Prior to nursing	After clinical experience
NQN1	*Nursing was at the bottom of my list…*	*I only learnt about nursing and how they work when we started our clinical training… I think it was in Year 2. I did not like it…*
NQN4	*I heard that nursing was not a good choice… Nurses do what you're [they're] asked to do… They're also supposed to clean vomit, change bed sheets…*	*I've been told that nurses only follow doctors' orders, and deal with grumpy doctors all the time… and I can say that it's absolutely right…*
NQN16	*I chose nursing because of their high salaries and dead easy to find a job…*	*It [nursing] is like slavery. We have no power, no authority, no voice… We just follow orders from the top people… I heard this before entering nursing but I never thought it could be that bad… Planning to leave here…*

Table 8: Confirmation of negative preconceived views of nursing.

The experiences and perceptions of many NQNs while studying and practising nursing seemed to support their preconceptions that the profession was less respected by the public. These reports can be linked to what was discussed previously, in Chapter Four: that nursing as a profession and its role in the provision of healthcare seemed unclear for many people. Therefore, NQNs reported that nurses are generally viewed with some underestimation or even disrespect. This made reconciling different views of nursing as a career even more challenging for NQNs. The participants' perceptions of the work-related challenges that contributed to making nursing a less popular career choice among nationals will follow.

5.4 Perceived work-related challenges

In addition to working with the other gender, nurses are often required to work outside normal working hours, i.e. evening and night shifts and public holidays. These working hours were presumed by families, particularly fathers, to expose nurses to higher risk of abuse and violence.

> *My father doesn't want me to work in areas where I would regularly work with men… and he also doesn't like seeing me going for night duties…. I think it is a matter of protection... He's told me more than ten times to move to any primary*

[healthcare] centre because they are divided into female and male sections and take Friday and Saturday off [the standard weekend in Saudi]. - NQN5

The preconception that nursing would be an exhausting career in which employees would need to endure heavy workloads was supported by the initial clinical experience of some NQNs. They thought nursing was a physically and mentally tiring job that required great time and effort.

Nurses would be standing all the time at work…. Evening and night shifts… No normal weekends [Friday and Saturday]. It's not like other office-work jobs…. That showed me that nursing is going to be a difficult job… - NQN3

I found out that it [nursing] is more than just giving medications. It involves supporting patients, their relatives, and colleagues, physically and psychologically: so, so much to do… - NQN5

Nurses work hard – they will be on their feet for the whole day. They do multiple tasks that I think no-one in the hospital can do. It's so energy consuming… - NQN8

In addition to the perceived challenging level of workload, some NQNs expressed their disappointment with the lack of appreciation of nurses' efforts. NQNs perceived that the nurses' contribution to patient care seemed to be overlooked by the public, and they believed the credit and appreciation would normally find its way to physicians.

What makes nursing work even worse is the lack of appreciation… No matter how hard we work, the response is always, "This is part of your job" … - NQN8

I reckon people still don't appreciate our work… People have an idea that if you are not a doctor then you are not important…. That's why I have seen doctors or managers receiving praise and thank-you cards from patients, but that never happened to any one of us. - NQN18

The NQNs' feelings of lack of appreciation were not the most unpleasant feelings reported; some NQNs felt underestimated by their managers and patients. They explained that the comments or suggestions they offered to improve the quality of their work were often ignored. Moreover, some patients were reported to overlook or ignore advice when it came from a nurse, but adhere to it when it came from someone with a higher position e.g. a manager or physician.

I feel that nurses are always underestimated… by both the admin and the public… One time, I told the head nurse that our policy for the central line dressing is old and there is an updated one... I showed her the latest one. Then she said it was better to put a doctor's name on top of my name, otherwise it would be kept in a drawer [ignored]… I was really upset… I felt like I'm worthless… Many patients won't listen to our advice, but when it comes from a doctor, then they listen and follow it. - NQN7

The initial overwhelming experience of some NQNs turned their preconceived views of nursing into beliefs. They believed, based on their clinical experience, that the status of nursing was miserable to the point that they compared themselves to "slaves".

It [nursing] is like slavery. We have no power, no authority, no voice… We just follow orders from the top people… I heard this before entering nursing but I never thought it could be that bad… - NQN16

My life became like 12 hours' work, and 12 hours' sleep… maybe that's why they [the public] call us maids… - NQN2

In summary, NQNs' initial experiences in practice were reported to exacerbate their doubts about whether they made the right career choice. Some NQNs perceived that shifts, heavy workload, and lack of appreciation and poor support from management had confirmed their preconception that nursing was not an ideal career for them. However, on the other hand, clinical experience in nursing practice was also reported to have transformed negative views of nursing into positive ones.

5.5 Transformation of perceptions: reconciliation

As discussed in Chapter 4, many participants had had little or no knowledge about the nursing profession or nurses' roles in clinical practice, prior to studying nursing. The NQNs' lack of knowledge of nursing often meant they concurred with the general public's view that perceived nursing as a demeaning and undesirable career. However, most NQNs, as a result of their initial clinical experience, had been able to develop their own perceptions of the profession, which sometimes differed from the public's. Although most NQNs had their negative preconceptions of

nursing confirmed by their experiences in clinical practice (as reported earlier in 5.2 and 5.4), others described their clinical practice positively, saying it had transformed their negative preconceptions into positive ones, which allowed supported them to reconcile conflicting views of nursing as a career.

> *I think I discovered real nursing when I started my internship… that was the real experience… You get to see everything with your own eyes… Nurses are very important part of the care team, if not the most important… not many people know that… I mean, the public don't really know our roles so they undervalue us… - NQN1*
>
> *During my study, I loved nursing and found out that my view of nursing was wrong… I thought nurses only did the cleaning and washing etc… - NQN2*

In Chapter 4, *Acquiescence,* the vast majority of NQNs stated that they struggled with a high level of ambivalence towards their "chosen" career. However, their early clinical training in different settings was thought to unveil the positive side of the profession and the vital role of nurses in the provision of healthcare. This reassured some NQNs that their career choice was sound and right.

> *I only learnt about nursing when we started going to clinical training at [name] hospital. I became more aware of our roles as nurses in saving patients' lives and I loved it. I never thought I would… - NQN7*
>
> *At the beginning, my friends and I didn't like nursing as all of us were planning to study medicine or dentistry. But I think the clinical training was a turning point. We changed our minds, and accepted it [nursing]… I liked it because our work is based on knowledge and evidence, rather than work culture… - NQN5*
>
> *After studying nursing and seeing the importance of our role in treating sick people and improving their lives, I loved nursing. I had a thought that nurses' work is very limited, not important and doesn't need high skills… I don't know where that thought came from but this is what I used to think of nurses… - NQN11*

Another NQN explained that s/he embraced nursing after witnessing the amount of dedication, compassion and selflessness that nurses offered to their patients. Again, the clinical training

experience was a positive turning point for some participants who had been uncertain about their career choice.

> *What I liked about nursing is that it has a noble message and is an altruistic job. The hard work and passion of senior nurses made me love the profession...They became like role models for us… Many of my class mates didn't like nursing until we met and worked with some of the seniors… - NQN13*

The positive clinical experience of these NQNs was also perceived as influential in changing their families' low perception of nursing. Having a member of the family who was a nurse seemed to help clarify the role of nurses and refute some of the misconceptions associated with the profession. Some NQNs reported that their views helped the families to judge the profession based on real examples (an insider's view) rather than relying on a general public perception.

> *My wrong view of nurses has changed since I got involved with nursing, and have seen what they actually do to help patients…. Even my dad has changed his view... They [family] were surprised when I started telling them about our roles and responsibilities and what we do at work… - NQN14*

The discovery of nursing and nurses' vital roles in healthcare provision did not only lead the NQNs to embrace their career, but also encouraged them to demystify the actual role of nurses in order to help their community to better understand nursing. This also seemed to help NQNs themselves in their attempts to reconcile work and social expectations. Some of the NQNs started participating in campaigns to clarify the image of nursing while studying.

> *After understanding everything around nursing, I loved it. It's totally different from what people think. My view of nursing was totally changed as I started going to hospitals for practice, and I loved it… We got excited and created a voluntary group… We launched events at shopping malls and parks to increase awareness of the nursing profession… - NQN9*

Learning about nursing and the experience of clinical training were reported to transform the attitudes of many uncertain NQNs so that they accepted and liked their career. Furthermore, it caused some apprehensive NQNs i.e. those who had felt negative from the beginning, to embrace the profession. The factors that worked as catalysts for the acceptance of nursing included the

vital role of nurses in the medical team and the rewarding feeling of helping people in need i.e. altruism. These clinical "real" experiences were reported to help NQNs reconcile their own positive views of nursing and their families' negative views of the profession.

The following table (Table 9) summarises how some NQNs' prior negative perceptions of nursing were transformed after studying and practising nursing i.e. started to reconcile.

	Prior to nursing	After clinical experience
NQN2	*People used to say things like: Nurses work like maids, and do nothing but clean patients…*	*During my study, I loved nursing and found out that my view of nursing was wrong… I thought nurses only did the cleaning and washing etc…*
NQN9	*My view of nursing was narrow, with some underestimation*	*My view of nursing was totally changed as I started going to hospitals for practice, and I loved it…*
NQN11	*I had a thought that nurses' work is very limited, not important and doesn't need high skills…*	*After studying nursing and seeing the importance of our role in treating sick people and improving their lives, I loved nursing.*

Table 9: Transformation of perceptions of nursing.

It thus appeared to some NQNs that their community held an inaccurate view of nursing as a profession. Therefore, some NQNs had taken the initiative to demystify the image of nursing and improve the public perception of nurses. This initiative can be considered part of a global movement that aims to improve the image of nursing and enhance its status. Nationally, as discussed in the Chapter 1, there have been attempts to improve the image of the nursing profession through various strategies, such as raising the status of nursing.

5.6 Nursing empowerment

This section will discuss the participants' perceptions of the economic incentives and attempts to raise the status of nurses, and how they had influenced their professional experience. These initiatives were also thought to support NQNs in their attempts to reconcile different views of a job in nursing.

- Economic incentives

The recent government efforts to improve the profession of nursing were seen as obvious by many participants, and they had no doubts about its efficacy. The participants reported that they noted several initiatives such as increased employment opportunities, pay rises, promotions and more focus on offering nurses more opportunities for career progression. Creating a large number of job opportunities in nursing appeared to be one of the strategies to attract more students into nursing. Some NQNs explained that this strategy was one of the reasons for considering career in nursing.

> *I think some of us [student nurses] got job offers by the end of the internship [upon qualification]. The recruitment department at [name] emailed all the interns to apply for available jobs… I didn't spend a day searching for a job. I guess I was lucky… - NQN2*

> *Finding a job in nursing was as easy as taking a sip of water… This is one the reasons that I dropped out of HR and studied nursing… - NGN16*

The increase in nurses' remuneration was also perceived as beneficial to improve the flow of recruits into the nursing workforce, and retain current nurses.

> *Our salary scale now is much better than ten years ago. It had to be increased, otherwise none of us would choose nursing. The increase in student's allowance during the internship was also helpful… NQN12*

> *I chose nursing because of their high salaries and it's dead easy to find a job… - NQN16*

> *Before, nurses [expatriates] would work here for few years then move to Qatar or Dubai because they offered higher promotions. Now, I think the salaries are almost equal if we compare the living costs, etc… - HN04*

However, despite recent increases, the pay rate for expatriate nurses was still thought to be lower than in neighbouring countries, and was considered the second most important factor in expatriates' attrition. Moreover, some participants expressed their dissatisfaction with what they thought was pay discrimination.

> *I've been here for 15 years, and a new [expat] nurses with four or five years of experience will get better salaries because they are hired on the new contract system! [the hospital has been recently converted into an autonomous organisation and started to offer better rates for new employees, compared to those on the older government contract] - CRN02*
>
> *Three of my [Malaysian] friends left here last year because they found better promotions in UAE – HN03*
>
> *The payment should be based on qualification and experience, not nationality! It's a problem in the Saudi health system… Why would a [nationality] nurse receive better pay rates than us [nationality]? it's not fair - CRN01*

- Recognising nurses

Some participants noted that acknowledgment of nurses' work had increased, and that more nurses had been granted access to higher positions within their organisations.

> *The ministry has started to give high administration positions to nurses. I'm so glad to see that. The previous minister wouldn't do it. We were voiceless… but now we at least have some hospital managers with a nursing background who know exactly what is happening at the nursing level. - NQN18*

The recognition of nurses' effort was not limited to the organisational (hospital) level, as a few nurses had been pulled out of clinical work and given positions in local and regional health departments, according to participants. These senior administrative positions have historically been dominated by physicians and administrators.

> *I like how nurses are getting more chances to be in administrative positions. Last year, an ICU nurse was appointed a general director of health affairs in Aljouf, and this year another one in Riyadh… It is the first time in our history for*

a nurse to be a general director… Also, other nurses have become hospital directors… - NQN19

The reported acknowledgment by higher management of nurses' effort seemed to contrast with some of the quotes discussed earlier on the perceived lack of recognition. However, the negative experiences appeared to occur within the organisation, while the support for nurses seem to come from regional health departments.

The perceived opportunities for career progression in nursing have been welcomed by most NQNs, and motivated some to develop professionally in order to enhance their social and professional status.

Mr. [name] is a hospital director now. He was ER [Emergency Room] nursing staff around 10 years ago... I think they chose him because he has a master's in disaster management… I'm going to do like him but I will study quality management… So, I could be a hospital manager one day… (laughs) Who knows?! - NQN14

With the new government, we've seen nurses in positions like general directors and hospital directors… That was impossible few years ago. There's a transformation everywhere in this country… Now, it's our chance to learn and develop and climb the career path… I wouldn't be surprised to see a new minister of health with a nursing qualification… - NQN19

In order to raise the status of nurses and prepare them to take more responsibility, the participants explained that the government, through the Ministry of Health, has invested in studentships and professional development training. They thought it was a step in the right direction to improve nursing practice and the status of nurses.

Now, Mashallah ['touch wood' in English], the number of nurses coming from abroad with masters and PhDs is increasing, and that is what we need, more qualified nurses who can participate in improving the policies and rules related to nursing… We also need more nurses on the executive boards so that we can deliver our voice and concerns… - HN04

I guess nursing is the quickest way to get a government scholarship… All hospitals, university and military hospitals, have a special scholarship path for

nurses… Two of my friends are studying DNP [Doctor of Nursing Practice] at John Hopkins… I think it's important to improve nursing practice here in our hospitals… - M02

It's difficult for me to go abroad to study for a masters… I'll apply to Princess Nourah University [in Riyadh]: they are offering a masters in advanced nursing… They're cooperating with an Irish university to deliver the programme… It sounds interesting and we don't have many nurse practitioners… - NQN5

At the ward level, some head nurses explained how they try to empower their nurses by improving the working culture, that is, to change the "the nurse will do everything" culture and remove non-nursing tasks from the nurses' shoulders.

I always encourage nurses to focus on their responsibilities only, and not to be distracted by other jobs. My nurses are nice and want to help, but others are taking advantage of that… Some doctors say, "Oh, the nurse will do everything", "the nurse will complete the file", "the nurse will take the blood sample to the lab". I want to change that; everyone should do their job…- HN06

Most expats are afraid of saying "No" to doctors or to any one from the management; they think it would cost them their jobs, which is not right… I'm trying to change that submissive behaviour in my unit…- HN05

The expatriate nurses' anxiety about their relationships with their managers was evident where a participant (an expat) expressed concerns that accepting a new promotion might impact on their relationship with their manager. This reflects the low autonomy of certain groups of nurses and how they need to be empowered i.e. given more authority and trust to make decisions independently

When I was promoted to a CRN position, I asked my head nurse, "Will we have the same relationship as friends?" ... So, he said, "inshallah [God willing] we will have a good relationship and we will support and help you in the learning," and really, he did support me a lot. - CRN01

Empowering nurses, according to the above participants, has taken different forms, including increasing employment opportunities and payment; better opportunities for professional development training and career progression, and changing what was described as a

"submissive" work culture. These attempts to bolster nursing, at both the organisational and regional level, were thought to have improved the status of the profession. Moreover, the government's focus on nursing through granting international scholarships for nationals was also reported. This effort aims to equip nurses with the knowledge and experience needed to lead the change in the profession. The associations between empowering national nurses and enhancement of the nursing profession will discussed in the next section.

- Incentivising national nurses

The new government human resources development plan was welcomed by many participants. One part of this plan, as discussed earlier, is the scholarship programme that aims to send students at all levels (Bachelor, Masters and PhD) to study abroad. These scholarships are exclusive to the most in-demand subjects that the local job market requires. This certainly includes nursing.

> *The deputy [health] minister once said, "Anyone with an unconditional offer to study bachelor in nursing will get a full scholarship straight away" ... but it has to be one of the top 100 universities. - NQN17*
>
> *The ministry [of health] offers tens of scholarships to study nursing. This tells me that the ministry is serious about developing nursing… - NQN19*
>
> *We have graduates from America, Canada, UK, and Sweden; thanks to the king's scholarship programme… I like that mix of thoughts. - P01*

The incentivising of national nurses was seen as expediting the process of change and improvement within their organisation. However, incentivising nationals can also be problematic when they are promoted beyond their competence as a head nurse explained.

> *Saudi leaders who are qualified can introduce big changes to the unit, e.g. promotions, unlike most expats who would normally wait for approval from the higher management… - M02*
>
> *Because we don't have many Saudi nurses with higher qualification, anyone who gets a masters or PhD will be given a managerial position straight away. I think this is wrong… Young managers can sometimes be a disaster when they don't have enough experience... - HN06*

Some participants thought that the government's transformative plan seemed to pay great attention to incentivising nationals, particularly women.

> *We're living through dramatic changes in every aspect in this country… Women are granted more scholarships and more access to higher positions… like ministers and deputy ministers, and at Shura council… it's nice. - NQN18*

> *A few years ago, there were more [local] male nurses than females… These days I think Albnat [girls] are taking over… - HN03*

> *Now women are taking the remote control…(laughs)… getting better jobs and leading the change…- NQN19*

The recent changes led by the government were thought to have had an impact on the local culture. Some participants thought the recent reforms are slowly changing the traditional roles of men and women in the local community.

> *Women are becoming the family primary earner… the leaders… It's not like my parents' time… - NQN12*

> *These days, many young women are educated, employed and can run a family… Our culture is changing fast... - HN05*

> *My dad allowed my older sisters to study up to Year 6. He had an idea that if a girl can read and write then there is no need for more studying… That was only about 40/50 years ago… Look at us now! It's a huge improvement and it's continuing. - NQN19*

The concurrent changes in the government systems and local culture have played a role in changing the perception of many careers, including nursing.

> *My youngest sister works as cashier in Panda [a major grocery company]. If you had asked me about this kind of job ten years ago, I would have said no. A cashier job was not accepted in our community; it was Ayb [shameful]… The same with nursing. Today it's different: everything has changed. - HN05*

The incentivising of locals that has been driven by the government was thought to be changing many aspects of the national culture, including attitudes towards nursing. The participants

reported major transformations including more recognition of nurses' roles in the healthcare system. They appeared to be generally optimistic that the recent reforms would improve the public perception of nursing and ultimately improve the flow of the younger generation into the nursing profession, as a whole.

- Rebranding the image of nursing

As explained in the *Workforce localisation* in Chapter 1, the percentage of national nurses has increased in the last two decades from 10% to nearly 43% (MOH, 2020). This improvement would not have happened without tackling the public's idea that nursing is an undesirable career. Some participants thought the public's perception of nursing had been altered through using the media to demystify the profession and its people.

> *The [health] ministry has been using the social media to publish heroic stories about nurses… It's like "See what nurses can do… they are saving lives …" - HN06*
>
> *Every month or so we read a nurse saved someone's life on an aeroplane, an off-duty nurse stopped and helped people involved in a car accident… I think these kinds of stories send indirect messages to the community and increase people's respect for nurses… - NQN18*
>
> *I think the pandemic [COVID-19] showed everyone what we [nurses] can do. It is nice that people on Twitter, etc., have started to appreciate our hard work… The [health] minister and his deputies have shared many tweets showing our role in fighting the virus… - M02*

Another strategy that was thought to have improved the perception of nursing is increased access to higher positions. In recent years nurses have been offered senior posts that were previously limited to physicians and managers. This strategy, according to NQN19, was thought to improve the status of nursing through introducing high-profile nurses in senior posts to the public, and improving how they are perceived within their professional community.

> *Appointing a hospital manager with a nursing qualification sends a message that nurses can lead and can be trusted… I think if the top management respects and values nurses then the whole hospital would do the same… It would become like a culture. - NQN19*

The study participants asserted that increasing the percentage of national nurses and granting access to higher administrative positions would contribute to the development of the nursing profession nationally.

5.7 Summary

Prior to entering nursing, the vast majority of NQNs had had a negative perception of nursing and its role in the delivery of healthcare. For some, their clinical experience had refuted these preconceptions, which reassured them that their career choice was right. However, the majority of NQNs thought their experience in nursing practice confirmed the general public's perception that nursing is an undesirable career, and, thus, regretted their career choice. Moreover, social barriers and factors associated with the work environment such as gender sensitivities, workload and shift patterns were thought to make reconciling work and personal life even more challenging for NQNs. In an attempt to resolve these concerns, many NQNs started to consider further studies that would let them move to higher positions that offered better working conditions. I conceptualised their intentions to move to better roles as attempts to reconcile conflicting views of nursing as a career and achieve equilibrium between work demands, social expectations and personal aspirations. They wanted to keep their jobs and simultaneously they wanted to avoid clashes with their society that still perceives nursing as a low status and working-class occupation. The study participants also expressed optimism about the recent reforms at the social and professional levels, and felt they were contributing to improving the status of nursing within Saudi and making it a more popular career choice for nationals.

In this chapter I discussed the NQNs' "before and after" perceptions about a nursing career, and about their initial experiences in clinical practice and how these impacted their preconceptions. Next, I will report the participants' views on their working environment and their experiences in continuously resolving work-related challenges.

Chapter Six: Perseverance

In the previous two chapters (*Acquiescence* and *Reconciling*), I reported the perceptions and experiences of newly qualified nurses (NQNs) when first getting into nursing, their initial clinical experiences and the influence of those experiences on their views of nursing as a career, and their attempts to reconcile conflicting views of nursing as a career. Prior to commencing nursing, the NQNs had felt that a job in nursing was not an ideal career choice, and the negative experiences of most of them in nursing practice had supported these perceptions. However, many of them, temporarily, acquiesced to nursing and began focusing on career progression rather than quitting – attempting to move forward in order to improve their social status. This chapter will discuss the NQNs' experiences of role transition from student to registered nurse, their perceptions of their new working environments and working teams, the work-related challenges they encountered and how they managed them while attempting to achieve their goal of bolstering their social status.

6.1 Performance concerns

As explained in Chapter 1, all NQNs were admitted on a 12-month residency programme to assist them with the role transition from students to becoming registered nurses. One part of the residency (the first three months) was termed a period of preceptorship, where each NQN was paired with a preceptor and shared their workload. During preceptorship, NQNs were not expected to have their own patients, so that they would have time to demonstrate that they had the competence and confidence to work independently.

- Feeling anxious

Feeling tense appeared to be a common experience among NQNs when moving to their new working environment. This feeling was reported to stem from various worries such as new co-workers, and fear of not meeting managers' expectations. A few NQNs attributed their anxieties

to unfamiliarity with the workplace, where everything, including the system of work and the workflow, seemed strange.

> *During the first couple of weeks, I was a bit nervous… I didn't know anybody and I had no idea about the hospital systems. I trained in [city] so I had no idea about [hospital] and how they work. - NQN2*

> *The first few weeks were difficult because I didn't know their system and procedures. Here, almost every procedure is different compared to [hospital name]. I was anxious that people might get a negative impression if I made a mistake. - NQN13*

Another reason for the increased nervousness was meeting and working with unfamiliar colleagues. Some NQNs thought it was intimidating and felt nervous because they knew little about their colleagues and their different personalities.

> *I felt nervous when they [other staff] asked me questions and my preceptor was not around… I was a bit nervous, but that was normal for all new comers. - NQN4*

> *It's nerve-racking when my patient deteriorates, and I have to ask the head nurse or the CRN for help. We don't really know each other… I don't know whether they would appreciate that I acknowledge my lack of experience, or they would think of me as an extra workload on them…- NQN5*

The fast pace of work in critical care units, which were the home area for a few of the NQNs, generally requires professionals to respond quickly and effectively to deal with sudden changes in patients' conditions. The fear of failing to meet these expectations was thought to be responsible for the feelings of apprehension. Thus, some NQNs felt worried that their response to urgent cases was below expectations.

> *I feel nervous when a doctor asks urgently for a medication. I feel I'm not responding as fast as senior nurses… It was my first time to give dopamine, and it is one of the high-alert medications. I was a bit nervous, and had to check with my neighbour [colleague] before giving the medication. - NQN3*

The brevity of the preceptorship was another source of stress. Some NQNs reported that they were not offered sufficient time to settle in and felt that they were rushed into taking on a full workload. NQNs felt trapped between accepting the new responsibilities or declining them. Taking on new responsibilities could contribute to nurturing trust between an NQN and their head nurse, while rejecting them could have the opposite effect, and their manager might develop a negative impression of them.

> *I didn't feel ready for practice following the 9-day preceptorship. I wasn't ready to work by myself, but I had to. I think If I told them [Head nurse and CRN] about my feelings they would hold that view forever and they wouldn't count on me... - NQN13*

From the statements quoted, it was apparent that moving to a new workplace, dealing with unfamiliar workmates and fear of incompetence were the triggers for the nervousness that some NQNs felt during their initial experience as registered nurses. Moreover, having only a short period of time to settle into their new working environment and increased responsibilities were also thought to affect the NQNs' confidence levels, making their initial experience even more challenging.

- Drop in confidence

The vast majority of NQNs agreed that their level of confidence had developed as they progressed through their nursing course. However, some of them reported a drop in their confidence level while transitioning to their new role as registered nurses. The change in confidence levels was linked to various internal and external factors, such as fear of failure and an unfamiliar work system.

Despite successfully building trusting relationships with managers, a few NQNs reported that they struggled with inner feelings of low self-confidence. They were able to prove themselves to others but struggled with self-trust.

Both my preceptor and the head nurse told me that I could start working alone, but I was a bit hesitant… [Preceptor's name] and [head nurse' name] gave me the chance, and encouraged me, saying: "You can do it, we trust you," but there was something inside me saying, "No, I can't do it." - NQN6

After passing all the competencies, my preceptor suggested that I should start working by myself [independently], but I wasn't confident enough. I told them, the CRN and preceptor, that I didn't feel ready. - NQN9

Other NQNs explained that their main fear was making mistakes, which they feared might lead to negative impressions about them, and to a failure to gain their new colleagues' trust. This concern made them anxious that making a single mistake would make others question their competence.

I was afraid of making mistakes… I was afraid of not doing the right procedures… I was afraid and was asking others before doing anything. I think it was about confidence. - NQN10

Before doing any procedure, I always liked to double check… Sometimes I checked three or four times… just to make sure. I didn't have the confidence to do it in on go. I didn't want to make any mistake. One stupid mistake and the trust is gone. The rest of the team wouldn't trust me anymore. - NQN4

Preceptors shared similar views and explained that it was not uncommon for NQNs to worry about their new responsibilities and feel uncertain and hesitant in the first few weeks of their professional lives.

They just need a push or reassurance. They need someone to give them the confidence to believe in their abilities, that's all…. A few nice words would do the job… Normally, after 2 or 3 months you see them [NQNs] running like seniors. Some take even less than a couple of weeks. - P01

It's ok for new nurses to lack confidence, that's normal. When I first arrived here, I had three years of clinical experience in [home country] but I was shaking… (laughs). The machines, protocols, health system is so different from where I came from… Some nurses need more time to adapt, others don't - P02

Some NQNs found moving from a trainee to a registered nurse role relatively easy because they had trained in the hospital. Almost half of the NQNs had trained in the same setting, and their role transition experience seemed less challenging compared to those who had trained in other hospitals. They felt confident in starting their new jobs as they were already familiar with the work environment and had developed good relationships during their clinical placements.

> *I already knew many people here, so it was like "welcome home" …- NQN1*
>
> *Yes, it felt quite different because I had more responsibilities, but it was fine… I was ready to have my own patients from day one. As I said, because I was used to the unit system and how it works. NQN3*

The association between the quality of the hands-on training and levels of confidence appeared frequently in several interviews. Many NQNs praised their internships (12-months practice-based training prior to qualification) for improving their confidence and making them practice-ready upon qualification.

> *I did my internship at [hospital name], and I had the best preceptor and the best work friends. They taught me everything. They dealt with me as if I were a member of staff, not a student… I became more confident in dealing with cases by myself, without asking my preceptor. She [preceptor] supported me to do so. - NQN2*
>
> *I trained at [hospital name]. It's better than here in terms of clinical training. They're not as strict as here. I was allowed to deal directly with patients while my preceptor was with other patients. That boosted my confidence and in time I became more independent. - NQN6*

Although some NQNs thought being allowed to deal directly with patients was helpful, some experienced nurses felt differently. Experienced nurses thought trainee-patient direct contact should be limited and closely supervised to ensure the quality of patient care.

> *Here at [hospital], we always put patient safety first... That's why we permit interns [trainees] to do only basic procedures like taking vital signs, patient history… but that would also be under the charge nurse's eyes. - CRN03*

Poor self-esteem, fear of making mistakes and insufficient clinical training were reported by NQNs to contribute to them feeling hesitant to begin independent practice. Generally, these NQNs struggled for a few weeks before overcoming the barriers created by their lack of confidence and they then started to settle in. Conversely, those who felt they had had sufficient training and/or had secured a job in the hospital in which they had trained felt more confident and ready for independent practice. For these nurses, role transition was perceived as relatively easy. The next section will discuss NQNs' perceptions of competence and their views about their own professional skills.

- Perceived competence

A few NQNs explained that their worries stemmed from their not feeling ready to work independently. Although NQNs felt safe working beside an experienced colleague (e.g. preceptor), some of them were uncertain about how to function independently. Moreover, the increased responsibility made some NQNs doubt their nursing abilities to manage multiple tasks at the same time.

> *To be honest, it was a bit difficult working alone… I had many unanswered questions at that time. When working with my preceptor I thought I knew everything but as soon as she left me, I realised that I knew very little...- NQN7*

> *Starting to work on my own was quite difficult, but not that bad. Maybe the first two or three shifts were difficult knowing that I became the main person responsible for my patients … more jobs to do and no more preceptors. - NQN11*

In addition to feeling anxious and doubtful about working independently, many NQNs mentioned some of the professional skills that they felt they lacked to function effectively as professionals. These skills included time management, prioritisation and clinical nursing skills. There was a general consensus that managing daily tasks at work (e.g. managing multitasks or pace/speed of task completion) was one of the biggest challenges for NQNs.

> *I always fail to follow or complete my plans. I develop a plan in the morning but by afternoon I find myself way behind… Sometimes, I allocate, let's say, an hour*

for medication, but it takes me two hours… or I plan 30 minutes for a dressing but it takes 45 minutes… - NQN4

Sometimes I would fail to complete all tasks on time. My time management skill wasn't that good. - NQN6

I think time management is a problem for me and my friends. We can't keep up with our plans. Because sometimes unexpected incidents happen, and it can ruin the plan for the whole day. It isn't easy to manage. - NQN7

It was difficult to finish on time. Most days, I would stay for an extra hour to finish my work before I go home… - NQN10

Some NQNs explained that prioritisation was a continuous challenge. They were finding it difficult to decide which task or assignment should be tackled or completed first.

Sometimes, I wish I had four hands… (laughs) I want to do several tasks at the same time… I can't prioritise one over another… I remember we had trained on prioritising tasks, but in reality, it's quite difficult…I ask my preceptor to say what's important and what's urgent… - NQN3

I need to learn when to say "No". Sometimes, I help others and leave my work till late, which is wrong… and I end up working another hour or two to finish my work. - NQN15

Despite the struggle with time management and prioritisation, some NQNs felt their lack of professional skills was acceptable from any new employee, and they felt they had developed professionally compared to when they started (3-6 months ago). Their perceptions were also supported by experienced nurses who explained how the number of questions from NQNs declines over time as their confidence in decision-making grows.

It's normal to for a baby to start crawling, then walking, then running… Looking at myself now and three months ago, I have become much better at planning and managing my duties… - NQN9

We see that every time: trainees ask many questions during the first few months; afterwards, they become more confident and independent in making their own decisions. - P03

Cannulation technique was another issue that a few NQNs found challenging. Therefore, they felt they needed reassurance from experienced nurses for some time before doing it independently. Feeling that they lacked competence in cannulation could be related to having insufficient clinical training. One participant in particular, (NQN10), was quoted earlier complaining about the quality of their preceptorship and how they felt that it did not provide adequate hands-on experience.

> *When I started here, I didn't even know how to insert a cannula or take a blood sample… I had to rely on seniors for little bit… the cannulation training was on manikins, but with real patients, it's different. I felt sorry for the patients, because sometimes I had to try two or three times to get it right in the vein. - NQN10*

This was a particular problem in relation to working with children. It appeared that the NQNs were trained only as general adult nurses, e.g. there were no specialist children's nurses.

> *My biggest challenge was how to start an IV line for a child. Children are more difficult because they keep moving and crying. I watched [name] a few times before I gave it a go… I did well. I never thought I would do it right first time… - NQN3*

Experienced nurses had diverging perceptions in regard to NQNs' level of competence. Managers thought that some NQNs had the nursing theoretical knowledge but lacked the clinical skills. This varied depending on the institutions they had graduated from.

> *I don't know where they do their internships: they are really not competent... Some are excellent, some are moderate and some, you need to work on them from square one… - CRN01*
>
> *In critical care, a one-year internship is not enough to learn all the skills needed to work as an ICU nurse. - CRN02*
>
> *Saudis [NQNs] aren't as competent as [nationality] nurses…. They [Saudis] speak fluent English, and they have the theoretical knowledge, but don't have the skills we need. - M01*

In contrast to managers' perceptions, preceptors who were more involved in direct contact with NQNs thought the NQNs' level of competence was more than acceptable. These preceptors

explained that most NQNs had the appropriate level of nursing knowledge and skills, with room for development of professional skills such as pace of task completion.

> *Honestly, I'm surprised by the new nurses' knowledge and skills… They've all the updates about nursing, their English is very good, they're good in the technical skills… they just need to get used to our procedures… - P01*
>
> *They [NQNs] have very good skills about research and evidenced-based nursing, They have studied this in detail, unlike us… We cannot say there are major concerns about their abilities to work as nurses. I think it's just a matter of time to be faster in performing different tasks… if dressing change takes me 10 minutes, it would take 20 minutes for a new nurse… it's just experience… - P02*
>
> *I think they have most of the required skills and information… They just need to learn how to better manage their time, and learn roughly how long each procedure might take… Also, to learn which procedure should be done first… It's about organising their day. - P04*

The different views about the clinical nursing skills of NQNs' are interesting. Whilst both the managers and the NQNs themselves, felt they lacked some clinical skills, e.g. cannulation, the preceptors appeared more satisfied with the NQNs' level of competence and related their low performance in some procedures to their lack of clinical experience. The contrasting opinions of managers and preceptors could be linked to their different expectations of NQNs, particularly in the first few months of practice. Although the preceptors were generally satisfied with the NQNs' performance, the NQNs themselves felt their clinical skills were below expectations and required improvement. Most NQNs thought that advancing their nursing knowledge and skills was essential to persevere in the face of their lack of confidence and their managers' distrust. In the next section, NQNs' experiences and perceptions of the level support provided to them will be discussed.

6.2 Level of support

- Feeling supported

The majority of NQNs' narratives focused on the challenges they confronted in a typical working day. However, on the positive side, some of them praised the level of support they received from their preceptors, and how it was encouraging and reassuring. The preceptorship was provided as part of a nursing residency programme (NRP), which all NQNs were admitted to.

> *My second preceptor, sometimes, dedicates like 30 minutes of his time just to teach me one procedure… I feel valued when he does this… The best thing about my preceptor, he shows that he cares and actually wants to see me improving… When I need help, and the preceptor isn't around, I can ask the CRN or anyone; they always help… - NQN1*
>
> *My preceptor in [unit] was nice and caring. I was in safe hands. She was around me all the time… Thanks to my preceptor and the whole team… They really helped me and would teach me a new thing every day… Their feedback also made me value the skills that I have, and pushed me to work even harder. – NQN2*
>
> *When I came here, I knew most of the procedures but didn't have the guts to do them. So, with the preceptor's support, I was able to break that fear. The preceptor's instant feedback improved my performance, and by the end of month 3, I was ready for separation. – NQN5*

The NQNs seemed to value the qualities their preceptors demonstrated, such as caring and being devoted to teaching new employees. Other NQNs appreciated the feedback from their preceptors and how their presence made them feel safe. Experienced nurses also added that NQNs were offered a probation period with a preceptor, continuous progress meetings and periodic assessments to ensure their progress.

> *They [NQNs] have a probation shift with the preceptor… We meet with them every week or so, we sit with them and see how they are progressing… Plus on-going bedside evaluation. - CRN01*
>
> *We do interviews with them every two weeks and we assess them on the competencies: they have the general competencies and the unit specific competencies. – HN04*

Other NQNs were more explicit about the type of support provided for them. NQNs explained that they were normally assigned to less complex patient cases.

> *Seniors have taught us some good techniques to stay relaxed and ask for help when needed. They told me that I don't have to deal with everything alone, and can ask for help at any time… She [head nurse] would normally give me the easiest patient, which was nice of her. - NQN3*
>
> *Both my preceptor and the head nurse were encouraging me to do a central line dressing for the first time… I knew the procedure but didn't have that push to do it. They stood by me the first time which really gave me the confidence to go for it… - NQN06*
>
> *I was given stable patients to settle and get used to the working system. My workload increased step by step. I think this was a good technique. - NQN5*
>
> *Usually new nurses are slow compared to experienced nurses… so we try to give them the simplest or easiest patient… That's normal, we accept that. We know they that will get faster day by day… - CRN02*

Interviews with experienced nurses who were involved in the delivery of the NRP revealed their interest in educating younger nurses and the benefits of mutual learning experiences (how trainers also learned from trainees).

> *I actually enjoy sharing my workload with preceptees… they help me and learn at the same time…I learnt a better way for dressing change from one of the preceptees; her technique was more comfortable for the patient… - P01*
>
> *Teaching is my passion… the feelings that I made someone do their job in a better way is so rewarding for me. - CRN01*
>
> *Sometimes I learn from the new nurses the types of research and how to develop questionnaires… I think they're well prepared specifically in nursing research. - P03*

Not only experienced nurses but also some patients and their relatives could be a source of support and encouragement for the NQNs. Some NQNs detailed how the recognition and encouraging words of patients helped them gain confidence and feel appreciated.

A patient asked for my full name when he was leaving the ward… A month later, I received an appreciation certificate from the patient relation office. It was a really nice surprise… I found out later that the patient's son went to the nursing office and told them about their nice experience in the ward and that he wanted to thank me. - NQN3

[Patients'] relatives have told me things like "my mum wants you to be her nurse" or "my mum feels more comfortable with you". This is a great feeling. This tells me that patients trust me… and value my work. – NQN7

The reported recognition of nurses' effort and positive experiences with patients and their relatives contrasted with some of the narratives presented in the previous chapter (Chapter Five) about the lack of appreciation for nurses. From the quotes of the participants, it appeared that those NQNs who felt less satisfied with their career tended to report more negative experiences, while those who had started to embrace nursing seemed to focus on positive experiences with either their patients or their colleagues. However, this could be all about selective recalls. NQNs thought the professional support at work helped by reassuring them, enhancing their confidence and ensuring their integration into their new working environment. Moreover, the positive feedback from patients and their relatives was considered a reassurance for NQNs to value their nursing knowledge and skills, and to feel appreciated. This was thought to help many NQNs persevere in their attempts to overcome their perceived lack of confidence and competence. However, not all NQNs had a similar experience: some reported the concerns they had during their initial experience as NQNs. These issues are described below.

- Lack of support

Some NQNs felt that the preceptorship period was not adequate and that did not meet all their needs. These NQNs reported that they were dealt with in the same way as experienced nurses, with little special support for them as new staff.

There was no extra support for us as new nurses. Apart from preceptorship, which was very brief, there was little support. I had to rely on myself and keep asking questions. - NQN7

Nobody asked us about the difficulties that we faced, and whether we needed more education or support. - NQN10

Some NQNs complained of the perceived short duration of the preceptorship and felt they were given too little time to settle into their new working area before being asked to start working independently. In addition, they felt they had to learn on their own despite being admitted to a residency programme.

My preceptor left me too soon. After 9 shifts, they told me that I should start working alone. So, I had to rely on my colleagues when I needed help. I had to learn all the critical skills on my own… It was really difficult times. - NQN13

I was left to learn by myself – I didn't know if I was right or wrong… There was no proper orientation. I didn't know how many beds were in our unit until two months later… They threw us into [unit], and wanted us to learn by ourselves without support. Google was my preceptor! - NQN16

In comparing the stories of NQNs, it seemed that the application of the residency programme (NRP) varied significantly between wards. While some NQNs reported that they had more than nine weeks of preceptorship, others had only about two weeks prior to being asked to work independently. According to the residency manual, though, NQNs were only expected to care for patients independently after completing the first three months of the programme.

Although some NQNs praised their preceptors for being supportive, the relationships with preceptors were mixed. Negative reported experiences with preceptors slightly outweighed the positive ones and ranged from "not good" to "bullying".

My first preceptor wasn't good with me… I had to change to another one. She [preceptor] was not interested in talking to us or teaching us…. She would barely answer a question… - NQN1

Some staff see helping new nurses as unwanted more workload… so sometimes I have to go to other departments, where my friends work and ask them. - NQN15

We had many issues regarding the residency, but no one was there to help us… My preceptor would only signpost me to others, that's her job. - NQN11

> *I felt like an idiot when I was working with my preceptor. He was always underestimating my skills. He made fun of me with his friends in their own language. I didn't understand them… - NQN16*

Other NQNs explicitly recalled their struggle with what they felt was a hypercritical manager. One NQN chose to alter her working pattern to night shifts in order to avoid clashes with the head nurse who regularly worked mornings. They persevered at work despite reported challenges using different strategies such as avoidance.

> *The head nurse would look for any small mistake to report me… One day, she reported to the management saying that I was wearing too much makeup… I changed my schedule to night shifts just to avoid her… - NQN14*

Experienced nurses also discussed their struggle with a lack of support and resources. They reported that preparation for the preceptor role was either insufficient or unavailable and there was a lack of resources, e.g. computers and offices. These deficiencies in training of preceptors and lack of teaching resources could have contributed to NQNs' negative experiences with their preceptors, and may have led to their negative experiences in clinical practice.

> *Honestly, there is no training. When I started as a CRN, I worked with an experienced CRN for nearly 3 weeks to learn the CRN's roles and responsibilities… We don't have an office for work, we don't have any computers for work. Sometimes we search for computers, we don't have enough resources. - CRN01*

> *Last year, I went to a one-day workshop for preceptors… very brief and didn't really tell us what our role involves… They told us about the ideal preceptor-preceptee relationship. They didn't tell us what to do with misbehaving or non-compliant new nurses. - P01*

Some NQNs reported that they felt overwhelmed in their initial days at work. They did not feel they had the support they needed as new professionals; they felt the preceptorship was too short, or felt they had been assigned to inappropriate preceptors who made their role transition more challenging. Therefore, they tended to change their working shifts or preceptors as a way of persevering in the face of lack of support at work. Furthermore, the preceptors themselves

felt they were not adequately prepared for their new role, which may have resulted in the negative experiences during their first days in practice that NQNs recalled. The connections between the workload and level of support from management will be discussed further in Chapter 7, *Discussion*. As the residency programme was cited by many NQNs, in the next section, I will report on their experiences and perceptions of the programme.

- *Experience and perceptions of the NRP*

- Experiencing the NRP

As detailed in *The nursing residency programme* in Chapter 3, the programme was developed to streamline NQNs' transition from school to workplace through improving their nursing competence and confidence. According to the NRP manual, this programme was developed to the standards of the American Nurse Credentialing Centre (ANCC) and assumes that NQNs lack clinical experience.

> *These nurses [NQNs] have completed four years of BSN in nursing from local or international universities but still lack clinical experience… This programme will be conducted for a period of twelve (12) months…- NRP doc, p.6*

This quote from the programme manual shows that it was not tailored to the national (Saudi) nursing curriculum. The length of the BSN course in Saudi, as explained in Chapter 1, is five years and requires students to complete a 12-month internship prior to qualification. Furthermore, the manual appears to deal with all graduate nurses equally; however, graduates may have different needs depending on how they were prepared. For example, a graduate from a local university may have different needs compared to a graduate from a US university, as the content and length of BSN programmes in the two countries vary significantly, as discussed earlier in Chapter 1.

On induction day, NQNs were informed that they would be placed on an NRP for 12 months to support them during transition to a registered nurse role. However, many NQNs stated that, in reality, the support was limited to the first three months before they were given a full workload which they considered equal to that of senior nurses.

They told us the programme was one year, but after three months we started working like any senior nurse… Have they changed their mind? - NQN1

There is no extra support for residents [NQNs]… There was nearly three months with a preceptor and nothing more, nothing more… - NQN4

I think they put us on OJT [on job training] because they had stopped the residency [NRP]. I'm on OJT, but I never received any training, apart from 9 days' preceptorship! - NQN15

On top of the confusion over the length of the programme, many NQNs thought that the introduction to the programme was too brief and gave insufficient detail, with many gaps left unfilled and multiple questions left unanswered. The introduction to the programme left many NQNs feeling stranded and confused.

We were a little messed up. They told us about the residency [NRP] but the induction day was very brief and didn't answer all of our questions… We had support for the first couple of months, and that was it, nothing more… I feel there is something wrong… I don't know if I'm missing anything…. - NQN5

This feeling of uncertainty was not exclusive to NQNs, even experienced nurses were not fully aware of the residency. Interviews with some experienced staff who were involved in the delivery of the programme corroborated the perception that the programme had been insufficiently communicated to staff working with NQNs and that many of them felt uncertain about the objectives of the programme

I work with OJT trainees and preceptees. OJT is only for Saudi fresh graduates. Preceptees can be any new staff who have moved from other hospitals… I don't know. OJT trainees work for one year, rotate every two months to different area… - P01

I don't know much about the residency programme… So sometimes when I arrive here, they will give us one student and we will teach them. - P02

Interviewer: Can you tell me about the residency programme?

Interviewee: Do you mean the OJT?... It is one year of training. The trainee will be assigned to a preceptor for the whole year. - HN01

For some NQNs, the experienced nurses' lack of awareness of the programme led to an experience that was not ideal.

> *On the first day of residency, I was in tears. The head nurse, at that time, didn't know anything about the residency, and she straight away wanted to give me four patients!... I tried to explain but she wouldn't listen… I ran to [NRP lead] to complain… - NQN6*
>
> *We have many complaints about the residency, but we didn't know the right person to talk to. Everyone was saying "I'm not responsible for this" or "I'm not the right person to talk to about this" … - NQN11*

If the individuals responsible for teaching and guiding NQNs through their role transition were not fully aware of the programme, it is unsurprising that the vast of majority of NQNs were feeling uncertain despite having completed more than six months in the programme.

> *I don't really understand the residency. I feel there is something wrong… I don't know if I'm missing anything… What is the point of the residency? - NQN2*
>
> *It [the NRP] was a bit confusing, even seniors didn't know much about it… I was let down… the residency was supposed to be one year long, but we were only given preceptor for less than two months. - NQN7*
>
> *It's been six months now, and I still don't understand the benefits of the programme. I don't feel there is any benefit… - NQN8*
>
> *…I'm going to complete the residency in few months… and I still don't understand the point of the residency… - NQN11*

Another confusing point was the eligibility criteria for applicants, i.e. for NQNs to enter the NRP programme. The programme was aimed at NQNs with "less than 12 months of experience post-graduation" (NRP doc. P.7). However, a few NQNs with more than one year of clinical experience were bitterly disappointed and puzzled that they were placed on the programme.

> *Before moving here, I worked about 14 months with Diaverum [dialysis centre] … and when I came here, they put me on a resident job title. -NQN15*
>
> *I have one year's experience; I didn't need preceptorship or a residency… I needed a better unit orientation… I think if there was a proper two- or three-week orientation, I would've been happier. - NQN17*

The ambiguity and conflicting understandings of the aims, objectives and content of the NRP sometimes left both NQNs and the programme delivery team feeling "lost and confused". This situation was thought, by many participants, to exacerbate the uncertainty of NQNs who had already been struggling with lack of confidence due to the change of workplace and role, and the programme did nothing but worsen the situation.

> *The problem is that the residency adds fuel to the fire… We barely complete our patients' tasks; how can we do all the competencies and case studies? Even the seniors think it's stupid… It's a lot of work for them and for us. - NQN4*

- Perceptions of the NRP

In praise of the residency, some NQNs thought working with a preceptor allowed them to settle into their new role and flourish as new nurses. They thought the preceptorship period helped them to consolidate their knowledge and improve technical skills.

> *The OJT [NRP] gets the best out of you; it released a different person inside me. I feel I have improved… in my skills, my self-trust… - NQN13*

However, the lack of clarity and the variation in how the programme was applied from one unit to another gave rise to a negative impression about the residency programme amongst NQNs. They doubted the necessity of the programme and its role in assisting them to adapt to their new role and working environment.

> *I did my internship here, and almost know everything… It [NRP] is just extra work with no benefit. - NQN3*
>
> *I don't think there is any benefit from attending the residency… There is no difference between other staff and myself… I think I would have developed my skills anyway… The residency hasn't affected my skills. - NQN8*

The 12-month internship embedded in the undergraduate nursing curriculum in Saudi and the residency programme were thought to serve similar purposes. As explained in Chapter 1, the

nursing undergraduate curriculum in Saudi includes a compulsory one-year internship prior to qualification.

> *I'm not thinking much about the residency because I think I don't need it… Why do we have to repeat the internship? It is boring… - NQN2*
>
> *Internship and residency are almost identical… can't see any difference, we work under supervision and we rotate…. it's like if the hospital doesn't trust the quality of our internship, so they ask us to do it again! - NQN11*

Other NQNs questioned the added value of the residency and thought it was no different from ordinary orientation programmes.

> *The programme is similar to other orientation programmes in different hospitals… It cannot be a year-long…. It would be a second internship (laughs)….. I think the first three months were enough. - NQN4*
>
> *I think the residency is similar to any orientation programme… There is no difference…. There is nothing special for us as residents. - NQN5*

In line with these thoughts about the length of the NRP, some experienced nurses agreed that NQNs needed roughly three months to be safely allowed to work independently. They also agreed on the shared similarities between the internship and the NRP and suggested combining them into one programme.

> *Most new nurses would need between three to four months to start working alone... Some may even need less than that. - HN01*
>
> *I think one month is enough for new graduates – and two weeks for those with previous experience… New graduates can ask for longer if needed… - P01*
>
> *So, for me, there's no difference. they [internship & NRP] can be made into one… if possible... the internship is normally not prepared well and does not match what the hospital needs. So, I think there should meetings between the hospital and the university to develop a better programme for interns. - CRN02*

The constraints within the NRP programme were also a major source of stress for participant residents. Some NQNs felt "handcuffed" due to a lack of autonomy and were upset that their area of interest had not been taken into consideration.

> *We did absolutely nothing but observe. I was handcuffed… I see residency as an obstacle, repetitive, boring, and holding us back. - NQN2*

> *They told me that ER is not included in the residency; I was upset… I wasn't happy: I was upset because I was asked to work in [unit], which I don't like. I felt I was forced to work. - NQN10*

The feelings that the residency programme was not helpful led many NQNs to ask to cease their preceptorship and begin independent practice. This required them to persevere by putting an extra effort to self-educate and improve their knowledge and skills to prove their readiness for independent practice.

- Escaping the cage: striving for independent practice

Many NQNs talked about the exciting moment of "having their own patients". However, according to the residency programme, NQNs were not allowed to take a caseload until they had completed the first three months. This requirement was seen as a constraint by some NQNs, especially those who thought they had sufficient training and felt ready for independent practice.

> *I don't think I need her [preceptor] anymore! If I need help, I would just ask my neighbour [colleague]... I feel like I want to start working as staff and be more serious… I think those who absorbed their training very well during the internship won't struggle to adjust to their new work… but the problem is that they [management] don't trust us. - NQN2*

According the programme manual, NQNs are only able to have their own patients after successfully completing the first three months. However, the impression that the residency programme was pointless and did not offer a significant support drove some NQNs to ask for independence from their preceptee-preceptor relationship.

I requested to work alone… I didn't feel it [having a preceptor] was helping me... So, there was no reason to stay with him [preceptor]… I felt I wanted some freedom and to do the work the way I like it to be done. - NQN8

My preceptorship was boring and a waste of time; I wanted to have my own patients and become independent. - NQN14

Other NQNs thought working with a preceptor implied some restrictions on their professional autonomy. This relationship was perceived as a hindrance to professional growth and autonomy; therefore, NQNs saw gaining permission to work independently as a victory.

I felt a bit constrained with my preceptor. Starting to work alone was like a bird escaping from a cage… I think I was ready and confident to work without a preceptor: I couldn't wait… I was excited to have my own patients. - NQN10

Self-reliance was taken as a personal challenge by some NQNs. They persevered in their attempts to complete their work independently and delayed asking for support to the very end – until it was really needed. The preference for self-reliance and avoidance of seeking help from others could reflect NQNs' perseverance and strive for autonomy, but it could also mean they did not find the support they needed.

Another personal challenge is completing my tasks by myself and on time, without asking for help… I always try to do everything by myself. - NQN3

I try my best before asking someone for help. It is kind of challenging myself… I always think of it as "What would I do if I were alone on a night shift?" ... - NQN5

The exciting moment of starting to work as a professional nurse was delayed by the requirement to complete the NRP, when NQNs were not allowed to have their own patients, especially during the first three months. Many NQNs felt they had no need for a preceptor, particularly those who thought they had already had sufficient training. Therefore, they were striving to end their preceptee-preceptor relationship and start to work independently. Furthermore, those NQNs who had trained in the same setting and had established some networks of friends felt that they

were already familiar with and had adapted to the work environment; thus, a preceptor's support was not needed.

In follow-up interviews with some key informants, they reported that the residency (NRP) was cancelled for the following year (2020/2021) for major revision. The feedback on the first version of the programme was largely negative and showed dissatisfaction on the part of most of the stakeholders (nurses, preceptors and CRNs). This corroborates the reports in this study.

> *I think the residency, last year, didn't meet the expectations of the top management… They appointed a new leader for the programme for improvement… - CRN02*
>
> *The new NRP is still under development… but my main points are proper orientation of the programme; educate the educators; reduce it to six months instead of twelve months… Experienced nurses are often busy and if supporting new nurses is not officially introduced and regularly monitored, there will be poor compliance… Supporting new nurses should not be left to their [senior nurses'] discretion, it should be a requirement… - M02*

From the transcripts, it was clear that the majority of NQNs criticised the unsatisfactory or inadequate support provided via the residency programme, questioning its worth. Many NQNs described the programme as unnecessary, unhelpful and "handcuffing" them – holding them back from progression as independent professional nurses. They attempted to persevere in the face of these challenges by self-educating and avoiding clashes with unsupportive managers. Furthermore, NQNs reported that they had to deal with other challenges at work. These will be detailed in the next section.

6.3 NQN's issues with organisation

- Heavy workload

As discussed earlier, some NQNs wished for more CPD opportunities to excel professionally. However, this suggestion clashed with their position in that NQNs always had their hands full:

they reported that they were always busy. Many NQNs felt that "keeping up to date" was a challenge due to the heavy workload and lack of spare time.

> *On top of our full schedules, we have to keep ourselves updated with the new tech systems… Now they are digitising all the forms; no more papers. So yeah, learning to work on these systems is another pain… - NQN1*
>
> *When I started the residency, I was always thinking about taking specialised advanced courses. But now, I just want to finish my duty and go home; it's too much. - NQN3*
>
> *Every day is a challenge. I continuously try to learn new skills, new information. keeping myself up to date is a daily challenge… No-one asks us to be updated, but it's a personal thing, I feel I need to update myself all the time… - NQN5*

The level of workload seemed to be an issue for many NQNs, particularly those working in critical care areas. The amount of work and pressure was perceived as overwhelming and did not allow them "a minute to breathe".

> *The workload here is huge and doesn't give you a minute to breathe. We, as Arabic speakers, have an extra work, which is interpretation… Sometimes I have to skip my break to help patients or friends [colleagues] with translation. - NQN3*
>
> *Here, in [unit], we are always under pressure, always running to get things done… Too many things to handle… I feel bad for myself because of the pressure… I arrive home shattered… I think I have changed: I've become more touchy… I get easily irritated…- NQN5*
>
> *Since I came here, eight months ago, ten nurses have left us and that has made the situation even worse…. More workload on us, less off-days, and shorter holidays." - NQN1*

In addition to the regular workload, NQNs explained how the residency programme added more work for them, including passing certain competencies and presenting patient cases. This additional requirement, according to NQN4, "adds fuel to the fire".

> *Period 2 (4th to 6th month) requirements:*
>
> *1. Complete at least 2 Case Studies (form H).*

2. Present at least 2 in-service educations (form I).

3. Complete the specific competencies according to the area of specialty. NRP-doc, p.6

The patient-related workload, which they saw as heavy, and the NRP requirements drove some NQNs to forgo opportunities for professional development. NQNs' hefty schedules were thought to allow little time for self- or professional development.

With our current workload, we can't leave our patients to attend the in-service education. It's annoying because we want to develop our skills but we don't have enough staff to cover. - NQN5

Not all head nurses would allow us to go to in-service… It depends on the workload on that day… and it's always busy… I have twice requested to attend seminars, but it was rejected and the reason is "no staff to cover me" … - NQN7

It is really difficult to think about self-development with these working hours and pressure. - NQN10

Permission to attend on-going professional courses is normally left to the managers' (head nurses') discretion. The difficulty of gaining leave from a head nurse to go on an educational course was explicitly stated by one of the participants.

We need to kiss their hands [beg them] to let us go. - NQN11

A few head nurses were interviewed and they spoke about the dilemma between maintaining their unit's workflow and staff development. They admitted that, due to high workload and shortage of staff, staff leave for educational purposes is sometimes declined. Moreover, they expressed a concern that applying for leave to attend educational courses was not always for a good reason – just an excuse to escape work; the bedside nursing that NQNs seem to want to escape from.

Staff shortage is our current main problem because the number of admissions is increasing every month. Two years ago, our average number of patients was five or six; today it is ten, in addition to the waiting list. We cannot admit more

cases because we don't have enough staff… I don't mind sending one or two for education, but patients first. - HN01

Some nurses take the seminars as an excuse to skip work and take a break… It's true… So, I only send those who are serious about learning. We normally have a shortage of nurses; how can I send them on 2- or 3-day courses? Who would cover? - HN06

The NQNs and head nurses interviewed agreed on the necessity of CPD courses to keep nurses up to date with the latest evidence-based practices. However, the current shortage of nurses was often blamed for allowing very limited opportunities for educational leave. In an attempt to deal with the issue of nurse shortages, 12-hour shift patterns were recently introduced by the nursing office. This, however, was perceived as exacerbating work stress by most NQNs. NQNs and key informants' perceptions and experiences of the 12-hour shifts will be discussed next.

- Shift patterns

Traditionally, nurses in Saudi work 48 hours a week, between 8 to 10 hours a day, with pro rata days off, plus an annual holiday entitlement of 35 days. The pattern of work can be manipulated to the style that best suited the unit or organisation. In this study, interviews with experienced nurses revealed that the nursing office undertook a poll about changing the working hours, in some units, to 12-hour shifts to cover shortages of nurses in some units.

There was a vote… and the majority of nurses chose the 12-hour shifts. I think it's better than the older system… It's easier to manage and good to cover some of the gaps in some departments, especially during the holiday season - CRN01

It [12-hour shifts] was introduced as a temporary solution to the current shortage of nurses... I know some nurses are complaining about it, but I hope the hospital bring more nurses… - HN02

The new system is 3 days' work then 2 days off, or 4 days' work then 3 days off… the head nurse can decide the best for their department- P01

A few of those who had been affected by the new system appeared to be in favour of the new shift pattern. They felt the 12-hour shifts were more suitable, less stressful and entailed longer

off-days. The new system seemed more flexible, depending on a unit's number of nurses and workload, as some participants reported working 3 days of 12-hour shifts then 2 days off, while others worked 4 days of 12-hour shifts then 3 days off.

> *I work 12 hours a day, 3 days' work then 2 days' break. It is good... I like it. Some of my friends find it difficult, but I don't. - NQN8*
>
> *I don't mind working an extra three hours [12-hour instead of traditional 9-hour shifts], as long as I don't work for five days in a row… Five days is too much... I do 4 days, then 3 days off… the 3 days off feels like a long weekend - NQN6*

Although a few participants seemed to enjoy the 12-hour shift pattern, the majority of NQNs (about 70%) who worked 12-hour shifts thought it caused difficulties with their social lives outside work. These NQNs complained of how the new shift pattern impacted on their social lives by isolating them from their normal social interactions.

> *The working hours here are really long… I had to skip our daily family afternoon coffee… Most of my meals are at the hospital… I have stopped seeing my family as much… - NQN2*
>
> *Outside the hospital, I've become lazy and more dependent. Thank God, I'm still living with mum… She does all the housework... Honestly, the working hours here took me away from my family and friends – NQN12*

The 12-hour shift pattern was implemented to help compensate for and mitigate the continual loss of nurses, as described earlier. However, this strategy was felt to increase work stress of remaining nurses, triggering them to seek to different positions that require a better working hours.

> *The only thing that is killing me is the long shifts. 12 hours is so tiring…. I'm thinking of leaving the hospital… At [name] or [name] hospitals, they do normal 5 days' work then 2 days off... 8-9 hours a day. - NQN1*
>
> *I think they are making it very difficult for staff to remain in the department…. Very difficult to stay in [unit], unless they change the shift hours…. - NQN3*
>
> *The only problem is the working hours... I think many nurses leave us because of that… If they don't change it, I'm going to move to Endoscopy [regular 8am – 4pm working hours]. - NQN5*

The NQNs' family commitments outside work were the main reasons for the 12-hour shift pattern being perceived as unsuitable. NQNs explained that they found it difficult to reconcile life and work responsibilities while working 12-hour shifts. Therefore, they showed intentions to move to somewhere else with better working shifts.

> *Some nurses left us because they couldn't balance family and work tasks…Those who are married or have children cannot cope. - NQN9*
>
> *12-hour shifts cannot fit in nicely with family and social life. They aren't ideal, especially for married nurses… If I were married, I would be divorced from the second week… (laughs). - NQN14*

Other NQNs thought that this pattern of working hours would be suitable for those who had fewer social commitments outside work, e.g. singles or expatriates.

> *12 hours' duty doesn't suit us [nationals]; it suits foreigners because most of them live in the hospital housing and are alone… Their family and kids are in their home country. So, they don't have much to do when they finish work… - NQN15*
>
> *I think those who don't have children and family to care for are okay with the 12-hour duties. - NQN10*

For a follow-up, six expatriate nurses were interviewed and none of them complained about the 12-hour shifts, suggesting that they were more willing to accept that shift pattern. For some staff, it was seen as beneficial as they could accumulate more days' leave in order to have a longer annual holiday.

> *My life is 12 hours' work and 12 sleep, nothing more… sometimes I stay at work after finishing my duty because I have nothing to do at home. When I go to my flat, I Skype my kids in [home country] and then go to bed… CRN03*
>
> *The new system [12-hour shifts] allows us to work more… instead of 48 hours [per week], I can work 60 hours [per week] … I also work extra days, and sometime don't take my days off …I keep them until the end of the year… I can have 50-60 days' holiday instead of [traditional] 35 days... or I can ask for extra pay… Almost all non-Saudis do the same thing… - P04*

The 12-hour shift schedules were introduced by the nursing management team to maintain the workflow while there was a shortage of nurses. It seemed to suit the majority of expatriate nurses and a few nationals, which could be linked to these participants having relatively fewer commitments and responsibilities outside work. However, this pattern of work seemed to increase other nurses' dissatisfaction with work. This particularly affected nationals as they tended to have more social commitments outside work. Thus, they attempted to move to different wards with more family-friendly working time in order to keep their jobs. The diversity of the workforce and how it is experienced by NQNs and other stakeholders will be explored next.

- Perceived cliquish behaviour

As explained in Chapter 1, the Saudi health system has been and remains largely dependent on expatriate nurses from different parts of the world. These nurses come from various cultures and backgrounds and speak different languages. This diversity of nationalities in the healthcare workforce was perceived by some NQNs as contributing to a cultural problem whereby nurses tended to group together with others from a similar background or country.

> *There is a bit of a nationality issue here; Filipino nurses prefer working with a Filipino charge nurse. Indians prefer Indians, etc… We [nationals] are a minority… (laugh)… Seriously, in each department, there are like five Saudis and 50 or 60 foreigners… - NQN13*

The NQNs, being fresh graduates, with almost no professional experience, were spread out among the wards. The rationale for this strategy was to ensure the safety of both patients and nurses.

> *We don't want to put many new nurses with almost zero clinical experience in one unit… It'd be a disaster for patients and for the whole team… We try to send new nurses to different units. - HN02*

However, this strategy of distribution of NQNs made them feel isolated from their peers. Moreover, the rationale for this strategy was interpreted differently by some NQNs, who felt that it was motivated by discriminatory attitudes to national nurses.

> *My request to work at [unit] was rejected, and the reason was that there were too many local nurses on that ward; I was shocked… The admins are non-Saudis and have a perception that we should "not put many Saudi nurses on one ward". - NQN12*

> *There is a wrong impression here that no Saudi nurses work hard, and none are serious in learning and improving their skills… That's wrong… No matter how hard I work, they all have that view… - NQN16*

Other NQNs blamed the current nursing management staff for nurturing this perceived behaviour in their workplace. They felt that the nursing office favoured a certain nationality, and discriminated against others. On the other hand, an experienced nurse considered it to be more of a cultural problem rather than explicit racial discrimination. However, the same participant (CRN01) was quoted earlier (in *Economic incentives* - Chapter Five) complaining about pay discrimination – they reported that nurses receive different pay rates based on their nationality.

> *Let's be honest, the [nationality] control everything here. Look at the nursing office and look at the management positions in all the wards... and you will understand what I mean… Most head nurses and CRNs are [nationality]… and some of them have only two- or three-years' experience... - NQN12*

> *Our head nurse doesn't like Saudi nurses. She is, Saraha [literally], pushing me to move to somewhere else. There were three Saudi nurses in our ward, two have left, and now it's only me… The issue of Saudi/non-Saudi is only within our ward. I don't think other wards have the same problem… - NQN14*

> *I don't think there is a nationality conflict… It's a preference… Everyone has a preferred working team… Maybe they [each nationality] prefer to work together so they can use their own language to communicate, instead of English… It may be easier for them… - CRN01*

Comparing NQNs' and expatriate nurses' relationships with their managers, expatriates reported more positive experiences. The different experiences of the two groups could be related to the NQNs' anxiety about and unfamiliarity with the workplace and new colleagues, reported earlier

in 6.1, *Performance concerns*. Moreover, the difference could also be related to the expatriates possibly having concerns over job security, and thus being unwilling [or afraid] to talk negatively about the management team. This issue will be examined further in the *Discussion*, Chapter 7.

> *My head [of department] was [name], he supported me a lot, and Mr. [name], he really supported me. [Name], our director, also supported me. I will never forget my head nurse, he helped me a lot. - CRN01*
>
> *Ms. [name] is my best friend. She is there [points at her]. When I arrived here, I didn't know much and she was the head nurse and she helped throughout… She talked to the administration and supported me to get the preceptor promotion… - P01*

The perceived issue of unequal treatment of employees in the workplace had left some NQNs considering a move to another unit or organisation. In a follow-up interview, one of the NQNs who had left the hospital cited racial discrimination as one of their top reasons for leaving.

> *Discrimination in this hospital is so high, it is unbelievable; we can't focus on work… It's the main reason to think about leaving this hospital. - NQN16*
>
> *To be honest, the dominance of [nationality] there is so upsetting. It's probably my second reason for leaving [hospital]… But I didn't write that… In the transfer request, I wrote "family reasons" to support my request… Otherwise it'd get rejected… - NQN19*

Cliques at work were seen by NQNs as an issue for them. Some NQNs had experienced what they described as cliquish behaviour. They described these experiences as disappointing and considered them to be a valid reason to leave their current employer. These participants felt that promotions to higher positions were largely influenced by nationality, reporting their belief that most of the nursing managerial positions were controlled by one particular nationality. Therefore, moving to different nursing jobs with better working conditions was used by some NQNs as a strategy to persist in nursing. However, some head nurses cited Saudi nurses relative lack of experience as a reason for their patterns of deployment. In the next section the hierarchical structure of the hospital and its influence on the relationships between nurses and other professionals will be discussed.

- Concerns with professional status

As explained in the *Background* chapter, there are two main undergraduate nursing qualifications in the Saudi higher education system: diploma (two years) and bachelor (five years). Nurses with diploma certification are hired as Nurse Technicians, while BSN holders are hired on a Nurse Specialist grade.

> *If you hold a bachelor degree you will be on a specialist nurse grade, and if you hold a diploma, you will be on a technician grade… I think there isn't much difference between us... Our salaries are a bit more than the technicians'… On the ward, we are all the same…. - NQN2*

Although the two grades (Specialist and Technician) differed officially, in some clinical responsibilities and associated work, but in practice there appeared to be no clear distinction. This mixing of roles and responsibilities was annoying for some NQNs, as they were trying to disassociate themselves from some basic patient care responsibilities, such as cleaning patients, which are associated with the Nurse Technician's [assistant's] role.

> *I have tried to explain to the head nurses about the different roles that technicians and specialists ought to do, but nobody cares. There is a difference… things like bed making and bathing should be the tech's responsibility… I always delegate these tasks to them [nurse assistants] - NQN10*

> *I don't like doing the housekeeping things, like cleaning or feeding patients… normally I pass it to the assistant [nurse]. - NQN16*

> *Some new nurses avoid things like patient positioning and changing diapers – saying that these tasks are the [nurse] technician's responsibilities... They [NQNs] might be right, but we don't have many technicians here, so we have to do everything by ourselves. - HN01*

> *Yes, the job description of the nurse technicians' states that they should assist the specialist [BSN] nurse in the basic patient care, like feeding and positioning… but in practice, we only have very few technicians, there is none in some departments, so nurses have to do the job… - M02*

From the narratives, Some NQNs thought that there was a difference in terms of what nurses are expected to do, i.e. their job description, and what happens in practice, i.e. what nurses actually do, which they found annoying, and caused a conflict between them and their managers. Where nurses work (the work unit) was also thought to influence the professional status of nurses. According to NQN9, nurses in critical areas are more trusted and respected than other nurses.

> *ICU nurses are more respected than other nurses. ICU doctors usually discuss patients' care plans with nurses, and consider their views… unlike here in [unit]. - NQN9*

Some NQNs also felt annoyed about the accountability and blame in their work culture. These participants felt there was a higher probability of being held accountable for any mistake that might happen in their unit, compared to physicians.

> *Doctors are always protected; it is always the nurse's mistake… Nurses in other units are blamed for any mistake. We need to change that culture. - NQN9*
>
> *I think some doctors feel insulted when corrected by a nurse… When I spot a mistake in the order, I always report to the head nurse just to be safe... I just try to avoid them [physicians] - NQN14*
>
> *In practice, nurses are always blamed and shouted at... Even if the doctor's order is obviously wrong, we cannot confront it… We have to go to the head nurses and explain everything, then she would talk to the doctor… Maybe because we're new staff, they don't trust us… - NQN16*

In terms of relationships with physicians, a few NQNs found dealing with physicians or communicating with them was "stressful".

> *The doctors' behaviours are a major problem for me… I try to avoid interactions with them… - NQN4*
>
> *Dealing with doctors is so stressful; they want us to be their secretaries and finish all their paperwork… - NQN16*

The lack of clarity over their roles and responsibilities in practice made NQNs feel dissatisfied. Moreover, feeling they lacked protection in the workplace increased their hesitancy to engage in

discussing medical decisions with physicians. They felt their status as "new employees" contributed to the lack of trust from physicians, which is understandable based on the NQNs' perceived level of competence and confidence, reported earlier in this chapter, *6.1 Performance concerns*. Again, NQNs tended to use avoidance as a strategy to persevere in the face of challenges associated with dealing with unfriendly co-workers.

6.4 Persevering

As discussed earlier, some NQNs began their jobs with little confidence and some uncertainty about their readiness to work as independent registered nurses. However, within a few weeks, according to NQNs, they felt they were able to improve in terms of their nursing knowledge and skills, and also confidence. Experiencing self-development seemed to increase NQNs' self-efficacy and stimulated their enthusiasm for further achievements.

> *The first ten shifts were quite difficult… but after reading all the unit procedures I became more confident on what to do… I feel successful and proud that I'm in my first year and caring for very serious cases…. I feel proud and satisfied that I'm saving someone's life… It is like a booster for the coming days… - NQN1*
>
> *It [nursing skills] developed day by day… I became better at managing my time and getting all my tasks done on time… My second-month evaluation was way better than the first month… I'm enthusiastic about my job and trying to develop and learn new things every day… - NQN2*

Some NQNs had begun to see their professional growth even prior to qualification, and these NQNs linked their development to the quality of the training they had received, which made them more committed to succeeding.

> *Training in ICU made us more confident when dealing with emergency cases… When we graduated, we were confident in almost everything… I find working in critical areas is more enjoyable because we are constantly learning new things… I would like to be a good role model for future ICU nurses… - NQN5*
>
> *My internship at [hospital] opened my eyes to many available opportunities… I'm excited, full of energy and looking forward to learning more… I want to*

improve myself, see new procedures, deal with different cases, and machines… - NQN7

Proving themselves to others was also considered a worry for some NQNs who felt they struggled with a lack of trust from their colleagues and patients. These NQNs thought it was difficult to establish trusting relationships when they were introduced as "NQNs", as NQNs are often assumed to be less competent. However, advancing their nursing knowledge and skills, being willing to take on more responsibilities, cooperate with others to cover unexpected shortages of staff and bonding with patients and their families seemed to help NQNs to persevere in the face of these challenges.

Everyone thinks, "Oh, you are new and cannot do [take care of] three patients." But I proved them wrong: yes, I can… Now, I'm better. I've even become the IT expert on our ward! (laughs) … Other nurses ask me if they have any problem with the new system [electronic patient records] … - NQN2

I was called couple of time during my off-days to cover my friends [colleagues] and I just could not say no, because they all have been really nice with me. We back each other and solve any problem within the unit… NQN6

Spending some time with patients and allowing them to speak freely strengthens staff-patient relationships... Even patients' families will have more confidence in you… My friends [colleagues] were surprised how I get along with patients and their relatives… maybe they [patients] feel more comfortable to speak to me because we speak the same language [Arabic] and understand our culture. - NQN8

Some NQNs used avoidance and minimised interactions to deal with unsupportive co-workers. Others felt the need to separate from their preceptors and start working independently in order to improve their confidence and stimulate professional growth. They thought they had the right qualities to function as independent nurses but needed empirical evidence to improve their self-esteem and to prove themselves to themselves.

When I began working by myself, I became more confident as a responsible nurse, and became better at knowing my roles and responsibilities… I, personally, have changed and become better at communication… how to talk to patients and how to ask for help… - NQN9

The above quotations show these NQNs' attempts to persevere in the face of some work-related challenges, such as distrust from patients and other nurses. At the time of the interviews, 3 to 6 months into the job, most NQNs felt they had settled into their jobs, had found their feet in the new working team and were focusing on improving their working conditions and achieving their career aspirations. This is explored in the next section.

6.5 Improving working conditions

As mentioned earlier, shift patterns seemed to be one of the working conditions that many NQNs were struggling most to adapt to. They felt it was difficult to reconcile their work with other personal and family commitments. This difficulty was considered a major reason to think about changing jobs, as discussed earlier in *Shift patterns*. Those who liked their jobs but found the 12-hour shift pattern unbearable intended to leave their current workplace for one with better working schedules.

> *Twelve hours [shift] is so tiring…. I'm thinking of leaving the hospital… My friends at [primary healthcare centre] do nine hours a day and take regular weekends [Friday and Saturday]. - NQN1*

> *If they don't change it [12-hour shift pattern in current unit], I'm going to move to Endoscopy: they work normal hours [9 hours a day, 5 days a week] … - NQN5*

To resolve the issue of long working hours, an NQN explained, one of the motives for seeking a higher position was to avoid the 12-hour shifts associated with clinical or bedside nursing. Having a regular weekend was also seen as one of the advantages of moving to a management position.

> *I'd love to work in the nursing office or become a head nurse… At least I'd be working mornings only and wouldn't be asked to work on Fridays and Saturdays… - NQN14*

Other NQNs thought that moving jobs would allow them to explore "what is out there" and enrich their professional experience. These NQNs thought satisfaction with one's current job was not incompatible with requesting a transfer to another job.

> *Working in different places gives you a broader picture of nursing and healthcare systems. I'm sure the system here at [hospital] is totally different from King Faisal or the Military hospital… If I find a chance there… why not? A new adventure to see what is out there. - NQN15*

NQN attrition is often associated with professional development plans such as postgraduate study, a head nurse said. They explained that NQNs would normally leave temporarily for further studies and return when they were completed.

> *I've been here for six years. Mostly, those who leave us leave for diplomas or postgraduate studies… We have two staff who left for a one-year diploma and returned last month to [unit]… - HN04*
>
> *Two of my nurses left to Australia to get their Masters in oncology. I'm still in touch with them; I think they will come back in 3-4 months. – HN05*

To improve their working conditions, some NQNs had plans – more than just intentions – to leave their current bedside nursing jobs. The work pressure and lack of professional development opportunities were some of the primary reasons they gave for leaving bedside nursing.

> *I found a diploma in OR [Operating Room] in [city] and applied but still haven't received the approval. It sounds promising… I will be specialising in the department that I love [OR] and I will get a higher grade… If I get accepted, I would resign from here… I'm not saying it's bad here, but I think the new job would be even better. - NQN7*
>
> *Everyone tries to get a job here because of its excellent reputation and high standards… but to be fair, if I find another job that will improve my skills and give me a better promotion, I would leave here… I'm like a footballer seeking better contracts. - NQN12*
>
> *If I stay at the bedside, I would burn myself out…. I will not continue at the bedside… I don't think I will stay at the bedside for that long [not 5 years] … - NQN14*

Unlike those who embraced their nursing career but were seeking better opportunities, many NQNs felt that nursing was not for them, particularly the bedside nurse role. They were planning to undertake further education which ultimately would help them find jobs away from the patient bedside.

> *If I got a good chance to leave nursing, I wouldn't think twice. I'm thinking of leaving the hospital either for a masters or to find another job. I mean, I don't accept the idea that I'm going to be a nurse for the rest of my life... - NQN1*
>
> *I'm not going to continue in nursing… I might even leave the profession altogether. I'm always thinking of finding a way out of nursing… maybe masters in health informatics is a nice one… - NQN4*

Other NQNs expressed their discomfort with the regular mixing with the other gender at workplace, which is culturally unfavourable by many in Saudi. Therefore, they were intending to move to single-sex wards to minimise interactions with patients and professionals from the opposite gender.

> *I wish I could go [move] to a primary healthcare centre or OPD because there are separate sections for males and females. - NQN3*
>
> *It's almost impossible these days to find a female-only workplace, but at least we can reduce the gender mixing by working in… for example, OB wards or female medical ward. - NQN10*

Many NQNs felt dissatisfied with their work due to associated work pressure, shift patterns or the regular mixing with the other gender at workplace. These NQNs attempted to persevere in the face of these difficulties by improving their work conditions through moving jobs within nursing or seeking higher positions that they believed involve lighter workload.

6.6 Summary

This chapter has explored the challenges NQNs face and their attempts to persevere during the transition period. It also reported on the perceived varied level of support provided to NQNs and

how it influenced their attitudes to their work. Many NQNs felt unhappy with their current role and some had already developed plans to move jobs, seeking better working conditions. Putting extra effort to meet work needs, taking on more responsibilities, building a good reputation and avoiding clashes with unsupportive co-workers were some of the strategies NQNs followed to deal with their work-related challenges. Moreover, they were attempting to delegate unwanted tasks, and minimise interactions with the other gender for social/cultural reasons.

The three findings chapters, *Acquiescence, Reconciling* and *Perseverance,* explored the NQNs' experiences of becoming a nurse, their reaction to their "chosen" career and how they attempted to reconcile the conflicting views of nursing as a career. They also reflected on the challenges NQNs face, the effect those challenges have on NQNs' work experience, and the strategies NQNs tended to use to persevere and overcome these challenges. In the next chapter, the *Discussion*, I will integrate the findings presented in these three chapters in order to conceptually explain the NQNs' transition process and how they were continuously attempting to resolve the aforementioned issues.

Chapter Seven: Discussion

The previous three chapters presented the theory of *Forward Escaping* and its subsidiary categories of acquiescence (Chapter Four), reconciling (Chapter Five) and perseverance (Chapter Six), and how they reflect the patterns of behaviour in which newly qualified nurses (NQNs) continuously engage to try to resolve their main concern: the perceived threat to their status associated with what I have termed the "bedside nurse role". The three subsidiary categories conceptualise the processes of adaptation which NQNs go through to remain in nursing: acquiescence begins during the period of "getting into nursing", reconciling occurs while "becoming a nurse", i.e. studying and practising nursing, while perseverance reflects persistence in the face of perceived challenges at work and the active search for career advancement opportunities "surviving nursing". It is worth mentioning that these three subsidiary categories do not necessarily occur in linear process, but can overlap with one another. Figure 10 provides an illustration of the three stages.

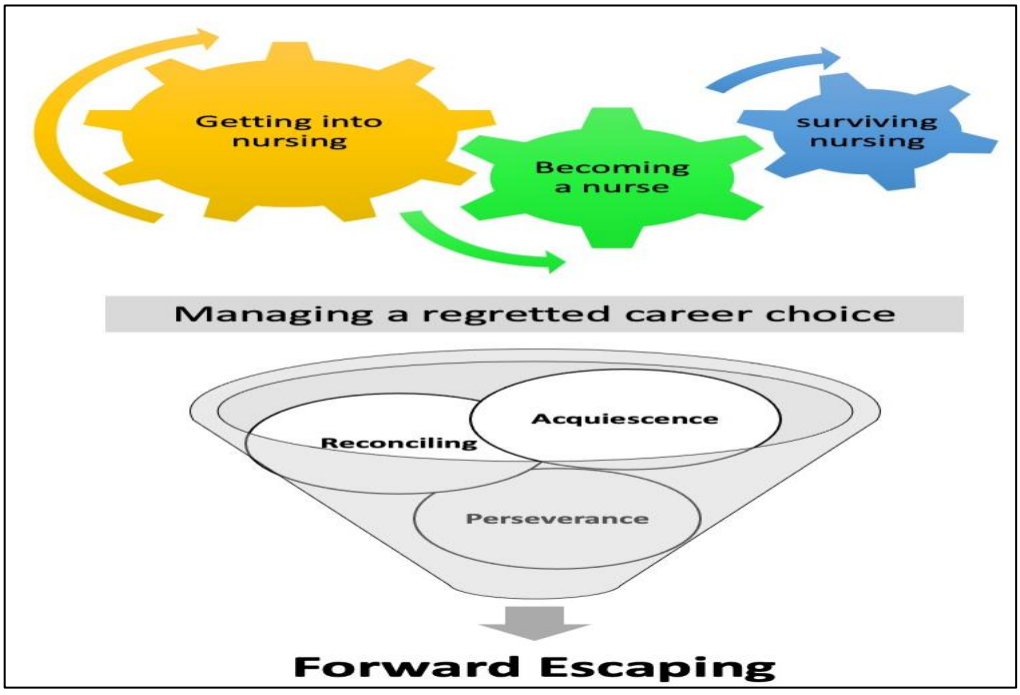


Figure 10: The transition experience to becoming a nurse: time continuum

The size of the cogs reflects the size of a cohort (student nurses).

The emergent theory and some of its related concepts corroborate Glaser's (1998) suggestion that a literature review prior to data collection may bring up some concepts that are of little importance to the substantive area. The literature that I reviewed in Chapter 2 of this thesis focused primarily on issues (notably, Transition Shock) that later turned out to be of minor importance to the NQNs who participated in this study. In grounded theory, a review of literature serves to integrate the emergent theory into the existing literature and modify it if appropriate (Glaser, 1998). In this chapter I discuss my generated theory of *Forward Escaping*, along with its subsidiary categories, with reference to the scoping review I conducted in Chapter 2 and a secondary (post-research) review of the literature. The subsidiary categories are presented in the same order as the findings chapters, to make it easier for the reader.

In regard to "acquiescence", the literature examining the motivations for choosing a profession, how it is perceived and commitment to the profession is discussed. The findings of this study suggest that the job content (i.e the job itself) is a major influential factor in how a job is perceived and the career decision-making process is influenced by social comparison. I attempt to place this into the context of the literature, discussing the concept of "dirty" work and theory of social comparison. In relation to "reconciling", the general literature surrounding workers' attempts to reconcile competing factors, such as their own aspirations versus social expectations is discussed. Although personal aspirations are normally shaped by social expectations, there can still be tensions between an individual's own aspirations and what their local community expects from them. The community that individuals belong to appears to be an influential factor in the process of career decision-making. Some people may focus only on personal interests; others comply with the expectations of significant individuals (e.g. parents) or seek equilibrium between social or family expectations and their own aspirations. In the third subsidiary category, "perseverance", NQNs engage in different strategies to manage what they perceive as negative working conditions, e.g. shift patterns. I try to situate this issue in the context of the literature dealing with factors affecting job attitudes, particularly in relation to two well-known theories: Herzberg's two-factor theory and the job demand control (JDC) model.

The emergent theory from this study explains that the main concern that NQNs express about their transition to nursing practice relates to accepting their roles as bedside nurses, particularly what they perceive as the "menial/dirty" tasks associated with this role. NQNs manage this concern through a three-stage process. Through acquiescence, they temporarily and conditionally accept their roles at the patient bedside. NQNs attempt to reconcile work demands, personal aspirations and social expectations, while developing a long-term plan to move to a role that requires less direct patient care or none. Finally, to legitimise their applications to "escape" to what they perceive to be better roles, NQNs persevere with the social and work pressures, while concurrently seeking opportunities for postgraduate studies or continuing professional development (CPD) courses. The whole process of *Forward Escaping* generally depends on both aspirations and persistence, together with the availability of opportunities for career advancement. This latter factor was perceived as influential in the decision to remain in or leave nursing. Higher career aspirations and opportunities for career progression act as pull factors encouraging NQNs to persist and stay in the job, while their absence acts as a push factor catalysing intentions to change job or even leave nursing altogether. Weighing up the pros and cons of remaining in the job characterises each step.

Following the emergence of the main concern of the participants, I revisited the literature using the same databases that I had used previously, which were CINAHL (the Cumulative Index to Nursing and Allied Health Literature), BNI (The British Nursing Index), PubMed, ERIC and PsycINFO. However, this time I used different key words, such as "ambivalence", "career choice" and "motivation", and some phrases, e.g., "attitudes to bedside nursing", "attrition of nurses", "role of women in workplace" in Saudi and similar contexts. This search generated different concepts to be integrated into the emerging theory in this study, which added more dimensions to the subsidiary categories already developed.

7.1 Getting into nursing: acquiescence

Acquiescence is a subsidiary category of the theory which emerged from this study. It was generated based on three categories, which were the limited spectrum of available career choices, ambivalence and commitment. Figure 11 summarises this category.

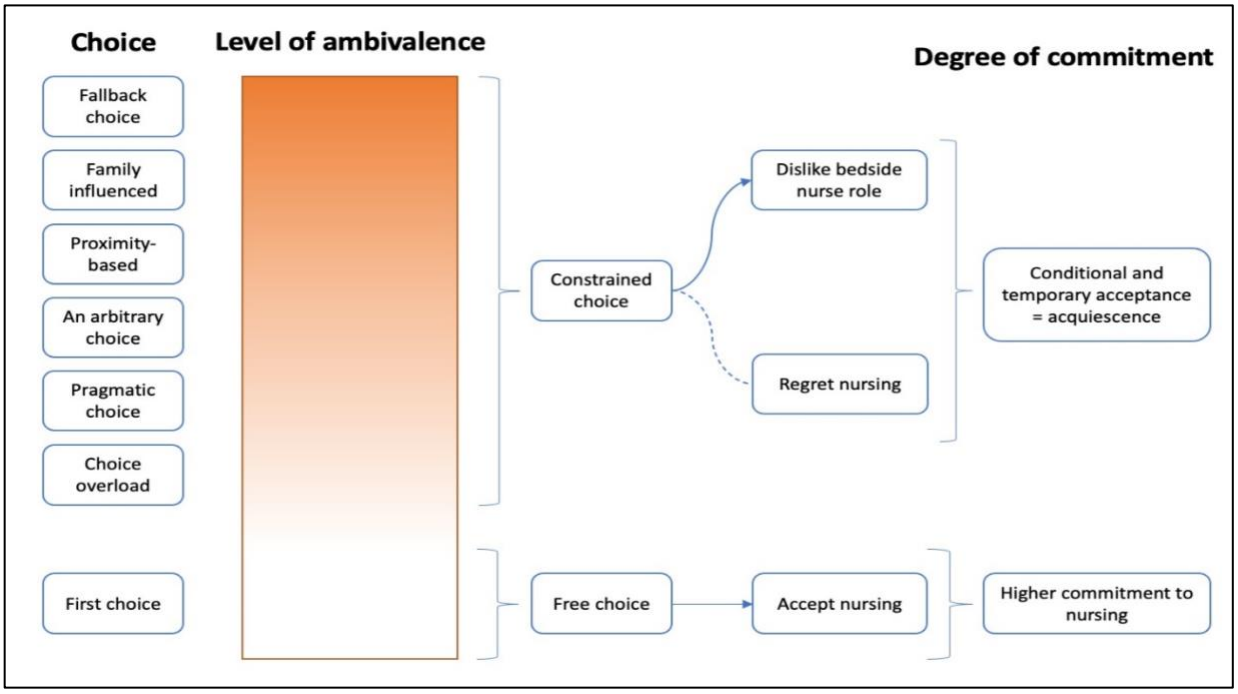


Figure 11: Acquiescence

(Full lines suggest stronger association between categories. Dotted lines suggest weaker association between categories).

The figure shows that NQNs who felt their career decision was a constrained choice were more likely to struggle with a higher level of ambivalence and lower degree of commitment to the profession. In contrast, the very small number of NQNs who expressed that their career choice was their top preference seemed to have a lower level of ambivalence and were more likely to accept their career choice and show a higher degree of commitment to the profession.

The vast majority of newly qualified nurses (NQNs) reported that nursing was not their preferred field of study. Following their graduation from high school with what they perceived as high GPAs, they applied to university and chose a health-track foundation year with the aim of securing a place on a medicine or a dentistry course. Prior to completing their foundation year, NQNs were asked to complete a subject preference list of four to six subjects that might be of interest, and often described putting nursing at the bottom just to fill the list. Moreover, their freedom when making a career choice varied significantly from a free choice to a restricted one.

What I have characterised as "first" and "constrained" choices and conceptualised as a spectrum of choices is based on the several parameters that NQNs had to consider when pursuing their careers. This refers to both the personal and academic criteria that influenced their career decision-making. Commonly, among those criteria was their high school grade point average (GPA). In this study, NQNs perceived themselves as high achievers as their GPAs were generally over 90%, which motivated them to study a course with high social status, e.g. medicine or dentistry, and increased their families' expectations accordingly. Other criteria included family influence on their career choice, which I characterise as a constraining factor. NQNs either complied with social expectations or ignored social pressure and focused on personal career ambitions, or found a way in between i.e. a path that reconciled personal interests and social expectations. The process of choosing to study nursing, for the NQNs in this study, was multifactorial, and could be linked to the students' performance, career interest and social constraints. Next, I will discuss "choosing" nursing as a career, the discovery of nursing and associated consequences.

- Choosing nursing

In exploring students' decisions about college choice in the UK and New Zealand, Ali (2018) and Pool (2012), respectively, shared similar thoughts on the lack of information about nursing courses, the role of nurses and career opportunities in nursing, suggesting that this makes nursing an "invisible" career choice. Consistently, most NQNs in my study, prior to studying nursing, had had limited knowledge about nursing and therefore had never considered a career in nursing. It

was unclear whether careers advice existed in their schools, as it was not mentioned in any of the NQNs' narratives. NQNs' decision to study nursing was influenced by a variety of types of constrained choice, which I characterised as arbitrary, fall-back, pragmatic, proximity-based, family-influenced choices and choice overload.

The discussion with the NQNs about their different motivations for taking up a nursing course revealed responses not commonly cited in the existing literature. Generally, the most frequently cited motivations in the literature for studying nursing included caring for people and altruism, followed by career opportunities (Traynor, 2013). Moreover, in a recent cross-sectional study including 10 European countries, the majority of nursing graduates (76%) reported that they had selected nursing as their first choice profession (Kajander-Unkuri et al., 2021). However, in the above-mentioned two studies, the graduates' grades at high school were not made explicit, although these have been reported as influential in career decision-making (Neilson and Lauder, 2008).

In my study, the majority of NQNs thought they had achieved a high school GPA that would allow them to join what they perceived as a highly respected profession. Only a small fraction of NQNs (5%) selected nursing as their first career choice, while the rest (95%) felt somehow pressured, or even duped, into studying nursing. Some NQNs discussed how a nursing programme was seen as a fallback choice for those who could not study their chosen course, while others tried to use it as a stepping stone to a better career. This perception, according to the NQNs, led many of them to assume negatively that students chose nursing only as a back-up for their original plan or as a stop-gap whilst waiting for the right chance to transfer to another programme, and thus they lacked a passion for nursing.

Moreover, some NQNs reported that their universities were encouraging prospective students to register nursing as a second option in case they failed to the meet the minimum requirements to study their preferred subject. This strategy can be double-edged. The current shortage of nurses and nurse applicants presents a serious dilemma for nursing academics and schools. Should they limit their admissions to applicants for whom nursing is their first choice, or fill their

vacant places with reluctant or less nursing-interested students? Choosing the former would ensure the development of passionate and caring nurses but may significantly reduce the number of applicants and subsequently nurse graduates. Meanwhile choosing the latter would increase the number of applicants but may lead to the production of less enthusiastic nurses who are more likely to quit their jobs at an early stage. This might partially explain the reported high rates of intentions to leave nursing among new Saudi nurses in Alboliteeh's (2015) study. He reported that 167 out of 741 (23%) of the study participants indicated that they intended to leave nursing within two years. Consistently, interviews with NQNs in my study suggested that the majority of them were not intending to remain at the patient's bedside for more than three years.

Although the NQNs' narratives suggested that *desiring to help* and *do something useful* played a part in career choice, many NQNs initially framed their decision pragmatically. This echoes the suggestion that the number of students citing altruism and professional values as their main motivation for their career decision has declined over time (Miers et al., 2007). In contrast, and more recently, a study of student nurses in the Netherlands suggests that conceptualising nursing as an altruistic profession was, along with pragmatic motives, of great importance in their career-decision making (Hoeve et al., 2017). The suggestion that pragmatic motives played a role in career choice was particularly common amongst NQNs in my study who could not secure a place on their preferred course. Apart from their first choice, NQNs often filled in their subject preference list based on extrinsic factors such as job opportunities and the possibilities for career advancement.

Choosing a university or career based on proximity was common amongst the NQNs. The preference for remaining in their home town was an influential determining factor in career choice. However, this issue tended to be more relevant to females than males. A few female NQNs stated that they would have chosen other careers if they had been allowed to study away from home to pursue their chosen career regardless of geographical location. They eventually chose nursing as it was considered the best available local option, which I have characterised as a "constrained" choice. This restriction could be attributed to the Saudi traditions that restrict women's movement and educational and professional choices (Hamdan, 2005). Many of these

restrictions have been legally lifted: women are now legally allowed to drive, and reforms of guardianship laws now allow women over 21 to travel without a male guardian's permission. However, many families, and women in particular, still experience a tension between embracing these changes or holding on to traditional values (Pilotti et al., 2021).

In my study, despite the recent socio-economic reforms enhancing women's participation in the workforce, many women still feel uncomfortable about these reforms because of cultural traditions, limiting their freedom to travel or study away from home. Similar findings were also suggested by Almaghaslah et al. (2021): namely that the geographical location of the college and the potential career were considered very important to Saudi pharmacology students when making a career choice. NQNs who felt constrained to make more limited career choices were more likely to experience higher levels of dissatisfaction and ambivalence during their studies even after graduation, as explained earlier (Chapter 4, Section 4.2.4: *Integrating choice, ambivalence, and commitment*). In contrast to students having constrained choices, the next section will discuss the process of dealing with many educational choices.

Prior to completing their foundation year, university students are generally expected to list four to six subjects that might be of interest (See 1.2.5 *The education system in Saudi*). This list of choices, regardless of whether they are real or not, is used as one of the criteria during the process of student selection. As discussed earlier, NQNs whose career choice was constrained experienced distress and dissatisfaction; however, those who were almost overloaded with choices fared no better. This indicates that having too many choices does not necessarily make those choosing more satisfied with their final decision. This could be linked to Schwartz's (2004) concept of "paradox of choice", which argues that having an overload of choices is not always beneficial, at least psychologically, and can sometimes be overwhelming.

In my study, some NQNs perceived that they were offered too many career choices and had to make trade-offs, with all except their first choice. For example, it was suggested to a few NQNs after being unable to secure a place on their preferred course that they might alternatively consider courses such as nursing, nutrition, radiotherapy or health administration. As a result,

they had to actually create a list of trade-offs including job opportunities, working environment and possibilities for career progression to make a decision. Experiencing trade-offs between *restricted* choices contributed to NQNs' feelings of dissatisfaction, regret and ambivalence about their eventual decisions. This study therefore also supports Schwartz's findings or as Schwartz (2004) puts it "being forced to confront trade-offs in making decisions makes people unhappy and indecisive" (p. 125). Schwartz's concept of social comparison is discussed later.

- *Discovering nursing*

While a minority of NQNs embraced nursing following their experience in practice, many later regretted their decision. The vast majority, including both satisfied and regretful NQNs, did not accept the "menial and dirty" aspects of nursing work, and were actively planning to escape their roles as bedside nurses. Hughes (1971) described the concept of "dirty" work as tasks and jobs that are likely to be viewed culturally as disgusting, demeaning and/or counter to moral positions. Building on this concept, Ashforth and Kreiner (1999) classify "dirty" work into three categories: physical taint, namely jobs that involve handling physical dirt (e.g. refuse collector); social taint, namely jobs that are perceived as being servile to others (e.g. housemaid); and moral taint, namely jobs that are viewed as sinful or of dubious virtue (e.g. abortion clinician).

The nature of a nurses' work, particularly bedside nurses, is likely to involve at least one aspect, if not more, of what is perceived as "dirty" work. This is often the unwanted dirty work of other colleague professionals (Simpson et al., 2012). For example, some participants found themselves dealing with bodily excretions when caring particularly for older, frail patients and viewed these tasks as "dirty" involving "physical taint". Participants also complained about finding themselves in a position of social servility when dealing with physicians due to the labour hierarchy in healthcare, which is dominated by medicine: an example of "social taint". An example of "moral taint" to the NQNs in my study was the requirement to work in a gender-mixed workplace, which violated Saudi moral and cultural norms and might be viewed as "quasi-sinful" by some in Saudi society. Therefore, this could partly explain the perception of NQNs in this study that viewed the role of bedside nurse as a "dirty" job.

The perceived unpleasant or "dirty" aspects of nursing work had also generated a feeling of shame and social stigma among NQNs as they considered them a threat to their social status. Some of them had their negative preconceptions of nursing confirmed – that it was a "dirty" job – and said that they tended to hide the "dirty" part of their roles, e.g. changing a patient's diaper, from their family and friends. Therefore, they developed plans to change their roles to distance themselves from the perceived threat. This is incongruent with some of the literature on stigmatised occupations, where workers tend to reconstruct their work identities by rationalising the work through payment or necessity, stress caring as valued work (nurses as "angels") to make their work meaningful and rewarding (Hughes, 1971). In a study of home care workers in the US, Stacey (2005) suggested that the participants brought value and dignity to their work by emphasising their mastery of skills in handling what they perceived as "dirty" tasks, e.g., bowel and bladder care, and that they provided a valuable service that many people avoided talking about, let alone performing. In this thesis, however, NQNs relied on avoidance strategies, that is, avoiding or delegating any tasks seen as "dirty" or "menial", and developed plans to escape these tasks by escaping bedside care.

NQNs' plans to leave working at the patient bedside could also be linked to the desire to escape the aspect of nursing which involves working with people's bodies – touching and "body work" – which is often stigmatised in nursing (Twigg et al., 2011). In Saudi culture, Halligan (2006) explains that touching strangers, particularly those of the opposite gender, is considered offensive; thus, touching to comfort patients in times of distress is not seen as part of the nurse's role and it is neither welcomed nor valued. This, however, does not seem to apply to other groups, e.g. members of the same gender or children. Furthermore, the findings of my study reinforce the suggestion that working directly on the bodies of others carried negative assumptions and stigma for participants, and was also associated with particular other nationalities (hence Saudi nurses being called Filipinos). Therefore, NQNs' intention to distance themselves from "body work" was probably a way of protecting their dignity and social status. This is similar to Lawler's (2006) suggestion that some nurses move away to more technologically-oriented roles in order to present themselves as "clean" professionals and therefore gain respect.

In this study, NQNs generally agreed that tasks such as bed changing and patient cleaning were considered *Ayb* (shameful or disgraceful) to do and were often perceived as housemaids' work or a non-Saudi's job. This perception was the primary reason for NQNs not accepting their role at the patient's bedside and wanting to change job. The perceptions that linked nurses' work to housemaids' work probably come from growing up in a "maid culture" (Al-Matary and AlJohani, 2021). In the Saudi community, following economic prosperity and social affluence in the late 20th century, hiring a foreign housemaid to help with domestic chores such as cleaning or even child-rearing became a social norm, where 80% of families had at least one or two live-in housemaids (Al-Matary and Ali, 2013). As a result, it has become a cultural norm that menial or dirty tasks such as cleaning are usually delegated to housemaids, or immigrants in general.

Therefore, as the public perceptions of nursing focus on the menial and dirty tasks, it became a taboo for nationals and an immigrant's job, with nurses seen as the equivalent of housemaids (Miller-Rosser et al., 2006; Mortell et al., 2017; Mebrouk, 2018). The culture of delegating "dirty" work to immigrants seems to be a worldwide issue: for instance, the experience of Caribbean nurses working in the most unpopular specialities in some British hospitals after the Second World War (Olwig, 2017), the disproportionately high employment of immigrants in the domestic service in the US, where women are often employed as domestic cleaners while men are found in institutional cleaning (Anderson, 2000; Duffy, 2007), and the contemporary use of immigrants to fill jobs at the bottom of the labour market in Norway (Orupabo and Nadim, 2020).

Another possible explanation for the stigmatising of nurses as equivalent to housemaids is that they (both nurses and housemaids) are often perceived as sounding alike and looking alike. The Philippines and India are the largest exporters of nurses, as well as domestic workers, to Saudi (Alreshidi et al., 2021). Thus, in the eye of the public, nurses and housemaids share similar nationality, ethnic background, social status and physical features, and sound alike when they speak their native language. Consequently, a perception has emerged that nursing and domestic labour are equivalent jobs. In other words, the public appears to have formed a perception that nursing work is for poor and low-status immigrants, and thus equate nurses to housemaids, or

as reported by one of the participants: "*they [the public] think we are housemaids… but educated*" (NQN16) (See 5.3 *Practicing nursing: experiences of NQNs* in Chapter 5).

It is worth noting, however, that the notion that the public perceive nurses as the equivalent of housemaids was often based on nurses' own accounts. In a cross-sectional study, Saied et al. (2016) asked 500 non-nursing Saudi citizens whether nursing is perceived as a servant's job, and the majority (59%) disagreed or strongly disagreed, while only 23% agreed or strongly agreed. Nearly 90% of the participants viewed nursing as a respected career; however, only a small percentage would consider a career in nursing (18% of females and 15% of males). These findings were corroborated by a study by Elmorshedy et al. (2020), suggesting that nursing is still perceived as an undesirable profession in Saudi for various socio-cultural reasons. However, the aforementioned two studies contained major methodological flaws which could have affected their findings. For example, both authors used convenience sampling techniques with unvalidated questionnaires, and their samples were unbalanced in terms of gender representation (about 80% females and 20% males), which might have affected the validity and reliability of the studies.

The strategy of selling nursing as a high-status profession in some academic institutions seemed an effective way to convince prospective students, particularly reluctant ones, to choose nursing as a career when applying to university. However, it contributed to over-inflated expectations about the nurse's role, leading some NQNs to consider themselves above providing basic nursing care (e.g. bathing and feeding). Many NQNs reported that they were taught that the provision of such tasks was not one of their responsibilities as BSN nurses – they believed it was the nurse assistants' job. This was supported by the recent local introduction of assistive roles such as the nursing care assistant (SCFHS, 2019), whose main responsibility is to assist registered nurses by executing basic nursing tasks, e.g. feeding. This strategy of distancing BSN nurses from patient personal care was clearly introduced to address the perceived low social status of nursing, which is one of the factors which students and nursing faculty believed discouraged individuals from pursuing a career in nursing (Alboliteeh, 2015; Alghamdi et al., 2019; Alharbi et al., 2019).

Moreover, the international literature discussing the delegation of some menial tasks in nursing to assistive personnel (Allan et al., 2016; Wagner, 2018) may also have contributed to NQNs' perspective that bedside care is the nurse assistant's job. Therefore, both the academic institutions and the literature seemed to play a role in forming the notion that BSN nurses, while remaining accountable, are no longer expected to perform basic nursing care, which can be delegated to their assistants. This is probably an attempt to raise the status of BSN nurses in clinical practice and create a better career path for them (e.g. advanced practice nurse). Another possibility could be that it is an effort to contain costs in healthcare by increasing reliance on nurse assistants to deliver some nursing tasks that do not require degree-level education, and who are much cheaper to educate and hire compared to BSN nurses. However, this could raise a question as what is core to BSN nursing and what can be safely delegated to assistants. Arguably, the delivery of basic nursing care should remain a core part of registered nurses' role to ensure patient safety, particularly given the lack of evidence to support the substitution of RNs with healthcare assistants (Griffiths et al., 2016b). The mismatch between the nursing curriculum/literature and practical nursing indicates that the former is out of step of the latter and sometimes paints an idealistic picture, which is difficult to implement in practice.

Furthermore, the increasing emphasis on theoretical learning in nursing education, outlined in the *Introduction* chapter, has probably constrained students' time on placement where they could learn from more senior students, experienced nurses and clinical educators (see *An overview of BSN programmes* in Chapter 1). Some NQNs also reported that there was a greater focus on advanced clinical skills (e.g. diagnostic and analytical skills) which raised their expectations of their role, but, when they started working in practice, their actual role was largely about providing what they perceived as basic nursing care. The NQNs' high expectations about their roles did not match with their practical experience; therefore, they felt confused, ambivalent and disappointed, and some expressed regrets about choosing nursing as a career.

- *Ambivalence and commitment*

Although it had been a long time since they had made the trade-offs, the vast majority of NQNs were still ambivalent about their career choice. Ambivalence about occupational choice seems to be relevant not only to NQNs but also to other professionals. Studies of newly qualified teachers in Norway and Oman also found that a significant percentage, 33% and 47% respectively, of the teachers expressed uncertainty about the future of their career and whether to continue in teaching (Roness, 2011; Chapman et al., 2012). The prevalence of ambivalence among new employees could be attributed to negative contextual factors such as high workload or inadequate management support (Maben et al., 2007), or it may be related to the social comparison concept (Schwartz, 2004).

Social comparison theory suggests that people have a tendency to assess their own abilities and traits by making comparisons with others in order to gain accurate evaluation of themselves (Festinger, 1954). People can compare themselves to others in a number of different ways, e.g. compare with others better than themselves (an upward comparison) or lower than themselves (a downward comparison). In a test of the social comparison theory, Wheeler added a proposition that people are more likely to compare upward when they believe their score is closer to the person above them than the person below them (Suls and Wheeler, 2013). Applying this to my study, NQNs had started an upward comparison with medical students from as early as their foundation year at university. The health-track foundation year that deals with all prospective health students as one cohort stimulates social comparison between them, where students who score high grades are selected for medicine, while others with lower results are distributed between other health courses, e.g. nursing, nutrition and health administration.

The foundation year can be responsible for breeding negative feelings that student nurses are perceived as low-achievers compared to medical students, and these feelings seem to stay with them even after the transition from school to professional practice. This probably mirrors the hierarchy of specialities in medicine, an example being that a career in general practice is commonly perceived as low status, compared to general surgery, and a fall-back career choice

for medical students who could not secure a place on a competitive specialist training programme (Merrett et al., 2017; Wainwright et al., 2019). In my study, with the negative social comparison as a contributing factor, many NQNs reported occupational regrets, lower levels of satisfaction and higher intentions to leave the profession. However, the foundation year does not necessarily produce negative feelings. The lower rating of NQNs compared to their peers during the foundation year might have played a role in raising their professional aspirations. Thus, many of them appeared very ambitious to pursue postgraduate studies. This supports the suggestion that people would seek to raise their aspirations if they were rated below the group average (Festinger, 1942). The vast majority of NQNs in my study felt motivated and developed plans to get away from the bedside nurse role as a way of elevating their social status either via further education or through a change of role.

A possible explanation for NQNs' motivations to leave their current job for further studies is the current scholarship programme for postgraduate studies. As reported in *Incentivising national nurses* in Chapter 5, the Saudi authorities consider nursing as one of the most in-demand professions and invest heavily in nursing education through international scholarships (Almalki et al., 2011a; Albejaidi and Nair, 2019). Therefore, because scholarships for nurses are frequently advertised, the NQNs interviewed typically wanted to seize these opportunities. Whether they were interested in nursing or not, these scholarships could pave their way to advancing professionally and socially. Those interested in nursing could have the chance to advance their knowledge and skills in a sub-speciality, e.g. advanced clinical practice or critical care, while those who regretted their career choice could have the chance to switch to other disciplines such as quality management. However, the benefits of these scholarships for nurses and nursing practice can be limited due to the absence, in the Saudi healthcare system, of standardised formal job titles and descriptions that reflect the role and scope of practice of different nursing sub-specialities (Hibbert, 2021). For example, due to a lack of legislation and regulation in the national health system, nurses with advanced nursing qualifications may have similar job descriptions and incentives to other registered nurses.

The prevalence of ambivalence among the NQNs led me to question their commitment to their profession and organisation. The degree of commitment varied between NQNs, but generally there was an association between the level of freedom when their career choice was made and ambivalence and commitment to the profession and organisation. NQNs who had enjoyed greater freedom when making their career decision showed less ambivalence and more commitment to their profession. Nonetheless, feeling satisfied with their career choice and showing professional commitment did not necessarily indicate loyalty to the organisation. This was associated with the possibility of career progression, where NQNs would move to other organisations that offered scholarships. Conversely, NQNs who felt that they had not made a free choice to study nursing expressed occupational regret and were more likely to discuss plans for changing their role or profession altogether. In contrast to Budjanovcanin et al. (2019) who suggested that greater social influence on career choice is associated with lower levels of occupational regret, I found that those NQNs who said their career choice had been largely influenced by social factors were more likely to experience career regret. Social factors, which included family interference, pressure from friends and social restrictions, often had a negative impact on NQNs' career decision-making.

However, career regret was not necessarily associated with lower levels of professional commitment. Many NQNs who regretted their career decision were focusing on moving to higher managerial roles within nursing rather than quitting the profession altogether. This may indicate that they embraced their choice of profession but could not tolerate, and wanted to escape, society's perceived low opinion of bedside nurses. However, the tendency to want to work in administrative positions does not seem to be exclusive to nurses in Saudi. Al Asmri et al. (2020) report that many Saudi general practitioners move to managerial, non-medical roles, despite the scarcity of physicians in the primary healthcare sector. Again, the escape to managerial positions could either be relevant to the social status of the respective occupation (nursing or general practice), for which reason they intend to seek a better position that satisfies their career aspirations, or it could mean that young Saudis simply prefer white-collar /managerial roles (Aldossari, 2020; Al Rawashdeh and Campbell, 2022). This process takes us to the next subsidiary category, *Reconciling*, to discuss how NQNs navigate internal and external expectations simultaneously.

7.2 Becoming a nurse: reconciling

The NQNs in this study engaged in attempts to reconcile the requirements of working as a professional nurse, their personal aspirations, and the expectations of their community. Figure 9 illustrates how NQNs attempt to reconcile competing social pressures.

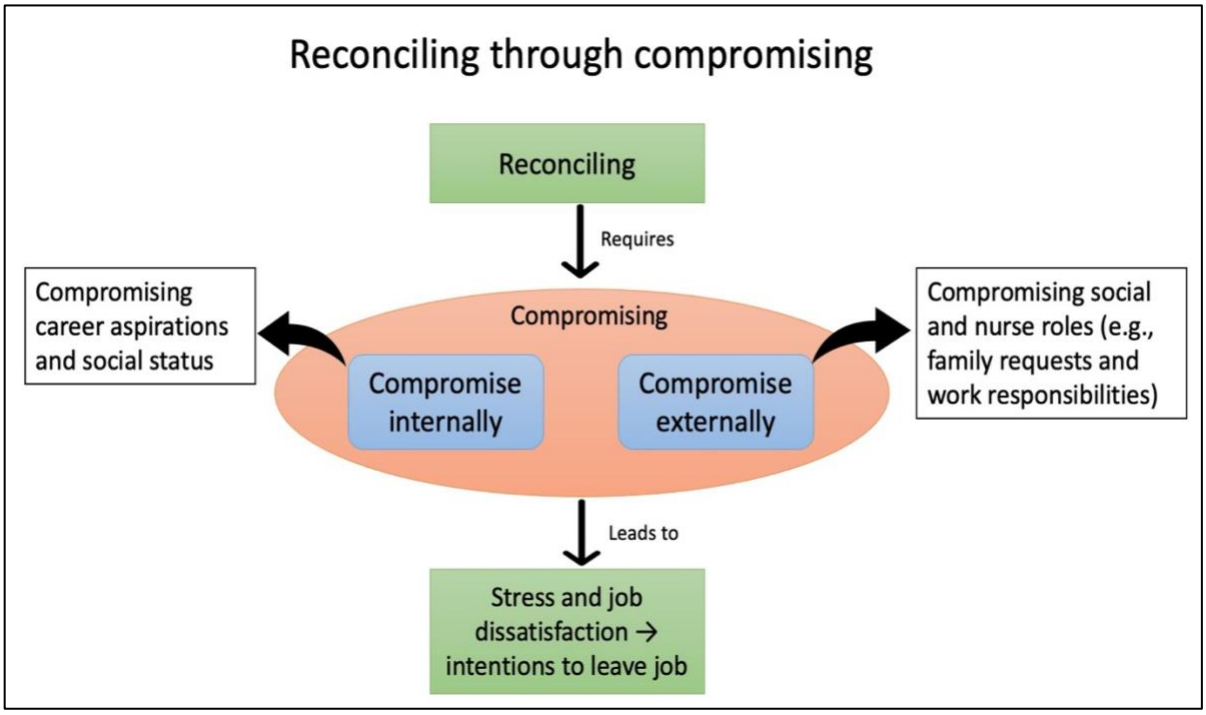


Figure 12 Reconciling

The NQNs' attempts to reconcile what they want to do (personal aspirations) and what they have to do (work and social expectations) led me to review the literature relating to the current thinking about reconciling different life courses. One aspect of reconciling is the concept of work-life balance, which has been defined as the relationship between work and non-work aspects of workers' lives, where individuals try not to spend more time on one side at the expense of the other (Kelliher et al., 2019). This concept has been discussed extensively in the literature, in terms of what it is, how to attain it and its impact on both workers and employers (Gregory and Milner, 2009; Masselot and di Torella, 2010). Although the research on work-life balance is extensive, a more holistic and contemporary understanding of the phenomenon requires further

consideration: for example, the level of importance of each component – how necessary work is to individuals?

In this study, some NQNs, all female, viewed work as important or "*temporary… until I get married*" (NQN11), but not a necessity, and thus, for them, life outside work often overrode work. This view could be related to the cultural and religious norms in Saudi society, where offspring, particularly women, are financially protected by their *Wali* (a male relative who could be a father, brother or husband) for as long as they comply with family obligations (Wilson et al., 2012; Almalki, 2020). This perception of female NQNs in my study was in line with a study of 300 Saudi males who showed strong traditional views about working women (Elamin and Omair, 2010). This indicates that women in Saudi are more likely to put both family needs and family/cultural values first. Moreover, the difficulty to reconcile work and life responsibilities may in turn lead to higher attrition rates amongst women and limited career choices for them. The rapid economic growth witnessed in the past decade in Saudi, along with significant expansion of women's employment, is likely to have changed many traditions and customs in Saudi society to some degree. However, more comprehensive work needs to be done at the educational, organisational and political level to facilitate a better work-life balance for all workers, particularly women as they are more likely to struggle to reconcile work and other commitments due to associated gender roles.

- Unfavourable working conditions

As social expectations seemed to be an influential factor when making a career decision, NQNs strove to select a career that was accepted by their social circles, and their families and friends in particular. A nursing job, in addition to its low public status, was also a particularly challenging career choice because nursing often requires irregular working hours, including night shifts and public holidays. The negative consequences associated with shift work, including poor sleep quality, fatigue and poor mental health, have been reported in the international literature (Pryce, 2016; McDowall et al., 2017; Imes and Chasens, 2019). This study adds that in the Saudi context shift work was also associated with concerns about being unable to get married or start a family.

The majority of NQNs considered irregular work hours, 12-hour shifts in particular, to be a barrier to fulfilling their future motherhood role. Therefore, there was always a tendency to move to roles that require regular daytime shifts and regular weekends. There was a striving for a balance that enabled a more "normal" life. This finding is consistent with the suggestion that Saudi female nurses tend to seek roles in outpatient clinics, where they can work regular shifts and take regular weekends, to avoid conflict with family commitments and expectations (Alsadaan et al., 2021).

In comparison with female NQNs, shift work did not seem to bother the male participants as much. This could be associated with direct family pressure, as a few female NQNs discussed their parents nagging them to change their working hours or move jobs, which was probably motivated by the intention to protect their daughters from the risk of violence believed to be associated with evening and night shifts (Alsaleem et al., 2018). It could also be related to the social expectations of gendered roles in Saudi society, where men are seen as the breadwinners, while women are the homemakers (Alyaemni et al., 2013). However, these traditional norms are slowly and steadily fading as a result of the recent socio-political transition in society, e.g. women's economic empowerment and increasing gender equity (Al-Khraif et al., 2020). It is of concern, though, that, in light of the rapid expansion of women's employment and the increasing proportion of dual-earner families in Saudi, the literature seemed to focus primarily on statutory policies and strategies facilitating growth of women's participation in the labour market, while doing very little to address the adverse effects on women's roles as mothers. This concern has been reported in contexts with a relatively high proportion of working women, e.g., Europe (Russell et al., 2009; Thévenon, 2011) .

In terms of shift patterns, the 12-hour schedules had a significant influence on how NQNs perceived their work. In general, NQNs viewed these shifts as too long, unsocial and associated them with increased stress and fatigue. This led to failure to reconcile work and life responsibilities and an intention to change jobs. Nurses' struggle with work-life imbalance due to anti-social working hours, and their associated adverse effects, has been long observed. The rotating or long (12-hour) shifts have been associated with fatigue and lower quality and quantity of sleep (Ferri et al., 2016) and higher risk of sickness (Dall'Ora et al., 2019). Similarly, the heavy

workload demands in nursing have been highlighted as a barrier to professional growth (Penz et al., 2007), job satisfaction (Gouzou et al., 2015), and retention (Holland et al., 2019). Consistently, the 12-hour shifts in my study appeared to trigger an intention to move to different nursing jobs that offered better working hours; however, it was not clearly associated with NQNs intending to leave the profession altogether.

A substantial amount of literature has discussed the high attrition rates of nurses, within the context of Saudi, citing heavy workload, perceived favouritism, poor support from immediate managers, and discrimination (Alotaibi et al., 2016; Falatah and Salem, 2018). Many NQNs, in my study, had experienced similar issues including dissatisfaction with how they were treated by doctors or managers. These unfavourable work conditions such as perceived discrimination and mistreatment by some colleagues make it more challenging for NQNs to reconcile conflicting views of nursing as a career and trigger intentions to leave. However, the focus of the aforementioned studies on attrition was limited to intentions to leave or anticipated turnover, rather than actual attrition rates. Moreover, the relationships between maintaining a work-life balance and intentions to remain in the job were not made explicit. Therefore, more comprehensive research on the association between work-life balance and intentions to leave the job is warranted.

Working in a mixed-gender environment was another controversial topic when it came to career decision-making. Generally, there was a public perception that gender segregation in public spaces, including the workplace, is preferred in Saudi (van Geel, 2016). This perception, according to NQNs in my study, contributed to making nursing a less desirable career and made reconciling conflicting views of nursing as a career more challenging. In a cross-sectional study of young non-nursing Saudi individuals, Elmorshedy et al. (2020) suggested that about one-third perceived the mixed-gender workplace to be a barrier to pursuing a career in nursing. This also applies in other non-medical fields such as tourism and entertainment (Almathami et al., 2020). The issue of the mixing of genders in nursing practice has been frequently discussed in literature related to the nursing profession in Saudi, and has been associated with job dissatisfaction and attrition (Alotaibi et al., 2016; Alboliteeh et al., 2017).

Surprisingly, this concern about intermingling with the other gender does not seem to apply to higher-status professions, e.g. medicine or dentistry. Halawany (2014) reported that nearly 50% of female dental students were actually encouraged by their parents/family to pursue a career in dentistry. It was not clear why gender sensitivity would be of concern in nursing but not with other professions. These contrasting responses to career choice could be attributed to the difference in social status between nursing and medicine/dentistry, where the former is still perceived as a less respected profession. The reports from NQNs in my study suggest that the perceived "dirty" work in nursing was a more important factor in their career decision-making compared to the issue of mixing with the other gender in the workplace. Another possible explanation could be connected to the fast-paced change and conflict in Saudi culture between traditional values and modern economic and consumerist values, or to ambition overriding gender sensitivity. Students with higher aspirations are more likely to challenge and overcome socio-cultural barriers to pursue their preferred career. This was evident in this study, where a passion for nursing in a small number of participants was a valid reason to violate some of the traditional norms, i.e. move away from hometown to study nursing.

In spite of the frequent reports of families, fathers in particular, rejecting nursing as a career choice for their children, the NQN participants continued in nursing. This implies that these NQNs were able to reconcile, at least temporarily, the social problems associated with choosing nursing as career. Mothers were often reported, mostly by female NQNs, to have helped mediate between disputing parties (NQNs and their fathers) in resolving the career choice conflict. However, Khalifa et al. (2018) argued that, in Saudi society, even if the family discussion about career choice does not involve the fathers, they are implicit participants as they always have the final say. In a phenomenological study to explore the social barriers that face Saudi female student nurses, Alharbi et al. (2019) explained that the participants were able to persist and continue in studying nursing despite family dissatisfaction and negative societal views. However, the limited alternative educational options for the students might have contributed to their decision to continue in nursing. Alharbi's study, in addition to the data from this thesis, corroborates the suggestion that recent demographic changes in the Saudi family structure have

started to alter the balance of decision-making power, giving the younger generation, particularly women, more autonomy over their career choice (Al-Khraif et al., 2020).

Many NQNs, as members of the public and prior to studying nursing, had had similar negative perceptions about nursing, e.g. in terms of status and autonomy. NQNs' initial clinical training was a decisive experience which either affirmed or refuted their preconceptions of nursing. At that stage, they became insiders and were able to develop their own understanding of the profession instead of making assumptions. Despite the significant progress towards improving the professional status of nursing in the last few decades, the status of nursing still seems to be a source of dissatisfaction (Hoeve et al., 2014). In my study, experiencing subordination to the medical profession, disrespectful behaviour by some physicians, and lack of recognition and appreciation were the primary factors that confirmed the NQNs' low preconceptions of nursing. However, their negative perception may have been selective and skewed by their self-concept before joining nursing. They could be seeing what they expected to see: a case of confirmation bias. This is congruent with suggestions that nurses are more likely to develop low self-concept if their community perceives nursing negatively (Gregg and Magilvy, 2001; Takase et al., 2002).

Nevertheless, self-concept does not necessarily align with how someone is perceived by the public, and can be altered by personal experience. Personal experience of the phenomenon (in this case, the nurse role) can offer adequate evidence to refute low preconceptions and the public's assumptions. In my study, some NQNs reported that discovering the importance of their role as nurses and their contribution to saving others' lives had made them embrace their work and develop a positive self-concept. Their positive clinical experience was also attributed to working with supportive co-workers and building good relationships with them. This highlights the importance of the working environment in shaping the nurse's professional identity. Several studies also reported similar suggestions that supportive work environments and professional interaction with colleagues are influential in developing a positive self-concept (Öhlén and Segesten, 1998; Gregg and Magilvy, 2001). Although it is important to change how nurses view themselves, it is even more important to improve how the public perceive nursing and nurses.

Despite the continuous efforts to rebrand the profession to make it a more respected and desirable career, nursing still struggles with an unimpressive social status, not only in Saudi, but also internationally (Glerean et al., 2017; Ali et al., 2018). For instance, Norman (2015) reported that UK high school students still do not perceive nursing as a profession, questioned whether it required a university degree, and perceived nurses as less academically or intellectually able. This to some degree corroborated the reported experiences of many NQNs in my study when attempting to reconcile conflicting views of nursing as a career. This indicates that the profession is still trapped in the traditional image that depicts nursing as a vocational career and subordinate to the medical profession.

Some participants in my study, however, reported that there have been attempts to rebrand nursing as a more powerful and influential career, which I conceptualise as *Nursing empowerment* (see Chapter 5). The participants happily discussed different reforms such as pay increases and the recent appointments of nurses to senior leadership positions that had historically been exclusive to physicians, e.g. hospital CEOs. They thought this recognition of nurses' work was likely to uplift the status of nurses within and outside work. Indeed, it encouraged them to pursue higher education and take on key roles in healthcare management. This is in line with the suggestions that nurses should seek leadership positions and improve their visibility in the media in order to move beyond their traditional role as carers to become influential leaders (Hoeve et al., 2014; Berghout et al., 2018).

7.3 Surviving nursing: perseverance

Despite feelings of dissatisfaction and regret about their career choice, and difficulties in reconciling work with social expectations, very few NQNs discussed plans for leaving nursing altogether. Rather, they persevered within the profession, perceiving possibilities for career progression as a major motivator to persist, despite feelings of dissatisfaction with their work. Figure 13 summarises the issues that NQNs continuously challenge at work.

Figure 13: Perseverance

Although evaluating job satisfaction was not the primary focus of this study, the participants (both Saudis and expatriates) frequently brought up this topic and linked it their intentions to either continue in or leave their current job. The two groups seemed to have different ideas about what might lead to job satisfaction. While national nurses, including NQNs, tended to focus on intrinsic (content) factors such as the work itself, achievement and responsibilities, the expatriate group seemed to pay greater attention to extrinsic (context) factors such as pay and working conditions. Job satisfaction and its associated factors have been studied extensively in the literature, which has resulted in the development of many situational theories, which are

concerned with the work environment, dispositional approaches, which focus on the personality of the worker, and interactive theories, which consider both person and situation variables (Judge et al., 2001).

As the participants seemed to view situational factors as important to job satisfaction, I focus on situational theories, Herzberg's two-factor theory in particular. The two-factor theory (Herzberg et al., 1959) has attracted much attention and was considered one of the most influential on the concept of job satisfaction (Judge et al., 2001). It has been widely tested and applied in several disciplines, including nursing, to determine job satisfaction amongst workers (Berent and Anderko, 2011; McGlynn et al., 2012; Derby-Davis, 2014). The theory, however, has also been subject to criticism for several reasons, which are discussed below in relation to the data in my study.

The two-factor theory was based on the notion that employees have two sets of needs: the need for growth and the need to avoid unpleasantness, which were categorised into "motivation" and "hygiene" factors (Herzberg et al., 1959). The motivation factors are intrinsic to the work, and include the job itself, advancement, responsibility and recognition, while hygiene factors relate to the context in which people work, which include working conditions, pay and interpersonal relations. Some of these factors, though, can arguably be classified differently. For instance, Bassett-Jones and Lloyd (2005) suggest that although recognition can motivate an employee that they had done a good job (motivator), it can also be considered a hygiene factor as it increases the employee's prospects of promotion, which may include an increase in pay. According to the theory, when motivating factors are satisfied, employees become what they aspire to be and this generates job satisfaction (Herzberg et al., 1959; Herzberg, 1968).

Moreover, the theory argues that the absence of motivation factors does not cause job dissatisfaction – simply a lack of job satisfaction; however, the data from this thesis does not support this aspect of the theory. The absence of the motivator "interesting work" did not simply lead to a lack of job satisfaction as proposed by Herzberg's theory – it actually caused job dissatisfaction. The job itself (bedside nurse role) contributed to generating negative feelings

among NQNs towards work and, indeed, intentions to leave. This finding corroborates the criticism of the theory that both motivation and hygiene factors contribute to both job satisfaction and dissatisfaction (Carroll, 1973; Wernimont, 1966; cited in Judge et al., 2001). The lack of "interesting work" and associated low status were thought by many NQNs to be valid reasons to consider moving to other roles or even to consider quitting the profession altogether.

- Intention to leave

Despite the reported improvement in job opportunities and pay for nurses discussed earlier in the Introduction chapter, intention to leave was widespread among NQNs. This is a major concern, particularly in light of the localisation (or Saudisation) programme that aims to improve the status of nursing in order to increase the number of qualified national nurses. The high incidence of intentions to leave among NQNs signals that the strategy of increasing pay to attract and retain national nurses in the job may be only partially successful. This is consistent with the suggestion of the two-factor theory that the use of hygiene factors (e.g. pay) could have "short term analgesic effects" (Herzberg, 1966, p. 81), but does not increase job satisfaction in the long term.

In this study, although "pay" was an important factor for NQNs to join nursing, it did not seem to produce job satisfaction or help in retaining them. Therefore, the findings of my study suggest that focusing exclusively on improving hygiene factors (e.g. remuneration) to achieve the aims of the localisation programme may be an insufficient strategy. Instead, since NQNs were generally concerned with the perceived low status of the bedside nurse role, a greater focus on improving the motivation factors (e.g. increase responsibilities and advancement) is more likely to improve the status of nurses and potentially increase recruitment and retention rates – the target outcomes of the localisation programme.

The actual content of the bedside nurse role, i.e. the work itself, which included what were perceived as menial and dirty tasks, was commonly responsible for generating negative feelings among NQNs towards the profession. It affirmed the NQNs' low preconceptions of nursing,

clashed with their perceptions of their socio-economic status and contributed to high levels of job dissatisfaction. This finding substantiates criticisms of Herzberg's theory for not taking employees' different socio-economic, culture and gender categories and personality traits into account (Furnham et al., 1999; Judge et al., 2002). The socio-economic status aspirations of NQNs seemed to be influential in the development of their attitudes towards work. They perceived status or position in the workplace and possibilities for growth as very important, and the absence of these factors was associated with negative feelings towards work. In contrast to national nurses, expatriates tended to perceive motivation factors such as status as less important compared to hygiene factors, e.g. pay and relationship with managers, as reported in *Economic incentives* in Chapter 5.

Although expatriate nurses were not the focus of my study, their brief reports, in addition to the relevant literature, contradict Herzberg's theory that positive hygiene factors such as pay cannot improve job satisfaction. Interviews with expatriate nurses in this thesis revealed that they largely related their job evaluation to factors associated with the work context (hygiene), such as remuneration. This was consistent with a prospective study of 124 expatriate nurses in Saudi, where 34% of the participants perceived improving financial incentives to be more important than solving understaffing (16%), and it would be more likely to influence their decision to sign up for long-term employment (Aljohani and Alomari, 2018). This indicates that financial incentives were particularly important for nurses to compensate for heavy workload and persevere in their jobs. Studies of Swedish mental health nurses (Holmberg et al. 2016) and Greek nurses (Gouzou et al. 2015) also suggested similar findings. They proposed that monetary incentives were perceived to be the most valuable component of satisfaction compared to professional status and autonomy, and were positively associated with job satisfaction, rather than merely eliminating dissatisfaction. Again, the Herzberg's theory seems to miss the influence of the socio-economic status of the employees.

For the NQNs, positive hygiene factors, such as feeling supported and perceiving their relationships with preceptors as effective, helped them to persevere in their job but did not produce job satisfaction. In comparison with expatriate nurses, nationals seemed more

concerned about building interpersonal relationships at work. This, according to Almansour et al. (2020), is partly because most expatriates share accommodation provided by the employer, which makes it easier for them to develop good relationship with co-workers, and partly because they do not expect to stay as long. It could also be connected to NQNs perceiving interpersonal relationships as important to build their reputation and progress professionally. However, in general, NQNs considered motivation factors to be more important than hygiene factors in generating positive feelings towards their work. This finding supports Herzberg's theory that hygiene factors have a weaker association with improving job satisfaction and, when present, they only contribute to reducing job dissatisfaction. The findings of Lundberg et al. (2009) and Hur (2018), albeit in two different fields, tourism and management, respectively, were also in line with the theory's argument that hygiene factors have only a very weak and insignificant effect on increasing job satisfaction.

- Shift patterns and workload

In terms of working conditions, there seem to be diverging views between NQNs and expatriate nurses, particularly in relation to shift patterns. As discussed earlier, the majority of NQNs expressed dissatisfaction with the 12-hour shifts as they negatively affected their social lives outside work. In contrast, expatriate nurses, who comprise the vast majority of the hospital nursing workforce, were in favour of the 12-hours shifts, influencing the voting to move from 8- to 12-hour schedules. The difference in opinion between national and expatriate nurses is reflected in the international literature debates. Conflicting views have been reported globally, with some, mainly from the US, opting for shifts of 12 hours (Stone et al., 2006; Stimpfel et al., 2012), while others, e.g. in Europe, are against it due to the associated poor quality of nursing care and patient safety (Ball et al., 2014), high levels of emotional exhaustion and low personal achievement (Dall'Ora et al., 2015). However, personal circumstances seemed to be overlooked in these studies (e.g. having a part-time job or care responsibilities at home), which may have influenced the nurses' preference concerning shift pattern. When it comes to individuals making decisions, families are more influential in Saudi compared to some Western countries,

particularly for female family members (Al-Alawi et al., 2021). Therefore, long working shifts have always been perceived as a troublesome for Saudi nurses (Alghamdi et al., 2019).

An interesting shared point between the advocates and critics of the 12-hours shifts is that they both want a better balance between their work and personal commitments. This indicates, from the workers' perspectives, that personal circumstances are the main motivator to either opt for or reject 12-hour shifts. In this study, expatriates' preference for the 12-hour shift pattern was probably associated with their migratory status (away from family and with fewer social responsibilities outside work) and more opportunities for overtime to increase their income. However, Saudi NQNs thought that the current shift pattern increased their workload and reduced their social time with family and friends. In addition to the increased work demands, they felt inadequately supported as their different social circumstances were not taken into consideration when the nursing office made the final decision to change some units' shift patterns. Overall, the perceived increased work demands and insufficient social support from the management contributed to NQNs feeling stressed and dissatisfied with work, and having no intention of remaining in their current job.

The reported experiences of NQNs dealing with high workloads and an inability to control their perceived adverse working conditions and hours were associated with increased stress. Receiving inadequate social support from their managers exacerbated this situation. In contrast, expatriate nurses, who perceived their managerial social support more positively, felt less dissatisfied at work. These findings can be related to the Job Demand-Control-Support (JDCS) model (Johnson and Hall, 1988), which is an expansion of the original Job Demand-Control model (Karasek Jr, 1979).

The JDCS model describes three crucial job aspects in the workplace: job demands, job control and worksite social support. It proposes that having decision latitude, i.e. control, over the work process and receiving social support from colleagues reduces risks of developing health problems, even with high job demands, whereas working in a high-demand, low-control and low-support job is perceived as the most toxic work situation, and was associated with stress related

to illnesses (Kuper and Marmot, 2003). This is precisely what was reported by some of the NQNs in my study. Consistent with the two-factor theory, the JDCS supports the positive influence of social support from co-workers (Herzberg would classify this as a hygiene factor) in reducing job dissatisfaction or moderating the negative effect of working in a high-stress job. However, evidence that supports the moderating influence of social support is limited (Velando-Soriano et al., 2020). In my study, despite reported support from some experienced nurses, most NQNs were not feeling satisfied with their work. Thus, it is possible that even when given more autonomy and adequate social support, NQNs' dissatisfaction may not be alleviated because the work itself (i.e. the bedside nurse role) was their main concern.

To summarise this subsidiary category, "perseverance", NQNs persevered in the face of multiple challenges, which included aversion to the bedside nurse role due to the perceived physical, social and moral taints associated with the role. Other challenges were the anti-social work hours and unsupportive work environment. NQNs develop various strategies to either minimise or overcome these challenges, such as delegating perceived dirty tasks, minimising cross-gender interactions and focussing on professional growth. I conceptualise perseverance as a process. During this process, NQNs try to improve their confidence and gain their colleagues' trust by working more independently. They try to develop their nursing knowledge and skills by attending relevant CPD courses, and try to build a good reputation at work through responding to calls to cover unexpected shortages of staff. Simultaneously, they search for postgraduate qualifications to legitimise their applications for different roles – away from the bedside – in order to escape what they perceive as a low status role.

The experiences of NQNs partially support the contention of the two-factor theory and the Job-Demand-Control-Support model that negative working conditions such as poor interpersonal relationships at work are associated with increased job dissatisfaction, which was a determinant of attrition among NQNs in this study. However, the experiences of NQNs were also in contrast to some of the aspects of the two-factor theory. The theory contends that absence of motivating factors such as job itself or advancements are not associated with increased job dissatisfaction, while these factors, for NQNs in this thesis, were perceived as primary reasons for job

dissatisfaction and intentions to move jobs. This finding substantiates the criticism of the two-factor theory that motivating factors can also play a role in generating job dissatisfaction. The experiences of NQNs in my study also did not seem to support the suggestion by the JDCS model that worksite social support can reduce job dissatisfaction. Most NQNs did not feel satisfied with their job and were actively looking for an escape from their current role, despite reporting supportive relationships with some of their colleagues.

7.4 Summary

Within this chapter I have attempted to discuss the three-stage process of transition from a student to qualified nurse role identified by this study in relation to existing theories and empirical literature. In general, the focus of the existing literature was on specific aspects of transition, such as reality shock associated with role transition or how newly qualified nurses experience the role transition. This study, however, identified different elements of the journey to becoming a nurse in an attempt to conceptualise the process. It attempted to conceptualise and shed light on the intrinsic factors that continuously drove newly qualified nurses away from the patient bedside, since their role in attrition has not been fully explored. Earlier studies have focused primarily on extrinsic factors such as working conditions in attempting to predict the determinants that lead to nurse attrition.

The *Forward Escaping* theory recognises that newly qualified nurses escaped, or attempt to escape, the bedside nurse role through career progression. Predominant among these indicators is how they perceive their role at the patient bedside. Perception of nursing before joining the profession and clinical experience were recurrent concepts throughout, since they informed NQNs' career decision making and generated their attitudes towards their new role. Generally, the clinical experience of NQNs affirmed their preconceptions of the nursing profession: that it struggles with negative public perceptions and poor working conditions. NQNs, initially, acquiesce to their bedside nurse role; however, this acquiescence is temporary. While working at the patient bedside, they attempt to simultaneously satisfy the demands of work as qualified

nurses, their career aspirations and their social obligations through avoidance of what they perceive as particularly undesirable responsibilities, e.g. “dirty” tasks. These types of tasks were, in particular, considered a threat to the NQNs’ social status, and encouraged them to change jobs. To legitimise their escape from the bedside, and essentially protect their status, NQNs attempted to pursue further (postgraduate) studies or acquire CPD certificates that supported their applications for different roles that required less or no direct patient care.

The conclusion of this thesis, recommendations for nursing education and practice, and limitations of the study will be presented in the next chapter.

Chapter Eight: Conclusions and Recommendations

8.1 Introduction

The aim of this thesis was to explore the transition experience of newly qualified nurses (NQNs) as they became registered nurses. The study design was exploratory, and it sought to delve into "What is actually going on" during a Nursing Residency Programme (NRP) that was intended to support NQNs in their role transition from students to registered nurses. However, as it used a classic grounded theory approach, and followed the leads and concepts emerging from the initial interviews, the study focus expanded from its original aim. The Nursing Residency experience and its influence on the role transition – the original aim – appeared to be of lesser importance to the NQNs than other issues. This study discovered that the main concern of the NQNs was associated with their ambivalence about accepting their role as bedside nurses, and thus the study developed a substantive theory of *Forward Escaping* as the means through which they attempted to resolve this concern. Thus, as mentioned in the *Methodology* chapter, the objectives of the study were developed accordingly. This chapter summarises this study's contribution to knowledge, reflecting on the theoretical and practical implications of its findings. Recommendations for nursing education and practice and for further research will also be addressed. Finally, the strengths and limitations of the study as well as dissemination plans, are presented.

8.2 Summary of the substantive grounded theory

The substantive theory of *Forward Escaping* was developed to account for the continual attempts by NQNs to resolve their main concern, which was to distance themselves from the bedside nurse role. This study presents a conceptual explanation of the ways in which NQNs managed daily tensions between work demands, personal aspirations and family expectations. It was conducted in a society where social status is highly prized, and where nursing is generally perceived as an inferior career choice. Thus, as I have explained in this thesis, the decision to pursue a career in nursing is often a constrained choice. The theory of *Forward Escaping* has been suggested to

explain how most NQNs attempt to *acquiesce* to nursing, *reconcile* the requirements of working as nurse with their personal aspirations and their families' expectations, and *persevere* with these social and work pressures in order to reach their long-term goal (a role away from bedside nursing), which allows a more stable reconciliation of the tensions outlined.

The negotiations between NQNs and their significant others leading to the decision to enter a nursing course was shaped and directed by cultural views and social expectations associated with gender roles. These had limited the freedom of educational choices for NQNs, leaving them with constrained career options. Upon completing their foundation year at university, most NQNs had to choose between two options, both of which they perceived as unfavourable. These were accept a place in nursing or dropout from university. A career in nursing was seen as the lesser of two evils by many participants. Therefore, the majority of NQNs rationalised their choice of nursing as the best *available* choice at that time. Most NQNs were deeply concerned about how their career was viewed by the public and how this might affect their social status. Moreover, their career choice was largely based on an uninformed decision, lacking sufficient information about nursing, apart from some negative views that were influenced by their society.

Therefore, the NQNs' journey from starting a nursing course to graduation was full of ambivalence and uncertainty about whether they had made the right career choice. Later, during the nursing course and in particular following their clinical experience, many confirmed their negative preconceptions that nursing was not an ideal occupation. Their practice-based experiences resulted in them sharing the negative public perception that nursing is not desirable career, but they had already invested several years in nursing and were reluctant to lose that time. They experienced this as a dilemma: they did not embrace their choice of profession and, at the same time, could not afford to lose the time they had invested in nursing. Their interaction with other student nurses seemed to exacerbate the situation, as there was a shared perception among them that nursing was a fallback choice, and many considered dropping out at this point. Eventually, the NQNs in this study decided to acquiesce to their compromised choice, that is, to temporarily and conditionally accept a job in nursing. However, the feeling that they were acquiescing to a constrained choice influenced their level of commitment to the profession, so

that the majority of them had no intention of staying in their current job, and were simply waiting for the right opportunity to leave either their job or nursing altogether.

In addition to ruing their career choice, the NQNs perceived that the nature of nursing work conflicted with some norms and cultural beliefs typically held within Saudi society. Most importantly, what NQNs perceived as "menial and dirty" tasks in the nursing role matched Hughes' (1971) theory regarding cultural perceptions of "dirty work". In Saudi cultural, these types of tasks are labelled as a maid or an immigrant's job, and there is a widespread cultural belief that Saudis are not expected to work in these occupations. Therefore, most NQNs in this study agreed that they tended to hide from their social circles what they perceived as the "dirty" tasks in their job in an attempt to reconcile work demands and social expectations. Furthermore, nurses were often required to work irregular hours and in mixed gender environments. These work conditions are considered undesirable in Saudi culture, particularly for women. These two requirements of nursing work were thought to be a barrier to meeting other social expectations required of Saudi women, namely to get married and raise a family. The NQN participants, once again, were in dilemma: they wanted to meet social expectations but also wanted to achieve their career aspirations.

Therefore, NQNs attempted to reconcile work demands, career aspirations and social expectations using different techniques and strategies. Firstly, they tried to find a job that required daytime shifts and did not require them to work on public holidays. Secondly, they sought positions in single-sex wards, and if that was not possible, they tried to avoid caring for patients of the other gender. These strategies helped NQNs fulfil some of their familial expectations and alleviate some of the associated social pressures. However, to achieve even better reconciliation, NQNs aspired to moving to managerial positions that would take them away from the perceived "dirty" work of bedside nursing and enhance their status both professionally and socially. This third strategy, which could be achieved through obtaining further qualifications, would help NQNs to reconcile their career aspirations and social/family expectations, and to resolve some of their complaints about their nursing work.

The clinical practice experiences of NQNs confirmed their preconceptions that the nursing profession in Saudi still struggles with low social status. The nature of nursing work was the primary source of job dissatisfaction amongst the NQNs, and acted as a push factor for them to leave their current role. In contrast, opportunities for career progression in nursing acted as a pull factor, encouraging NQNs to persevere and remain in the job. The NQNs' reports that the job itself and opportunities for career development were influential in their decision to stay in or leave their job supported the two-factor theory (Herzberg et al., 1959) in that when these motivating factors are satisfied then job satisfaction increases. Moreover, the NQNs' strong intention to leave nursing practice indicates that the increase in pay that comes with becoming a registered nurse (a hygiene factor) does not necessarily improve nurse attrition rates. This also corroborates the two-factor theory in that tackling hygiene factors will only result in reductions in job dissatisfaction but with no concomitant increase in job satisfaction. By contrast, for expatriate nurses pay seemed to neutralise job dissatisfaction and influence their decision to remain in their job. This, however, could be associated with their status as economic migrants who do not have the job security, permanent residence and alternative sources of income that many Saudi nurses have.

Furthermore, although most NQNs felt they were able to develop rapport with their colleagues and preceptors, they reported poor relationships with their managers. The absence of this hygiene factor (co-worker relations) was associated with increased job dissatisfaction. It was considered a significant push factor, leading some NQNs to change their schedules to night shifts to avoid interaction with their managers, request a transfer to another ward or even leave the hospital for another one. The NQNs' reports suggested that they were working in a high-demand, low-control and low-support work environment, which the Job Demand-Control-Support (JDCS) model considers to be the most toxic type of workplace (Karasek Jr, 1979; Johnson and Hall, 1988). These perceptions of their work environment led many NQNs to consider moving to different roles either within or outside their organisation.

These novel insights emerged from the data of this thesis and I have found that three complementary theories (the dirty work, motivation-hygiene and job-demand-control), have

helped illuminate my findings. This study sought to explore the process of role transition to becoming a nurse in Saudi and, in doing so, it has provided new insights into the experiences of NQNs from a Saudi perspective. Hopefully, these different perceptions and experiences can be used as a catalyst to improve current practices in admission onto nursing courses and the transition from school to professional practice in Saudi and possibly other countries sharing similar socioeconomic characteristics.

8.3 Study recommendations

Based on the findings of this study, several recommendations can be identified in relation to the process of choosing nursing as career which, if further investigated and acted upon, may help improve the recruitment and retention of nurses in Saudi. These recommendations are outlined below:

- Recommendations for policy makers:

The social image of nursing in Saudi continues to deter many young students from considering nursing as a potential career for their future. The findings from this study strongly suggest that nursing is still perceived as undesirable career, and often considered as the least popular career choice. Therefore, the following actions are recommended:

- Ministerial departments such as the Ministry of Health and Ministry of Media should work more collaboratively to increase awareness about the nursing profession, using social media, TV shows and films to promote the positive aspects of nursing. For example, a strategy which could enhance the social status of nurses could be the use of a public relations campaign publicising when off-duty nurses save a life.
- The Ministry of Health could increase the visibility of Saudi nurses, for example, in news stories, to help change the misperception that nursing is a foreigner's job.
- The Ministry of Health could increase the opportunities for nurses to be senior leaders in healthcare teams, thus enhancing their autonomy, making nursing more a professional rather than menial occupation, and so improving the social status of nurses.

- The Ministry of Human Resources and Social Development and Ministry of Health should develop a standardised formal clinical career ladder together with explicit job titles and descriptions of different nursing roles. This could help nurses to comprehend and fulfil the roles which they have been prepared for.

- Recommendations for nursing education:

The findings of this study identified some recommendations, which might be useful for nursing education and academic institutions, in relation to the recruitment of nurses and their preparation for practice. These recommendations are as follows:

- The promotion of nursing as a career by academic institutions should be more realistic in terms of balancing the actual role of clinical nurses with leadership opportunities, and convey an accurate image of the nurse role to those considering nursing as a career pathway. Prospective student nurses should be provided with a clear career structure so that they can develop more realistic expectations about their role and the possibilities for professional growth.
- The Ministry of Education should be flexible in learning and recognise the value of blended learning in BSN courses. This could help prospective students to overcome social issues such as the difficulty of studying away from home.
- Nurse academics should engage more in clinical practice as this could improve their clinical credibility and help them convey a more realistic image of clinical work. This would support them to maintain a balance between teaching high standards of care and the realities in nursing practice. However, the workload level on the educators should also be considered to minimise burnout and job dissatisfaction among them.

- Recommendations for practice:

The data from this study suggest that there are a number of organisational issues that need to be considered to improve working conditions in nursing. To address these issues, I propose the following:

- The findings show that there is role conflict and ambiguity affecting different nursing roles, e.g., nurse specialist (BSN) and nurse assistant (Diploma-qualified nurse). Therefore, clarifying the role and scope of practice of different nursing roles, i.e., healthcare assistant, nurse assistant and clinical nurse specialist, etc., is essential to improve role clarity. Moreover, the term "professional" should be reserved to registered nurses to differentiate from non-professional nursing roles like health care assistants (HCAs). This can be achieved through the recommendation mentioned earlier about developing a standardised formal career framework for nurses.
- More opportunities for continuing professional development – including access to both theoretical and clinical masters and doctoral degrees - should be offered for nurses so that they can use evidence-based practice to deliver patient centred effective and efficient health care. This helps ensuring safe and high quality nursing care for patients, and also help in meeting the nurses' needs for career growth (a motivating factor).
- Offer different roles for registered nurses that might match their career aspirations and encourage them to remain in practice, e.g. nurse practitioner and advanced nurse practitioner. This, however, should be offered after a certain length of clinical experience and attainment of relevant qualifications. Granting access to these positions facilitates rebranding the profession of nursing in multiple ways: it presents nursing as a career with great potential for professional growth, improves the quality of nursing care, introduces nurses to the public as reliable influential leaders, improves nurses' self-concept, and makes nursing a more attractive career pathway.

- Recommendations for future research:

- Participants in this research showed strong intentions to leave bedside nursing; therefore, a longitudinal (3-5 years) study could be beneficial to determine whether their perceptions of nursing had changed over time. This could help understand the barriers and enablers for nurses to either leave or stay in in their jobs.

- A qualitative study looking at the demographics of those who actively choose nursing as a career and the reasons why could help identify who and what make people may consider a career in nursing.
- The literature on nursing attrition in Saudi seems to rely largely on intentions to leave, rather than actual attrition rates. Thus, a retrospective study to identify the actual attrition/retention rates of nurses is essential in order to develop adequate nurse staffing strategies. Moreover, surveying those who had already left nursing could help determine reasons for quitting and their next destinations.
- A cross sectional study of NQNs within Saudi, or even cross-national (e.g. GCC countries), could help understand their motivations for studying nursing and career plans. It could also test the *Forward Escaping* theory developed in this thesis.
- A further study could be conducted to examine whether offering a prolonged clinical training for students (e.g. 12 months) prior to qualification, as in this study, can help them to feel more confident and prepared for independent practice.

8.4 Strengths and limitations of the study

Grounded theory methodology provides conceptual power to the research study, enabling abstraction of data into conceptual theory (Glaser, 2003). However, the use of the methodology can be influenced by the researcher's skills and experience. Although substantial effort was invested to enhance theoretical sensitivity through reading in several fields, it is necessary to highlight that, as a novice researcher, the breadth and depth of the theoretical coding may have been limited by my limited experience and the time constraints of the PhD programme. This may have prevented the findings from reaching the conceptual level and they remain at the descriptive level. In order to improve my analysis skills, though, I attended multiple relevant courses and workshops (e.g. a grounded theory troubleshooting seminar) to obtain the necessary skills and I regularly discussed the research process with my supervisory team, who have substantial experience in different research methodologies, including grounded theory. Moreover, I sought methodological consultation from a grounded theory institute to ensure the principles of grounded theory were followed rigorously. I thought these additional steps helped

in strengthening the quality of my research and this thesis. Other strengths of my study, such as the use of constant comparison technique, theoretical sampling, triangulation of data and maintaining openness have been discussed in detail earlier in *3.4 Research Methods.*

The theory of *Forward Escaping* conceptualises one pattern of behaviour. Therefore, it is possible that newly qualified nurses (NQNs) may also be engaged in different patterns of behaviour that need further investigation. For example, unlike other studies examining the role transition to becoming a nurse (Kramer, 1974; Duchscher, 2009) which have identified the influence of transition shock on the decision to change jobs, this did not turn out to be relevant within the *Forward Escaping* theory. This is not essentially a limitation of this research, as the concept of reality shock did not seem to have significant fit or relevance to the data collected from participants in this study. Indeed, this has highlighted a topic for further investigation through theoretical sampling. It is important to restate that this study did not intend to explore the NQNs' entire range of behaviours. Instead, it offers a substantive theory that accounts for and explains one main concern in a specific area and how it is continually resolved. However, it would have enhanced the theory further if it had been possible to carry out theoretical sampling elsewhere as well. For example, amongst other significant individuals, such as parents of NQNs and their university tutors who were involved in NQNs' career decision-making. This could have helped to further elaborate the emerging theory. Other limitations in terms of data collection, such as being a male researcher interviewing a largely female sample, have been highlighted in *3.4 Research Methods and 3.5 The inbetweener-researcher role.*

While it has been highlighted that there is a potential for the theory presented in this study to demonstrate conceptual generality, it is necessary to recognise that this potential can only be achieved through additional theoretical sampling in different fields or areas. For example, exploring the experiences of NQNs in multiple countries that share similar socioeconomic characteristics, e.g. GCC countries. I believe this substantive theory has the potential to present a general explanation of the ways in which members of certain professions manage concerns about their career choice, and can be used as the basis for generating a formal theory with a more general applicability.

8.5 Dissemination

During the course of this research, preliminary findings were presented at two international conferences: a post-graduate showcase in the UK and the 40th Annual International Nursing & Midwifery Research & Education Conference 2021 (Ireland). Moreover, the review of literature presented in Chapter Two was used as the basis for a paper published in the *International Journal of Nursing Studies*. It is hoped that the disseminated knowledge, in addition to final findings, will be helpful to nursing education, research and practice in general, and to the nursing profession in Saudi in particular. While students and researchers with academic affiliations enjoy greater access to published literature, including PhD theses, some clinical nurses and other professionals are limited to nursing journals and conferences should they wish to expand their knowledge. Therefore, to further disseminate my research and communicate with these groups of professionals, I plan to:

- Deliver a comprehensive presentation of the study at the hospital where the study was conducted, which would enable participants and other key informants to discuss and respond to the findings of this study.
- Present the findings at national and international conferences such as the International Nurse Education Conference (October, 2022), which could help it to be compared and contrasted with studies from different contexts.
- Publish a paper that discusses the role transition of newly qualified nurses in the Saudi context in a relevant journal, such as *International Journal of Nursing Studies or Nurse Education Today*.
- Publish another paper in the *Journal of Nursing Management* or similar on the career decision-making process in Saudi in light of the recent socio-economic reforms and demographic changes in Saudi society.
- Share a lay summary of the study with nurse educators and Saudisation stakeholders such as the Ministry of Human Resources and Social Development and the Ministry of Health.

8.6 Conclusion

This chapter has provided a summary of the developed substantive grounded theory and offered recommendations for relevant parties (policy makers, academics and clinicians) to help improve the recruitment, preparation and retention of nurses. Moreover, the strengths and limitations of this study have been highlighted, in addition to areas that warrant further exploration. Finally, this chapter concluded with a plan to disseminate the study findings in order to reach as many interested individuals as possible. This thesis offers a unique insight into the transition experiences of newly qualified Saudi nurses, which could be beneficial in improving the transition experience from education to professional practice within Saudi and in many other counties that share similar characteristics.

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Appendices

Appendix 1: A published literature review (scoping review)

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Newly qualified nurses' transition from learning to doing: A scoping review

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ABSTRACT

Objectives: To identify newly qualified nurses' experiences during transition to professional practice, and explore their and other key stakeholders' perceptions of nursing transition programmes.
Design: Scoping review using the Arksey and O'Malley framework.
Methods: Several electronic databases were searched for relevant articles, which were supplemented by hand-searching and internet searches for grey literature. 1823 potentially relevant articles published between 1974 and 2019 were retrieved from the initial search, and an additional ten articles were obtained from the supplemental search. Each article was independently reviewed, leaving 60 articles eligible for inclusion in the review.
Findings: Two overarching themes emerged: 1) the transition experience; 2) the perceived benefits of nursing transition programmes. Evidence that nursing transition programmes positively impact the transition experience is inconclusive. Some studies suggest a positive impact on newly qualified nurses' competency, level of confidence and attrition rates; others reported no impact. There was a general consensus that newly qualified nurses still encounter difficulties when transitioning into professional practice. Most articles found were quantitative in nature, focusing on measurable outcomes of nursing transition programmes. Few investigated the experiences and perceptions of newly qualified nurses, preceptors, and managers regarding the transition to professional practice.
Conclusions: Literature mapping suggests that newly qualified nurses frequently struggle to successfully complete the transition into professional practice, and that this transition is complex and multifaceted. There is limited evidence to justify the widespread implementation of nursing transition programmes. Additional research focusing on experiences and perceptions of newly qualified nurses and their transitory process is warranted.
Tweetable abstract: Are newly qualified nurses receiving sufficient transition support (e.g. #nursing residency programs or #preceptorship)? #Nurse #Nurses #nursing_intern

What is already known about the topic?

- The global shortage of nurses is linked to a decrease in healthcare quality and an increase in patient mortality.
- Newly qualified nurses are leaving the profession at alarming rates, due primarily to workload pressures and the lack of professional support.
- There are claims that participation in a 12-month nursing transition programme led to positive effects on confidence and competence and helped newly qualified nurses better integrate into a team setting.

What this paper adds

- The majority of studies reviewed focused on measuring outcomes of nursing transition programmes, but there was no general agreement as to which outcomes were important, and many studies used poorly validated outcome measures.
- Although a formal quality assessment was not performed, a methodological discussion of the included articles suggested that evidence for the impact of nursing transition programmes on the transition of newly qualified nurses was inconclusive.
- Insufficient studies scrutinised the experiences and perceptions of newly qualified nurses, preceptors, and managers

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Appendix 2: Table 5: Data extraction

Author and date	Country	Study Sample	Methodology and Methods	Findings
Primary studies				
Abualrub and Abu Alhaija'a (2018)	Jordan	A purposive sample of 30 NQNs and 6 nurses from three different hospitals.	**Methodology:** Qualitative study **Methods:** Interviews and focus groups	• Challenges for implementing NTPs included the regulation process, payment issues for those involved in NTPs, and monitoring and evaluating novice nurses during NTPs.
Al Awaisi et al. (2015)	Oman	A purposive sample of 15 NQNs, 8 interns, 6 preceptors, 5 clinical instructors, 5 head nurses, and 4 mangers.	**Methodology:** Case study **Methods:** Interviews, focus groups, observations, and documentary analysis	• NQNs felt confused due to differences between expectations and reality. • NQNs felt they had a high level of theoretical knowledge but limited practical skills. • Clashes occurred between NQNs and preceptors for various reasons; some preceptors were perceived as less qualified.
Aldossary et al. (2016)	Saudi Arabia	98 NQNs convenience sampled from three different hospitals.	**Methodology:** Cross-sectional design **Methods:** Surveys	• NQNs who attended an NTP improved overall leadership skills significantly. • There was no statistically significant difference found between those attended the 6-month or 12-month NTP in terms of leadership skills performance.
Allan et al. (2018)	UK	Unclear sampling. 33 NQNs, 10 HCAs, 12 nurse mangers.	**Methodology:** Ethnographic case study **Methods:** Observations and interviews	• Most preceptees liked their preceptorships, but shared common negative aspects (e.g. time constraints, staffing level, workload). • A reflective learning style helped many NQNs to cope with difficult situations by reflecting on their work and learning from their mistakes.

Ankers et al. (2018)	Australia	A purposive sample of 7 NQNs from one hospital.	**Methodology:** Hermeneutic phenomenology **Methods:** Interviews	• Inadequate ward orientation made adjustment to the ward harder (e.g. 4 days' support, then working alone). • As time passed, all NQNs felt that they became more confident in their practice. An advantage of the programme was the ability to 'off load' confidentially.
Berkow et al. (2008)	US	A purposive sample of 5,700 frontline nurses.	**Methodology:** Quantitative study **Methods:** Online surveys	• Only about 25% of nurse leaders were fully satisfied with clinical and non-clinical NQNs' skills. • Survey results supported research evidencing a correlation between more education and greater nurse proficiency.
Bérubé et al. (2012)	Canada	Unclear sampling. Questionnaires and focus groups.	**Methodology:** Evaluative study **Methods:** Questionnaires and focus groups	• A 46% increase in recruitment rate of NQNs was observed when comparing the same period of time before and after implementation of the NTP. • NQNs' retention rate one year after the NTP rose by 26%. • The use of simulation was favoured by participants.
Blegen et al. (2015)	US	Random method. NQNs and preceptors were recruited from 82 hospitals.	**Methodology:** Longitudinal, randomised, multisite design **Methods:** Online surveys	• The retention rate after one year in high preceptor support (HPS) hospitals was 86% and 80% in low preceptor support (LPS) hospitals. • For overall competence, preceptors in HPS rated their NLRNs significantly higher than NLRNs in LPS hospitals.
Bratt and Felzer (2011)	US	464 NQNs were surveyed at baseline, at 6 months, and at 12 months	**Methodology:** Quantitative study **Methods:** Repeated measures design	• Job satisfaction was significantly lowest at 6 months and highest at 12 months. • Job stress was found to be lowest at 12 months and organisational commitment was highest at baseline. Clinical decision-making was highest at 12 months.

Clark and Holmes (2007)	UK	A purposive sample of 105 NQNs and 5 nurse managers	**Methodology:** Qualitative study **Methods:** Focus group and interviews	• The majority of NQNs felt unprepared for independent practice. • Most NQNs needed 6 months to feel confident to practise independently. • There was a focus on competencies rather than overall competence (what NQNs could and couldn't do). • There was no agreement on what to expect from NQNs during preceptorship.
Cline et al. (2017)	US	A convenience sample of 1,638 NQNs.	**Methodology:** 10-year retrospective analysis of an NTP **Methods:** Surveys	• Communication/leadership, patient safety, and confidence scores improved significantly during transition. • Adding simulation classes to the programme increased post-intervention scores. • NQNs had a low level of stress, and the NTP had little influence in reducing it. • Support and professional satisfaction showed statistically significant decline during NTP.
Cubit and Ryan (2011)	Australia	A purposive sample of 16 NQNs were surveyed at 4 different points, followed by focus groups.	**Methodology:** Evaluative study **Methods:** Online surveys and focus group	• Only 50% were given supernumerary days due to lack of awareness of clinical managers or staff shortage. • Some NQNs did not feel the need for supernumerary status, as they had previously worked in the same ward during clinical training. • The NQNs sensed an increased 'accountability and responsibility, which were associated with increased stress. • Debriefing was identified as the best part of the GNP.
D'Addona et al. (2015)	Canada	A purposive sample of 12 nursing leaders	**Methodology:** Qualitative **Methods:** Interviews	• Challenges within NTPs included budget constraints and exclusivity for NQNs. • NTPs facilitated the transition and improved NQNs' retention.

Duchscher 2008	Canada	A purposive sample of 14 NQNs.	**Methodology:** Qualitative. **Methods:** Focus group and interviews	• NQNs progressed through the stages of doing, being, and knowing to becoming professional RNs. • NQNs realised that they were unprepared for the responsibilities and workload of professional RNs. • Findings suggested managers should wait 6 months before introducing NQNs to critically unstable patients.
Dyess and Parker (2012)	US	A purposive sample of 89 NQNs from one hospital.	**Methodology:** Mixed method design **Methods:** Pre-post surveys	• Skill acquisition occurred and retention improved. • Retention rate was 80%, compared with retention of 65% of NQNs not participating in NTPs. • NQNs' leadership skills developed.
Figueroa et al. (2013)	US	Unclear sampling. 108 NQNs and 100 preceptors.	**Methodology:** Mixed method study **Methods:** Surveys and focus groups	• 90% of preceptors surveyed found the NTP to be beneficial to NQNs. • Turnover rate was not measured statistically. Instead, preceptors were asked whether the NTP influenced the retention of NQNs; 86% agreed.
Forde-Johnston (2017)	UK	A purposive sample of 37 NQNs and 17 nurse managers.	**Methodology:** Evaluative study **Methods:** Questionnaires and focus groups	• 75% of NQNs had not spent clinical time "at the bedside" with their preceptors and were not given observed feedback on their clinical skills in practice from a preceptor or other experienced nurses. • Bi-weekly and monthly review meetings with preceptors were found to enhance the preceptorship.
Friday et al. (2015)	US	A convenience sample of 46 NQNs.	**Methodology:** Longitudinal quantitative study **Methods:** Surveys	• Although the retention rate at 2 years was still considered high compared to the national average, the 30-month overall retention rate dropped to 68%.
Glynn and Silva (2013)	US	A purposive sample of 8 NQNs.	**Methodology:**	• NQNs developed their nursing knowledge and skills during the programme.

			Qualitative descriptive design **Methods** Interviews and questionnaires	• NQNs became more proficient as time passed. • NQNs thought the programme assisted their role transition.
Goode et al. (2013)	US	Unclear.	**Methodology:** Retrospective analysis **Methods:** Surveys	• Retention rates for NQNs in the NRP increased considerably in the participating hospitals. • NQNs' competence, confidence, and leadership skills showed statistically significant increases over the one-year NTP.
Guay et al. (2016)	Canada	Purposive and theoretical sampling of 10 NQNs	**Methodology:** Grounded theory **Methods:** Interviews	• NQNs gradually became more confident, and, by the end of the programme, became adjusted and ready to practice independently. • Rotation during the programme was thought to delay transition.
Henderson et al. (2015)	Australia	A purposive sample of 78 NQNs	**Methodology:** Mixed method design **Methods:** Survey and focus group	• Interactive days were perceived as important, as emotional support and collegiality contributed to their confidence. • Elements valued by NQNs were study days, positive working relationships with their preceptors, and the positive contribution of the nursing team where they worked.
Hopkins and Bromley (2016)	US	A purposive sample of 149 nurse managers, mangers' assistants and RNs.	**Methodology:** Cross-sectional **Methods:** Online survey	• 63% of nurse mangers were satisfied with NQNs' competencies in interprofessional communication, compared with the national average of 38%. • Participants reported 56% satisfaction in the ability of NQNs to work as a team, compared with 37% reported in the national study.
Hussein et al. (2017)	Australia	A purposive sample where 87 NQNs	**Methodology:** Mixed method design	• Over the 2 periods, there were no significant changes in NQNs' confidence level, nor their satisfaction with clinical

		were surveyed at baseline and at completion of a 12-month NTP.	**Methods:** Pre-post surveys	supervision, clinical practice environment, unit orientation, or overall experience of the programme. • NQNs struggled with high workload with minimal support from experienced staff. • NQNs experienced lack of confidence and insecure feelings.
Jones et al. (2014)	UK	A purposive sample of 15 NQNs and 5 ward managers.	**Methodology:** Evaluative study **Methods:** Surveys and interviews	• NQNs found the programme useful, enjoyable, supportive, well-structured, and up-to-date lecturers compare to university. • Negative comments included: some repetition from university, classes needed to be more specialised, organisational issues (e.g. cancellation with no prior notice).
Kramer et al. (2012)	US	A purposive sample from 907 nurses from 20 different hospitals	**Methodology:** Qualitative **Methods:** Individual and group interviews	• NTPs were highly valued by all interviewees. • NQNs had difficulty in "prioritising patients or care." • Coaching sessions were perceived as the most effective strategies for learning how to prioritise care for a group of patients.
Kumaran and Carney (2014)	Ireland	A purposive sample of 10 NQNs.	**Methodology:** Heideggerian hermeneutic phenomenology study **Methods:** Interviews	• NQNs initially felt excited, happy, delighted, and relieved, then nervousness and vulnerable due to the increase of responsibilities and accountability associated with the new role. • Fear of making mistakes, lack of knowledge and experience, lack of organisational skills together with the accountability associated with the new role increased NQNs anxiety levels.
Lea and Cruickshank (2005)	Australia	A purposive sample of 10 NQNs interviewed while attending a	**Methodology:** Hermeneutic phenomenological approach	• NQNs were dissatisfied due to inadequate support during the programme.

		12-month NTP	**Methods:** Interviews	• Some NQNs believed they were misled by the programme advertisement and were disappointed with the content and structure.
Lewis and McGowan (2015)	UK	A purposive sample of 8 novice nurses.	**Methodology:** Qualitative **Methods:** Interviews	• Most NQNs felt there was little time to meet with their preceptor. • Most NQNs said that preceptorship enabled them to develop their knowledge and skills. • Some preceptees thought filling in the forms requested by the programme was a challenge, as it added to the ward workload.
Lima et al. (2016)	Australia	A convenience sample of 47 NQNs.	**Methodology:** Quantitative longitudinal study **Methods:** Surveys	• NQNs' competence developed gradually from 40% at commencement to 76% upon programme completion.
Linus et al. (2014)	US	A purposive sample of 39 nurse leaders	**Methodology:** Mixed method study **Methods:** Online surveys and focus group	• Participants thought NTPs helped improve NQNs' confidence and accelerated their engagement on their working unit. • There was a need for clarification regarding the roles and expectations of preceptors during NTPs. • There was a decrease in NQNs' first year turnover.
Marks-Maran et al. (2013)	UK	A purposive sample of 44 NQNs	**Methodology:** Mixed method design **Methods:** Questionnaires	• Preceptorship helped improve NQNs' communication skills and clinical skills. • 82% of preceptees found difficulty in arranging meeting times with the preceptor. • Issues of time, conflicting shift patterns, and priority of preceptorship meetings were concerns raised by preceptees.
McKillop et al. (2016)	New Zealand	A purposive sample of 122 NQNs and 14 preceptors.	**Methodology:** Mixed method study	• The programme was believed to help to improve NQNs' nursing knowledge, skills in patient assessment, and application of critical thinking to clinical practice.

			Methods: Online survey and focus group	• It enhanced interprofessional communication and knowledge sharing, and had a positive impact on professional awareness and career planning.
Muir et al. (2013)	UK	A purposive sample of 44 preceptors.	**Methodology:** Mixed method design **Methods:** Questionnaires and one-to-one interviews	• 75% of preceptors felt that they had a positive impact on preceptees' confidence and competence in communicating with colleagues, patients, and relatives. • 66% of preceptors felt that preceptorship had enhanced their attitude to their own career development and had a positive impact on their knowledge, understanding of NQNs' needs for emotional support, and teaching role skills
Nour and Williams (2018)	Canada	Snowball sampling of 14 NQNs	**Methodology:** Grounded theory **Methods:** Interviews	• ''Theory Becoming Alive" reflects NQNs' four-stage journey; entry into practice (initial journey into professional workplace), immersion (how NQNs immerse themselves in clinical practice), committing (pledge to the profession and life-long learning), and evolving (becoming comfortable and gaining confidence and insights into clinical practice).
Olson-Sitki et al. (2012)	US	A convenience sample of 31 NQNs.	**Methodology:** Mixed-methods design **Methods:** Surveys	• Results showed statistically significant differences in NQNs' confidence, skills, and abilities at 12 months. • NQNs' turnover declined from about 14% prior to implementation of NTP to nearly 9%.
Pittman et al. (2013)	US	A purposive sample of 219 nursing leaders	**Methodology:** Cross-sectional **Methods:** Online survey	• There was a relatively high level of adoption of NTPs. • Financial cost and diverting staff from other work were the greatest challenges.

Rush et al. (2014)	US	A purposive sample of 245 NQNs from 7 hospitals.	**Methodology:** Mixed method **Methods:** Online surveys	• Some NQNs felt bullied, and bullied NQNs were less able to access support when needed and had a poorer transition experience. • Formal NTPs provided support that attenuated the impact of bullying on NQNs.
Setter et al. (2011)	US	A purposive sample of 100 NQNs.	**Methodology:** Cross-sectional, descriptive design **Methods:** Surveys	• The retention rate dropped to 60% 3 years after completing the NTP. • Several NQNs mentioned that there were frequent conflicts with scheduling work and classes during the NTP. • Support from the NTP was found the lowest reason for staying.
Silvestre et al. (2017)	US	Unclear sampling. 1,032 NQNs from 70 hospitals.	**Methodology:** Comparison study **Methods:** randomised, controlled, multisite design	• NQNs' turnover rates in NTP hospitals were 15.5% and 26.8% in the control group. • A positive return on investment was found, which provided additional evidence in favour of implementation of NTPs in hospitals to decrease NQNs' turnover from a business perspective.
Slate et al. (2018)	US	A convenience sample of 124 NQNs surveyed at baseline, 6 months, and at completion of a 12-month NTP	**Methodology:** Longitudinal quasi-experimental, multiple groups **Methods:** Time series design and surveys	• NQNs felt disappointed due to multiple preceptors with varying effectiveness. • During the first two testing points, NQNs felt uncomfortable regarding their skills in responding to emergency cases, management of chest tubes, and tracheostomy care.
Spiva et al. (2013)	US	A convenience sample of 21 NQNs from one hospital.	**Methodology:** Grounded theory **Methods:** Interviews	• Preceptors varied and either enhanced or hindered NQNs' transition. • Professional growth and confidence improved gradually.

Whitehead et al. (2016)	UK	Snowball sampling of 40 preceptees and nurses, 10 preceptors, and 2 nurse leaders.	**Methodology:** Case study **Methods:** Interviews, document analysis, and focus group.	• There was a need to acknowledge the preceptor role. • Preceptors' limited time was a major barrier to effective preceptorship.
Wierzbinski-Cross et al. (2015)	US	A convenience sample of 123 subjects, including staff nurses, nurse educators, and leaders.	**Methodology:** Quantitative **Methods:** Online survey	• Costs, lack of preceptors, staffing pressures, and lack of knowledge of the purpose or definition of NTPs were the most frequently identified barriers. • There was a concern that implementing an NTP meant withdrawing more experienced nurses from the bedside and increased workload for others.
Reviews of literature				
Bakon et al. (2018)	Australia	Integrative literature review	30 studies	• Many studies failed to delineate the elements included in their transition programme. • Studies suggested NTPs' length to be between 3 and 12 months. • There was inappropriate allocation of RNs to fulfil the preceptor role without considering their patient-related workload. • There were some ambiguity, role conflict, and misconceptions on both sides of the preceptor/preceptee relationship.
Cochran (2017)	US	Systematic review	22 papers (US only)	• NTPs were a cost-effective method proven to reduce attrition rate of NQNs. • The most effective programmes were 12 months in duration. • Critical thinking, knowledge, and confidence increased significantly after the completion of a one-year NTP.

				• Nursing preparation needs to be considered when developing an NTP. • Diploma-prepared nurses may have different needs than BSN-prepared nurses.
Eckerson (2018)	US	An evidenced-based literature review	12 papers	• Use of NTPs showed increased satisfaction and retention of NQNs over a one-year period. • The improved retention rates were also shown to have positive financial implications. • There was moderate evidence to support an increase in satisfaction with the use of an NTP.
Edwards et al. (2015)	UK	Systematic review	30 articles	• Almost all types of support during transition led to positive outcomes. • NQNs competency increased regardless of the duration or type of programme. • Studies did not use validated tools to measure confidence, either it was self-reported or researchers observed participants. • Studies of transition solutions varied in methodological approach and quality; many had weak designs.
Irwin et al. (2018)	UK	Systematic literature review within the UK	14 papers	• None of the papers defined competence or confidence. • There was no concrete evidence that preceptorship had a direct impact on confidence/competence.
Ke et al. (2017)	Taiwan	Systematic review	6 papers	• The most commonly adopted preceptorship model was a fixed preceptor/preceptee model with duration ranging from 1-3 months. • Preceptorships significantly increased NQNs' overall competence. • The effect of preceptorships on NQNs' professional socialisation, job satisfaction, and retention was unclear.
Monaghan (2015)	UK	Critical analysis review	8 studies (UK only)	• NQNs felt not enough time was dedicated to the production of clinical skills during their training.

				• The use of simulation and preceptorship programmes were found to reduce the transitional stress associated with becoming a qualified nursing practitioner.
Pasila et al. (2017)	Finland	Systematic review of qualitative studies	13 studies	• Many NQNs wished the NTP was longer than 3 months. • Some NQNs experienced confusion when working with more than one preceptor, received unrealistic expectations from experienced nurses, did not feel included as team, and were subject to bullying. • Ward rotations during orientation were seen as a positive way to widen NQNs' knowledge base, improve skills, and increase interprofessional skills.
Quek and Shorey (2018)	Singapore	Integrative review	20 articles	• Preceptors who were less experienced or inconsistent in their guidance may have bred annoyance and negativity in NQNs. • The majority of preceptors experienced either mild or moderate stress. • Pre-registration nursing education was insufficient on its own to prepare NQNs for the realities of nursing. • Preceptees with higher qualification e.g. MSc, felt that their colleagues felt threatened by their educational level.
Whitehead et al. (2013)	UK	Systematic literature review	24 articles	• The main problems for preceptors were: role ambiguity, role conflict. and role overload. • Preceptors showed signs of stress and anxiety in relation to time shortage due to clinical responsibilities. • Although preceptorship was found to be effective in recruitment, it had no link to retention of NQNs.
Grey literature				
Capital Nurse Preceptorship Programme (2017)	UK	-----	Policy	• It was suggested that preceptorship should be available to all newly registered nurses and should be a minimum of 6 months.

				• Preceptors may volunteer or be asked to undertake the role by their managers. • Research showed that the best preceptors are those who volunteer.
HEE (2015)	UK	-----	Review	• Patients' and professionals' unawareness of NQNs level of experience added more pressure to NQNs. • Further focused reviews are needed to determine whether preceptorships should also be offered as a formalised follow-on programme and/or integrated as part of pre- and post-registration training.
Hillman and Foster (2011)	US	-------	Commentary	• Implementation of an NTP resulted in significant cost savings due to increases in NQNs' one-year retention rates. • Frustration with the orientation process and the lack of support was the prime reason for NQNs' turnover.
IOM (2010)	US	-----	Report	• All stakeholders should support nurses to complete an NTP after they have completed a pre-registration nursing programme. • Current NTPs should be assessed for improving NQNs retention, expanding their competencies, and improving patient outcomes.
RCN (2017)	UK	-----	Policy	• It was anticipated that preceptorship enhances the quality of patient care, improves recruitment and retention of staff, boosts staff morale, and reduces the risk of complaints.
Snow (2013)	UK	-----	Report	• Implementation of preceptorship varied across the UK. • Private trusts used preceptorships as a strategy to attract the best NQNs and improve the quality of care provided. • Preceptors also needed training to develop their understanding of the programmes' objectives and the needs of NQNs.

Appendix 3: Study advertisement letter

MANCHESTER 1824
The University of Manchester

An opportunity to participate in a study about:

The nursing transition programme (the OJT programme)

You are invited to participate in a research study, as part of a PhD student's project that aims to explore the experiences of individuals involved in the OJT programme.

Are you:

- A new graduate nurse at KAMC or a member of staff who has some involvement in the OJT programme?
- Participating, or already have participated, in the OJT programme?
- Willing to be interviewed?

If so, please consider taking part in this study:

- Participating in this study is voluntary.
- Date and time of the interview will be arranged at a convenient time for you.
- The interview will be held at a private location within the hospital premises that is convenient to you.
- It is one-off interview, around 60-90 minutes, with a possible shorter second interview (if needed) for clarification.

If you would like to participate or have queries about this study, please contact: **Nasser Aldosari** via:

Email: Nasser.aldosari@postgrad.manchester.ac.uk OR

Appendix 4: Interview topic guide

MANCHESTER 1824
The University of Manchester

Interview Topic Guide (updated)

Theme One: Choosing a profession:

1- **What made you decide to do nursing?**
Prompts if needed:
- What did you know about nursing before you came in?
- Did anyone influence you?
- Did you talk to family and friends about this?
- What were family and friends' reactions?
- Was there any social and financial impact?

Theme Two: Learning nursing:

2- **Can you please tell me about your training?**
Prompts if needed:
- Which university? And how long the nursing course was?
- Did you attend a BSN or a bridging course?
- Can you describe the learning system there?
- What was the theory/practice ratio?
- How many years did it take you to graduate?
- How did it feel to graduate?
- What happen next?

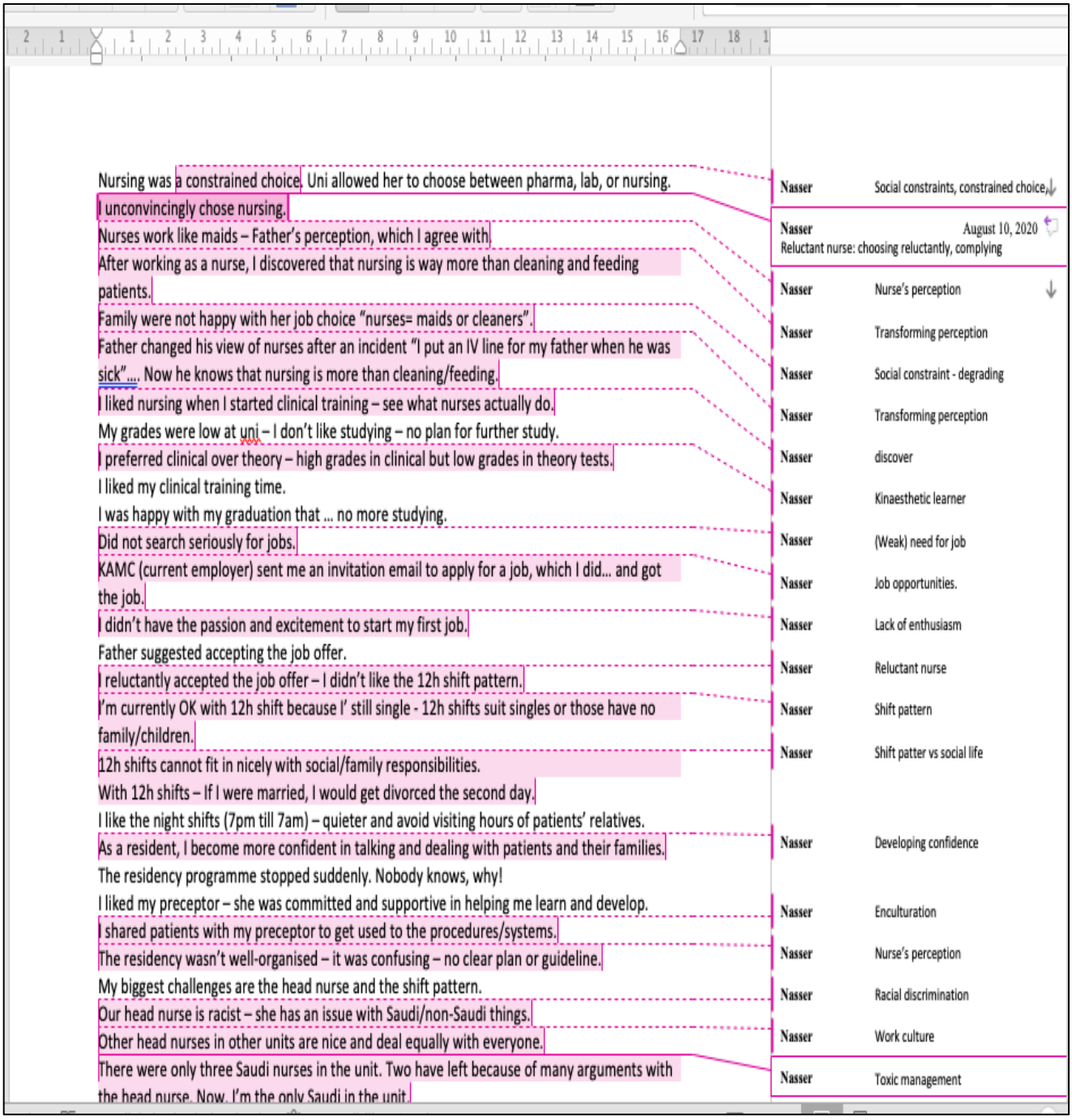
Theme Three: Life as a NGN:

3- **Can you please tell about your transition from school to hospital?**
Prompts if needed:
- How was your job searching?
- What made you choose to work in this hospital?
- How do you feel about the transition from student to professional RN?
- How is life in the ward going?
- How do you find the OJT programme so far?
- What is your thought about the current working environment as a NGN?
- What are your suggestions to improve the experience of NGNs' transition?

Would you like to add anything?

Thank you very much for your time and effort. The end.

Appendix 5: Example of open coding



Appendix 6: Example of a memo

Need for nursing

is a property and has degrees… strong or weak need for nursing.

She needs nursing to get a job.

Complying

She is complying with available choices.

She is not complying with society

Ambition

Why they are there? What do they want?

Career options

Career is a property of nurse… (dimensions: availability, interest, pay and proximity)

She wanted a job in chemistry but it wasn't available within her home town (proximity - not).

A nursing job has the dimensions availability, proximity and pay.

Proximity

Proximity seems to be a decisive factor. Why?

She picked a job that was closer to her home; despite her interest in another job, which would require 2h commute.

She cancelled her further study plan due to unavailability in her home town (proximity).

Drudgery work

Bed making, feeding, bathing tasks are a part of nurse job/role.

New nurses like providing nursing care procedures e.g. medications and invasive procedures, and don't like the drudgery work.

This reminds me of the phrase in the UK "too posh to wash"

Discovering "transforming perception"

Nurses may change their preconception of nursing after living the clinical experience first-hand.

Her clinical experience showed her the real practice of nursing, which she liked it.

Nurse

Dimensions of nurse's perception; nursing education, image of nursing, and work culture.

Autonomy

Autonomy is a need for new nurses to prove worthiness to themselves and to others.

She felt the residency with the rule "observe but don't touch patients" is an obstacle for her development.

Appendix 7: Ethical approval from the University of Manchester

2nd Floor Christie Building
The University of Manchester
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Tel: 0161 275 2206/2674
Email: research.ethics@manchester.ac.uk

Ref: 2019-5141-9284

11/02/2019

Dear Mr Nasser Aldosari, Prof Steven Pryjmachuk, Dr Hannah Cooke

Study Title: A study of a nursing transition programme in Saudi Arabia

University Research Ethics Committee 3

I write to thank you for submitting the final version of your documents for your project to the Committee on 05/02/2019 09:44 . I am pleased to confirm a favourable ethical opinion for the above research on the basis described in the application form and supporting documentation as submitted and approved by the Committee.

Please see below for a table of the title, version numbers and dates of all the final approved documents for your project:

Document Type	File Name	Date	Version
Data Management Plan	DMP	12/11/2018	1
Participant Information Sheet	Participant information sheet (PIS)	20/11/2018	1
Distress Protocol/Debrief Sheet	Distress Protocol	20/11/2018	1
Lone Worker Policy/Procedure	Lone Worker Policy and Procedure	20/11/2018	1
Additional docs	Participant's demographic data	20/11/2018	1
Data Management Plan	DMP	20/11/2018	1
Default	Interview topic guide	01/02/2019	2
Advertisement	Advertisement letter	01/02/2019	2
Consent Form	Consent form	01/02/2019	2
Additional docs	IRB Opinion Letter - 18-488	01/02/2019	1
Additional docs	Required amendments	01/02/2019	1

This approval is effective for a period of five years however please note that it is only valid for the specifications of the research project as outlined in the approved documentation set. If the project continues beyond the 5 year period or if you wish to propose any changes to the methodology or any other specifics within the project, an application to seek an amendment must be submitted for review. Failure to do so could invalidate the insurance and constitute research misconduct.

You are reminded that, in accordance with University policy, any data carrying personal identifiers must be encrypted when not held on a secure university computer or kept securely as a hard copy in a location which is accessible only to those involved with the research.

Reporting Requirements:

You are required to report to us the following:

1. Amendments: Guidance on what constitutes an amendment
2. Amendments: How to submit an amendment in the ERM system
3. Ethics Breaches and adverse events
4. Data breaches
5. Notification of progress/end of the study

Feedback

It is our aim to provide a timely and efficient service that ensures transparent, professional and proportionate ethical review of research with consistent outcomes, which is supported by clear, accessible guidance and training for applicants and committees. In order to assist us with our aim, we would be grateful if you would give your view of the service that you have received from us by completing a **UREC Feedback Form**. Instructions for completing this can be found in your approval email.

We wish you every success with the research.

Yours sincerely,

Appendix 8: Ethical approval from the hospital

مدينة الملك عبدالله الطبية
KING ABDULLAH MEDICAL CITY IN HOLY CAPITAL

المملكة العربية السعودية Kingdom of Saudi Arabia
وزارة الصحة Ministry of Health
مدينة الملك عبدالله الطبية بالعاصمة المقدسة King Abdulla Medical City in Holy capital
اللجنة المحلية لأخلاقيات البحث Institutional Review Board

Institutional Review Board Opinion Letter

Protocol Title	Key stakeholders' experiences of a nursing transition programme in a tertiary hospital in Saudi Arabia: A grounded theory study
Version	1.0
Principal investigator	Nasser Mubarak Aldosari
IRB number	18-488
Sponsor	NA

Dear Dr. Aldosari,

This is to inform you that the above mentioned proposal has been the subject of expedited review by KAMC IRB registered at the National BioMedical Ethics Committee, King Abdulaziz City for Science and Technology on 14-07-1433 (Registration no. H-02-K-001).

The decision for **expedited review** was based on the following submitted documents:

1. The protocol version 1.0
2. Interview topic guide version 1.0
3. Consent form version 1.0
4. Participant information sheet (PIS) version 1.0
5. Participant's demographic data version 1.0

The opinion of the IRB is to **approve** this proposal with its current design:

- The study is approved for one year from the date of this letter. Extension can be requested one month before the expiry of the approval.
- To conduct research as per the approved documents
- Amendments to the approved documents require IRB approval before implementation
- End of study report is expected before expiration of approval
- The study conduct may be subject to audits by KAMC Human Research Protection Program (HRPP)
- Research participant confidentiality should be protected at all times and may be subject to audits by KAMC HRPP
- Document retention: all study documents should be kept by the principal investigator for a period of three years from study completion

General Approval conditions:

- **If your study involves participants consent: Copy of all consents should be submitted to IRB**
- **Final manuscript should be acknowledged by IRB before Journal Submission**
- **If patient's clinical photo would be used for publication or presentation additional patient consent will be required and should be submitted to IRB before publication.**

N.B.: Please note that this letter gives you ethical clearance to perform your study according to the approved documents but you will still need to obtain necessary administrative approval from the site/s where the study will be conducted.

Dr Tahani Hassan Nageeti	T. Nageeti	**02-Jan-2019**
(Name of IRB Chair)	*(Signature)*	*DD/MM/YYYY (Date of approval)*

مدينة الملك عبدالله الطبية
KING ABDULLAH MEDICAL CITY IN HOLY CAPITAL

Appendix 9: Participant information sheet

Title: key stakeholders' experiences of a nursing transition programme in a tertiary hospital in Saudi Arabia: A grounded theory study

Participant Information Sheet (PIS)

You are being invited to take part in a research study as a part of a PhD student project. This sheet will provide you with clear information about the purpose and objectives of the research. Before you decide whether to take part, it is important for you to understand why the research is being conducted and what it will involve. Please take time to read the following information carefully and discuss it with others if you wish. Please ask if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

Who will conduct the research?

The study will be conducted by Nasser Aldosari, a full-time PhD student at the University of Manchester (Division of Nursing, Midwifery and Social work). The researcher obtained his nursing degree in 2009 and obtained a Master's degree in nursing education in 2014. The supervisory team of this research project are Prof. Steven Pryjmachuk and Dr. Hannah Cooke from the University of Manchester.

What is the purpose of the study?

This study will explore the experiences and perspectives of individuals who are participating (or have participated) in the nursing transition programme, referred to as the On-Job-Training (OJT) programme. Your experiences and perceptions of the OJT programme will assist future developments of the OJT and potentially improve the experience of future students as they transition to practice.

Why have I been chosen?

You have been invited because you are experiencing the OJT programme or because you have some involvement in the OJT programme.

What would I be asked to do if I took part?

Appendix 10: Consent form

Title: Key stakeholders' experiences of a nursing transition programme in a tertiary hospital in Saudi Arabia: A grounded theory study

Consent Form

If you are happy to participate, please complete and sign the consent form below:

	Activities	**Initials**
1	I confirm that I have read the attached information sheet (**Version 1, 20/11/18**) for the above study and have had the opportunity to consider the information and ask questions and had these answered satisfactorily.	
2	I understand that my participation in the study is voluntary and that I am free to withdraw at any time without giving a reason and without detriment to myself. I understand that it will not be possible to remove my data from the project once it has been anonymised and forms part of the data set. I agree to take part on this basis	
3	I agree to the **interviews** being **audio recorded**.	
4	I agree that any data collected will be transferred to the UK, and may be published in anonymous forms in **academic books, reports or journals**	
5	I agree that the researchers may retain my contact details in order to contact me if a follow-up interview is needed or to provide me with a summary of the findings for this study.	
6	I understand that there may be rare instances where during the course of the **interview** information is revealed which means that the researchers will be obliged to break confidentiality and this has been explained in more detail in the information sheet.	
7	I agree to take part in this study	

Data Protection
The personal information we collect and use to conduct this research will be processed in accordance with data protection law as explained in the Participant Information Sheet and the Privacy Notice for Research Participants.

_____	_____	_____
Name of Participant	Signature	Date
_____	_____	_____
Name of the person taking consent	Signature	Date

[Insert details of what will happen to the copies of consent form e.g. 1 copy for the participant, 1 copy for the research team (original), 1 copy for the medical notes]

Version1
Effective date: 02-Jan-2019 Expiration date: 02-Jan-2020

Appendix 11: Distress protocol

MANCHESTER 1824
The University of Manchester

Distress Protocol

Prior to study

Prior to commencement of the study, the participants will be given a participant information sheet with details of who to contact if they experience distress (e.g. nursing director or transition programme head) and these details will be reiterated again with the participant at the conclusion of the interview.

During the study

Should a participant report or show signs of distress and feeling uncomfortable while being interviewed, the following actions will be taken by the researcher:

Step 1

- Suggest that the participant take a break of 10-15 minutes and have a drink of water.
- Ask the participant how they are feeling, listen with empathy and offer support.

Step 2

- If the participant would like to continue, he or she will be reassured that they can stop the interview at any time to take a break.
- If the participant would like to stop or appears highly distressed such as increased frustration, follow the actions in **Step 3**

Step 3

- Stop the interview.
- Encourage the participant to speak to their department manager for support OR offer to do so for the participant.
- In all instances the researcher will seek support from their supervisor/line manager.

Follow-up actions (adjust as needed based on study requirements)

- Offer to follow participant up with a phone call the following day.
- Offer the participant the opportunity to withdraw from the study and for their data to be destroyed
- Recommend the participant to contact the transition programme director, if they continue to feel distressed.

Version1, 20/11/18