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Navigating a complex transition: From qualifying as a nurse to becoming a confident practitioner.

by

Rachel Pascoe

A thesis submitted to the University of Plymouth

in partial fulfilment for the degree of

Professional Doctorate in Education

January 2024

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Author's Declaration:

At no time during the registration for the degree of Professional Doctorate in Education has the author been registered for any other University award without prior agreement of the Doctoral College Quality Sub-Committee.

A third party has proofread this thesis; no factual changes or additions or amendments to the argument were made as a result of this process. A copy of the thesis prior to proofreading will be made available to the examiners upon request.

Work submitted for this research degree at the University of Plymouth has not formed part of any other degree either at the University of Plymouth or at another establishment.

A programme of advanced study was undertaken, which included taught modules taken, other as relevant.

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Abstract

This thesis explores the complexities of transition to professional practice of newly qualified nurses following an undergraduate professional preparation programme. Transition to professional practice from student to qualified nurse and then to confident practitioner has been explored since the late 1960s and is recognised as a complex and multi-faceted issue for the newly qualified nurses. They can feel unprepared for clinical practice and for the organisational demands who require competent and confident personnel to join the workforce.

Adopting a social constructionist approach, this study utilises a combination of diaries and interviews to gain a deeper understanding of the experiences and perspectives of six newly qualified nurses during this transitional phase. Diaries are utilised as a research tool in this study to provide an intimate and personal account of the experiences, thoughts, and emotions of newly qualified nurses as they navigate this transition. These diaries offer a unique insight into the learning process, the challenges faced, and the strategies employed to enhance competence and confidence were collected over the first 6 months post-qualifying finishing with a semi-structured interview. The conceptual framework was proposed and then checked by the participants and subsequently refined. The interviews were also conducted to gather further in-depth information and to explore the socialisation process and the formation of professional identity during this transitional period, in order to further develop a conceptual framework.

The findings of this study contribute to the existing body of knowledge on the transition from qualification to competent practice in nursing, the analytical process determined that it is the convergence or combination of skills, socialisation and development of identity that enables the achievement of a successful transition. It is hoped that the insights gained from this research will inform educational programmes and support strategies for newly qualified nurses, ultimately enhancing their transition and facilitating their professional growth. Additionally, this research contributes to a broader understanding of the social construction of transition to professional practice.

Glossary of Terms/ Acronyms

NQN	Newly Qualified Nurse
NMC	Nursing and Midwifery Council
RCN	Royal College of Nursing
NHS	National Health Service
EdD	Professional Doctorate of Education
UK	United Kingdom
USA	United States of America
ICU	Intensive Care Unit
SN	Staff Nurse
SSN	Senior Staff Nurse
WM	Ward Manager
HCA	Health Care Assistant
REG	Registrar
IV	Intra venous
BLS	Basic Life Support
CCN	Critical Care Nurse
HEI	Higher Education Institution
HEE	Health Education England

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1. Introduction

This thesis explores the complexities of transition to professional practice of newly qualified nurses (NQNs) following an undergraduate professional preparation programme. Transition to professional practice from student to qualified nurse has been explored since the late 1960s and is recognised as a complex and multi-faceted issue for the NQNs. They can feel unprepared for clinical practice as a qualified practitioner and for the organisational requirements who need competent and confident personnel to join the workforce. This thesis seeks to gain an insight into these challenges for nurses following a professional preparation programme for pre-registration nurses on the complexities of transitioning from a student nurse to a qualified practitioner and makes recommendations to improve, facilitate and develop this transition in the future.

1.1 Background

Professional preparation programmes for nurses across the United Kingdom have gone through diverse changes, with a philosophical shift over the past thirty years; from the apprenticeship model of training to the Project 2000 programme, the move from hospital-based training to university-based education in 1995 and finally to all degree professional preparation programmes of 2012 onwards, the Nursing and Midwifery Council (NMC, 2004; NMC, 2009; NMC, 2010; NMC, 2018). There has been extensive discussion of the transition phase, including preceptorship (Whitehead et al., 2013, Whitehead et al., 2016), measures of job satisfaction immediately post registration (Redfern et al., 2002) and the development of professional confidence and competence (Carraccio and Burke, 2010) but there has been minimal exploration of this transition from the perspectives of those undergoing this change in real time, exploring what they are going though when they are going through it and how they respond to the literature already presented.

The research involves the in-depth enquiry into the experiences and reflective accounts of nurses following their first six months of professional practice and the exploration of the transition from student nurse to qualified professional. This focusses on their ability to move from qualifying to confident practitioner and development of their professional identity in the clinical practice area. The concepts of ‘socialisation and transition’ are

inter-related and key within the literature discussion how NQN become integrated in the workplace (Duchscher, 2009) and are fully explored within the literature review.

In studying and investigating this transition from student to competent and confident practitioner from the perspective of the newly qualified nurses' themselves, a conceptual framework was developed that could:

1. Make recommendations for the enhancement of pre-registration undergraduate curricula and further enquiry.
2. Evaluate support mechanisms following registration to facilitate transition.
3. Develop a conceptual framework to inform educationalists and clinicians to assist in professional preparation of student nurses at the point of registration to aid transition.

1.2 Rationale and Context

I have been interested in the subject of transition throughout my professional career, as a qualified nurse myself, I have made the transition from student to qualified nurse. I have moved from different clinical settings and specialities, from different organisations and eventually from clinical practice to the educational setting. I have also undergone the process of transition in multiple ways and have a unique insight into the challenges of these changes. Although I can acknowledge that the process of transition differs for each of us, there are common themes that affect us, are discussed, and shared across many sources as well in print and media. I have certainly examined and read about transition throughout my career with colleagues and friends both inside and outside the profession. I am very conscious that the notion of transition can evoke a range of complex emotions; some are comfortable with change and others find it difficult and challenging. I relate to these feelings as I have gone through the process and have at times felt unsettled. Therefore, I find this field of enquiry very interesting, challenging and as such seek to understand and investigate it further.

The process of transition has for me evoked feelings of uncertainty, vulnerability, and isolation as well as confidence, assuredness, and comradery. With each move, I have reverted to the 'novice' in the setting moving gradually immersing myself and becoming a competent member of the team, feeling secure in the environment. These experiences

have made me aware of the move from 'novice to competent' and finally 'expert' (Benner, 1984) and how this transition develops when in a clinical setting.

Several factors contribute to the transition in nursing. Firstly, education plays a crucial role in shaping the professional identity of nurses. Nursing education programmes provide students with the knowledge, skills, and values necessary for professional practice. Sun et al (2016) confirm that through classroom instruction, clinical experiences, and simulation exercises, students develop an understanding of the nursing profession and its role in promoting health and well-being. Education also exposes students to the ethical and legal aspects of nursing practice, helping them develop a strong sense of professional responsibility (Sundean et al., 2019, Pullen, 2021).

This research was undertaken in 2018-2022, it is unrealistic not the mention the C0VID-19 pandemic and its effects. The impact of COVID-19 on healthcare in the United Kingdom (UK) from March 2020 was significant and posed numerous challenges to the healthcare systems and to all staff associated within NHS, as well as all those involved in the education and development of its professionals. As the number of cases began to rise rapidly, hospitals and healthcare facilities faced immense pressure to cope with the influx of patients. I like most involved, faced extreme challenges and the progression of this research following data collection through to analysis and completion was significantly delayed, this meant that although the data collection phase had been completed in March 2020 and then no further progress was made for over a year.

1.3 Nursing Today

The state of the nursing profession in the UK currently is a mix of immense dedication and commitment in its emerging and qualified professionals and is coupled with various challenges and strains (Stubin, 2017). Nurses play a pivotal role in the healthcare system, providing essential care, support, and expertise to the population. To qualify as a registered nurse in the UK, you must complete a nursing degree recognised by the Nursing and Midwifery Council (NMC). Programmes typically last three years and combine academic study with practical experience. After graduation, registration with the NMC is sought, and the nurse can then seek employment in any setting or area within clinical practice.

One of the most pressing issues facing nursing is the considerable strain on the workforce, and retention of personnel in frontline healthcare roles. There is a considerable shortage of nurses, especially in certain specialities, leading to increased workloads and burnout among those already in the profession. This shortage is further exacerbated by an aging population, the prevalence of long-term conditions, and the ongoing impact of the COVID-19 pandemic.

The demanding nature of the job, combined with the shortage of staff, has resulted in many nurses feeling overworked and undervalued (Zheng et al., 2023, Halpin et al., 2017) resulting in burnout. This has led to high levels of stress, mental health issues, and a significant number of nurses leaving the profession. There is a need for greater support and recognition for the vital work that we as nurses do, as well as an increased focus on retention strategies to keep experienced nurses in the workforce (Duru and Hammoud, 2022) to advocate for the profession. Despite these challenges, nursing in the UK continues to be a respected and admired profession. Nurses are highly skilled and dedicated individuals who consistently provide high-quality care to patients across a variety of settings, including hospitals, community care, and primary care (Wray et al., 2021, van Rooyen et al., 2018). The COVID-19 pandemic has highlighted the resilience and adaptability of the nursing workforce in the UK (Davey et al., 2022, Baskin and Bartlett, 2021). Nurses are at the forefront of the response to the pandemic, demonstrating courage, compassion, and a relentless commitment to patient care (Powers et al., 2021). While nursing faces significant challenges, it remains an essential and valued profession (Murray et al., 2020). Addressing the current issues facing the nursing workforce, including staffing shortages and burnout, is crucial to ensure that nurses can continue to provide the high standard of care that the population relies on. Strengthening and supporting the nursing workforce will be vital in shaping the future of healthcare (Whitehead et al., 2013, Whitehead et al., 2016) in development and delivery of a robust preceptorship programme.

Several key strategies could be implemented to retain the nursing workforce in the UK, these could include improved working conditions, which could include providing manageable workloads, supportive management, and safe staffing levels can help reduce burnout and improve job satisfaction among nurses (Missen et al., 2014). Additionally

giving the professions competitive compensation, offering competitive salaries and benefits can help attract and retain nursing talent, as well as providing opportunities for career advancement and professional development (Williams et al., 2015). Enhanced support and recognition of the valuable contributions of nurses through awards, public acknowledgment, and access to mental health support can help boost morale and job satisfaction (Guveli et al., 2015). Flexibility and work-life balance, offering flexible working arrangements, such as part-time hours and remote work options, can also enable nurses to better balance their professional and personal lives. Whereas continuing education and training, providing opportunities for ongoing learning, skill development, and career progression can enhance job satisfaction and retention among nurses (Mlambo et al., 2021). As well as addressing workplace culture, creating a positive and inclusive workplace culture, addressing issues of bullying and harassment, and promoting diversity and inclusion can help create an environment where nurses feel valued and respected.

Significantly, mentorship and preceptorship development has a substantial impact on the NQN, investing in preceptorship programmes and mentorship development opportunities can help nurses feel supported and valued in their career growth. Preceptorship in nursing is a formalised process in which a new or inexperienced nurse, often a recent graduate or newly qualified practitioner, is paired with an experienced nurse, known as a preceptor (Gerrish, 2000, Hoffart et al., 2011). The purpose of preceptorship is to facilitate the transition of the new nurse into their professional role by providing guidance, support, and practical experience in a real-world clinical setting (Whitehead et al., 2013, Whitehead et al., 2016).

The key goal of preceptorship is to promote the development of the new nurse's clinical and professional skills, as well as their confidence and competence in delivering high-quality patient care. The preceptor acts as a role model, mentor, and guide, offering hands-on instruction, constructive feedback, and opportunities for the new nurse to apply their theoretical knowledge in a practical context (Henderson et al., 2015). Preceptorship also serves to promote continuity of care, patient safety, and the overall quality of nursing practice by ensuring that new nurses are well-prepared to meet the demands and challenges of their role. It helps to bridge the gap between theory and practice, enabling

new nurses to gain valuable clinical experience while benefiting from the wisdom and expertise of more seasoned professionals. By fostering a supportive and nurturing environment, preceptorship ultimately aims to enhance retention rates, job satisfaction, and the professional development of new nurses, thereby strengthening and sustaining the nursing workforce (Powers et al., 2021) . Although highly recommended in clinical practice, it is not implemented in every setting, and currently none of the clinical areas in the study had a working preceptorship programme.

1.4 Personal Background

Over the past 25 years I personally have experienced the transition from student, to NQN, Ward Manager, senior nurse practitioner and then to university lecturer, this has influenced my interest in this phenomenon. I have distinct memories of each of these transitions, as I have entered each different workplace setting with trepidation, unsure of myself, my abilities, and what to expect from the environment and what is expected of me as a professional. On reflection I have realised that there are different attributes and support structures that have been valuable to me as I have made these moves. As a university lecturer and personal tutor, I have been aware of the increasing levels of anxiety and stress felt by the final module students as they approach the end of their course and are faced with the prospects of registration. The students are looking at all the influences of their choice of workplace, the support networks that will be available and the previous experiences they have had and the responsibilities they will undertake.

Throughout my nursing career I have witnessed multiple changes in healthcare policy, nurse education and clinical practice which have resulted in the differing priorities and expectations of the nursing workforce. The aim of all professional preparation programmes is to adequately prepare the student for the world of clinical practice as a confident/competent practitioner, being able to make safe and effective clinical decisions about patient care and working collaboratively with other professionals but it seems evident that not all students feel ready at the end of three years. Kramer (1975) coined the term 'reality shock' used to describe the feeling of nurses as they join the workforce as a NQN or qualified practitioner, but can be used to describe any transition of role. On embarking on this research, I am left thinking why are students not ready to qualify, feeling ensure of the knowledge and skills and what could our professional preparation

programme do to ease the transition? This query comes from comments from newly qualified nurses, via formal and informal feedback and social media posts that have been shared and discussed within professional groups. As a nurse educator, I am made aware of the fear and anxiety that final module student have at the thought of qualifying and embarking of their clinical careers.

It is also important to acknowledge my own professional and educational transition during the Professional Doctorate in Education (EdD), moving through the programme has inevitably influenced the study. I am an established and experienced university lecturer, but have moved from one University to another, with vastly different management structures and clinical practice areas, a quite different regional demographic. This has generated a new learning environment and moved me back into the relative 'novice' state, introducing me to a varied organisational and pedagogical culture. This acknowledgement of my 'novice' status was a powerful and challenging experience, causing me to question my own competence, confidence and abilities, this juxtaposition of my own transition and that of the NQNs, I was researching made me very aware of the challenges of the situation. I feel I can understand and make sense of this transition, in a unique way as I have been through the process many times. I have knowledge and experience of the move from student to a registered nurse, then a manager, a leader, and an educator throughout my career. I have also discussed and shared this experience with many colleagues, professional and personal to gain further insight in order to attempt to comprehend and make sense of others undergoing this transition.

I am conscious that my position as a lecturer and personal tutor made me an insider researcher within the educational setting. My position gave me vital inside information and knowledge of the course, clinical environment, and the organisations that the NQNs are working within. This insider position had a positive impact, affecting what the participants divulged in both their diaries and interviews, allowing them to be honest and disclose the reality of clinical practice, knowing that I would understand what is being shared (Baldwin et al., 2017). Although insights into the possible negative influences and conflicts, awareness of insider-outsider perspective and research reflexivity will be explored thoroughly in Section 3.11.

1.5 Policy Background

The context of the study is amid the constantly changing and challenging environment of the National Health Service (NHS) and reflects the contemporary nature of nurse education. The title 'nurse' is not a protected title, meaning that anyone can call themselves a nurse, therefore throughout this thesis I am referring to registered nurses and to qualify as a registered nurse with the NMC an individual is required to have undertaken a recognised professional preparation programme. This programme is at undergraduate level and students are required to spend 50% of their educational preparation undertaking theoretical components of their programme in university and 50% in actual or simulated placements undertaking practice or practical components in clinical healthcare settings (NMC, 2010; NMC, 2018). In order to work within the National Health Service (NHS) as a nurse, you are required to be registered with the NMC, be added to the national database, and recorded as a 'registered' nurse.

This transition from unregistered student to registered staff nurse signifies the end of the formal preparation process and starts the professional phase of nursing practice (Nash et al., 2009, Leigh and Roberts, 2018). There has been much written and researched regarding the extent to which the newly registered nurses are ready to practice competently and confidently at the point of qualification, from both the perspective of the policy makers and the nurses themselves. At a policy level, recent developments and reviews in the UK have highlighted concerns regarding the newly qualified nurses' competence and confidence at the point of registration (NMC, 2004, NMC, 2009, NMC, 2015, NMC, 2018, Willis, 2012, Willis, 2015).

Clark and Holmes (2007) state that '*it cannot be assumed that the newly qualified* [nurses] *are competent to practice independently and without supervision at the time of registration'* (p. 1217), supporting the policy concerns. Leigh and Roberts (2018) reiterate that competency at the point of registration '*remains to be seen*' (p. 1071) following the successful completion of a professional preparation programme. National and International research reiterates, from the student and staff nurses' perspectives that the transition to professional practice is both complex and stressful, citing increase in responsibility and accountability and perceived lack of competence and confidence (Draper et al., 2010, Garside and Nhemachena, 2013, Klein and Fowles, 2009, Gerrish,

2000, Saghafi et al., 2022) also articulating the significant difference between the real-life experience of clinical practice and the ideal world and comparative comfort of the university setting (Mooney, 2007, Tzeng, 2004, Lin et al., 2010, Guveli et al., 2015, Pullen and Ahchay, 2022). This would make further research vital specially to try and establish what educational provision in the Professional Preparation Programme could be added or enhanced to ease the transition and increase the level of competence and confidence at the point of registration.

Public and professional concerns have highlighted that the move to an all-degree profession could have resulted in the newly registered nurse being competency focussed, less compassionate, unwilling to carry out 'basic' nursing care and unable to make valid and reliable decision in clinical practice. Hence, at the point of registration being unable and ill-prepared to undertake the complex tasks demonstrating capability required in a qualified nurse (Buchanan, 2013, Graf et al., 2020).

The Francis Inquiry examined the causes of, and the failings in care that took place at Mid Staffordshire NHS Foundation Trust between 2005 and 2009. The Francis Report (2013) made a total of two hundred and ninety recommendations, including the need for increased openness, transparency, and candour throughout the health care system. Many were focussed on the nursing profession specifically and led to significant criticisms of nurses and nursing, with commentary on the lack of compassion and poor-quality nursing care being delivered. Reports of inadequate care came from patients, carers and the Care Quality Commission (2013), suggesting that this is not isolated but endemic practice in clinical practice (Buchanan, 2013, Graf et al., 2020). It would however be easy to blame solely the educational preparation programme and ignore the organisational issues inherent within the NHS itself, (Jack, 2015, Annesley, 2019), but the 'training' of our profession was the focus of significant criticism.

Nurse education has come under attack from an anti-intellectual lobby of journalists and public commenters who blamed the academic nature of nursing for the problems with the professional itself and the entire NHS. The discourse published in the UK media was that nurses and nursing was uncaring, not compassionate, and unable to deliver competent basic nursing care and was reflected in the Francis Report (2013). The suggestion explored that '*spurious academic qualifications*' had resulted in the graduate

nurse '*wrecking the caring profession*' lacked valid assertions (Bergen and While, 2005), but was cited widely. There is a contention that the degree nurses focus on the theory and research rather that the practical experience and technical skills, graduate nurses are accused of being poor decision makers and lacking in competence when they first qualify (Roberts and Johnson, 2009, Taylor et al., 2010, Girot, 2000). This accusation comes from the media, the professional organisations, and the professionals themselves but is seldom if ever focussed on other graduate professions outside health and social care. The theory-practice divide is cited as an issue, highlighted in the practitioner's inability to transfer the ideological knowledge gained in the university setting to the real-life practice encountered in the clinical setting (Clark and Holmes, 2007, Whitehead et al., 2013, Monaghan, 2015). University educated nurses have been described as *'too posh to wash*'; '*too clever to care*'; and have their heads full of '*sociology non-sense*' and unable or unwilling to perform basic nursing care, but if we empower graduates with knowledge and courage to challenge and critique, we can only drive the profession forward (Annesley, 2019; Buchanan, 2013; Francis, 2013).

1.6 Preceptorship

Preceptorship in nursing in the UK is the recommended programme of structured transition for newly qualified nurses during which they are supported by a nominated experienced practitioner (the preceptor). The aim is to bridge the gap between student and autonomous, confident, and competent practitioner. The principles of preceptorship are designed to ensure that new nurses develop confidence, competence, and the necessary skills to provide high-quality care (DoH, 2010). Preceptorship should provide a structured and defined period of support for newly qualified nurses, ensuring they have a clear understanding of what to expect during this time (HEE, 2022) and how to effectively make the transition to qualified practitioner. The focus is on the continued professional development of the newly qualified nurse, with opportunities for learning, reflection, and skill enhancement. The preceptorship period is aimed at helping new nurses to consolidate their clinical skills and knowledge, becoming competent and confident in their practice (Mlambo et al., 2021). An experienced nurse is assigned as a preceptor to act as a role model, mentor, and guide, providing guidance, feedback, and support (HEE, 2018), and aiding the transition to confident nurse.

Recognising that each new nurse has unique needs, preceptorship programmes should be flexible and tailored to the individual's learning style, pace, and area of practice, ensuring that the new nurse practices safely is paramount. The preceptorship period should focus on reinforcing professional standards and the importance of patient safety. Inspiring reflective practice helps new nurses to think critically about their experiences, learn from them, and apply this learning to future situations (Whitehead et al., 2013, Whitehead et al., 2016). The preceptorship should help new nurses to build their confidence in making clinical decisions and in their interactions with patients and the multidisciplinary team.

The ultimate goal of preceptorship is to support the transition from supervised practice to independent practice as a registered nurse. Preceptorship supports the understanding and integration of the NMC standards and the Code for nurses and midwives, emphasising the importance of professionalism in nursing (NMC, 2015) and the development of the NQNs into a competent practitioner. Encouraging new nurses to develop and utilise support networks within the workplace which includes peers, managers, and other healthcare professionals. Identifying the importance of the new nurse's well-being and resilience and providing resources and support to manage the emotional demands of the profession (NMC, 2020). Providing information and guidance on potential career pathways and opportunities for further education and specialisation. Regularly evaluating the effectiveness of the preceptorship programme to ensure it meets the needs of new nurses and adapts to changes in healthcare practice.

During the preceptorship period in the UK, newly qualified nurses (NQNs) are provided with a range of resources and support systems to aid their transition into the nursing profession. These resources are designed to enhance their learning experience, promote professional development, and ensure they are able to provide safe and effective patient care. A designated experienced nurse who provides one-to-one guidance, support, and feedback (HEE, 2022). The preceptor acts as a mentor and role model, helping the NQN to develop clinical skills and professional behaviours and the resources and support systems, such as an induction programme continuous learning opportunities, networking opportunities and well-being support are designed to create a comprehensive and nurturing environment for NQNs, (NMC, 2020) enabling them to develop the competence

and confidence required to practice independently as registered nurses (HEE, 2018). The recognised preceptorship programme although recommended for all practitioners on qualifications, in the area under investigation this programme was only available for those undertaking a rotational post/role. The inclusion/exclusion criteria cited in Chapter 3 in Table 2. (p. 58) outlines that the NQNs on rotational posts were not include in the study. The participants in this study took posts in clinical setting that did not utilise or implement the preceptorship programme as I wanted to explore how the transition process occurred when there was no formalised preceptorship programme in place.

1.7 Defining Transition

Transition refers to the process of changing or moving from one state, condition, or environment to another. It involves a period of adjustment, adaptation, and reorientation as individuals or entities navigate a shift in their circumstances (Burton, 2011). Transitions can occur in various aspects of life, including career changes, personal relationships, physical or developmental stages, and societal or organisational shifts. The process of transition often involves both internal and external adjustments, as individuals or entities come to terms with new roles, responsibilities, expectations, and environments. Successful transitions require flexibility, resilience, and the ability to embrace change (Hampton, Smeltzer & Ross, 2020).

Transition to professional practice refers to the process of moving from a student or trainee role into a professional or working role within a particular field or clinical setting. There are different stages or phases of transition, from student to NQN, from NQN to confident practitioner, from NQN in a new setting and the NQN feeling part of a setting or feeling socialised in the clinical setting (Darvill, Stephens & Leigh, 2021). This whole process typically involves acquiring and applying the necessary knowledge, skills, and competencies to succeed in a professional setting. It often includes integrating theoretical knowledge gained through education with practical experience gained through internships, on-the-job training, or mentorship. In many professions, the transition to professional practice also involves adapting to the culture and norms of the workplace, understanding relevant professional standards and ethics, and developing a professional identity (Kralik, Visentin & van Loon, 2006). This may entail learning how to collaborate

with colleagues, communicate effectively with clients or customers, and navigate organisational structures and hierarchies.

Workforce issues, including staff shortages, can significantly impact the transition process in nursing. When there is a limited number of experienced nurses, new graduates or transitioning nurses may find themselves thrust into demanding roles with less mentorship and support (Wray et al., 2021). This can lead to increased stress and a steep learning curve for incoming nurses. Workload becomes a critical factor as well; with fewer staff members, the workload for each nurse intensifies, potentially leading to burnout and job dissatisfaction. This can create a cycle where the pressures of the job cause more nurses to leave the profession, exacerbating the shortage. Additionally, a strained workforce can hinder the ability to provide comprehensive orientation and training programs for transitioning nurses (Mackintosh, 2006). This lack of structured support can compromise the development of clinical competencies and confidence, which are crucial for effective patient care and professional growth. Accordingly, healthcare organisations should address workforce challenges to facilitate smoother transitions and ensure the sustainability of nursing staff.

Additionally, the transition to professional practice may involve adjusting to increased expectations, responsibilities, and accountability. This could include decision-making autonomy, client-facing interactions, and adherence to professional regulations and standards. It may also involve continuous professional development to stay current with industry trends and best practices. Overall, a successful transition to professional practice requires a combination of technical competence, interpersonal skills, consolidation of knowledge, adaptability, and a commitment to lifelong learning and the development of the practitioner's professional identity (Fitzgerald and Clukey, 2022). It is a critical phase in the personal and professional development of individuals entering the workforce and is essential for success and growth in their chosen field, the whole process will be the focus of the study.

1.8 Outline of Thesis Structure

Chapter 2- Literature Review -Discussion of literature and research related to the concepts of transition to professional practice, the exploration of the move from student to qualified practitioner and the exploration of themes such as socialisation, competence/confidence, knowledge /skills, and professional identity. The development of a conceptual framework of progression to transition from the point of registration to the emergence of a competent practitioner and discussion of the development of a conceptual/theoretical framework that explains the transition to professional practice of student to qualified practitioner.

Chapter 3- Methodology -This outlines the research aims, methodology, study design, the methods, a framework of the participant information including demographics of participants and cohorts. The discussion of the strengths and limitation of the thesis were defined, and ethical issues were explored.

Chapter 4- Series of Cases -Presentation of case series will outline the detailed accounts from the diary entries and interviews. It will then evaluate the trustworthiness of the data, explore the emerging themes and sub-themes that arose through the data collection and analysis.

Chapter 5- Discussion -Discussion of the key findings emerging from the case series, discussion of the diaries and interviews and their impact on the conceptual framework from the literature.

Chapter 6- Conclusions -Conclusions drawn from the key findings and how they link to the aims, the development of a revised conceptual framework to aid the understanding of the complexities of transition for students to assist prior to the point of registration.

Chapter 7- Recommendations -Make recommendations for educational programmes and a discussion of the possible adaptations that should be explicitly embedded into the curriculum to assist in transition and to make suggestions for further enquiry and a concluding statement.

Chapter 8 - Epilogue- A review of the participants' stories following the COVID pandemic.

1.9 Chapter Summary

As outlined in this introduction, there are many themes that influence the complex transition to professional practice, the themes of healthcare policy, nursing today in the UK, my own personal transitions and transition to professional practice are interconnected and crucial in shaping the journey itself. Healthcare policy reflects the government's commitment to providing accessible, high-quality care to all citizens and addressing emerging health challenges. It also plays a significant role in shaping the nursing profession by setting standards, regulations, and funding for education and training. Nursing today in the UK is characterised by a focus on patient-centred care, evidence-based practice, and the integration of technology into healthcare delivery. The transition to professional practice highlights the critical period when newly qualified nurses apply theoretical knowledge to actual patient care. This phase requires organisational support, development of competence and confidence and a continuous development of knowledge and skills to ensure a smooth integration into the workforce. In conclusion, these themes underscore the dynamic nature of the transition, socialisation to the setting, development of knowledge and skills, confidence and competence and the development of professional identity are the key aspects of transition and the focus of the evidence explored.

2. Literature Review

This chapter is a narrative review of the literature examining the published evidence that has explored the themes of transition to professional practice focussing on socialisation, confidence and competence, knowledge, and skills, and professional identity. The critical analysis aimed to highlight the common threads in relation to the existing research and identify any gaps related to this initial phase of transition to professional practice. This exploration aimed to inform the study and assist in the development of education strategies and practice needed to inform the transition to professional practice. A literature review as outlined by Grant and Booth (2009) describes '*published materials which provide an examination of recent and current literature' (p. 97)* and can cover a wide range of various sources and may include various research findings. A literature review is a generic term which aims to examine and explore published material, and using the Search, Appraisal, Synthesis and Analysis (SALSA) approach (Grant and Booth, 2009) following thorough searching, not including a structured quality assessment exercise, applying a flexible and rigorous synthesis method, and using this analytical approach to produce a narrative review to support this study.

2.1 Introduction

The introductory chapter identified the several factors that influence the study, and the literature related to this subject is vast. Consequently, it was necessary to take a focused approach to the existing literature, to undertake the review in order to underpin the research. While searching for terms such as '*transition to professional practice*', many papers were identified, but the focus was on the key themes cited and exploring the intricacies of the transition itself from the perspectives of the practitioners. A conceptual framework or visual representation was then developed embracing the themes and to help frame the review and, in an attempt to organise the literature to use as a research aid or tool. This was in order the frame the review and present it to the participants in order to ascertain whether the agreed with the literature and seek their opinions of conceptual framework. The literature also served to address the aim and objective of the study.

2.2 Search Strategy

The narrative literature review aims to identify and analyse the evidence related to the subject of transition to professional practice from student to registered practitioner. To ensure the review is rigorous and robust, the SALSA (Search, Appraisal, Synthesis, and Analysis) approach allowed for a structured method for conducting the narrative literature review, ensures a comprehensive and systematic examination of the existing literature.

The first stage was to formulate a clear and specific research question to guide the entire process. The appropriate search terms were utilised, key words, relevant synonyms and associated truncations were applied. While conducting the search the Boolean operators were used – *and/or/ not* were used to combine the keywords and refine the search. These included:

'Transition,' 'transition to professional practice,' 'student nurse transition,' 'newly qualified nurse/s,' 'socialisation,' 'integration,' 'confidence/competence,' 'knowledge acquisition,' 'knowledge and skills,' 'professional identity.'

The initial strategy was to examine a wide range of databases, Pubmed, CINAHL, Cochrane Library, Scopus, and Wed of Science to capture the depth and breadth of evidence associated with the concept of transition. Key journals were searched online such as '*Nurse Education Today*,' '*Nurse Educator*,' '*Nurse Practitioner*' and '*Nurse Education in Practice*,' this was to add a thorough approach and ensure that it located all the studies that address the related issues. A snowball approach was taken to the reference list to explore any related issues (see Appendix vi - Prisma Diagram).

A systematic search was undertaken of all relevant and applicable publications to try and neutralise selection bias. Clear inclusion and exclusion criteria included primary/empirical studies, using English language, and was published between 2000 and 2023. Although some seminal works from outside this time frame were also cited for appropriate context. These seminal works, such as Kramer (1975) and Benner (1984) are cited by multiple authors as a foundation to their literature reviews and the research. These works also significantly influenced my own personal thinking at the start of this research. This was a wide timeframe, ensuring the evidence was not only contemporary, but also gave a comprehensive background to the study.

A further search of key UK, USA, Australian and International nurse education journals was also conducted using a snowball technique to determine further key words to enhance the process. Databases that were used to facilitate the process, chosen due to the wealth of available citations using the English language and their focus on nursing. A thorough outline of the process is outlined in Figure 1 below.

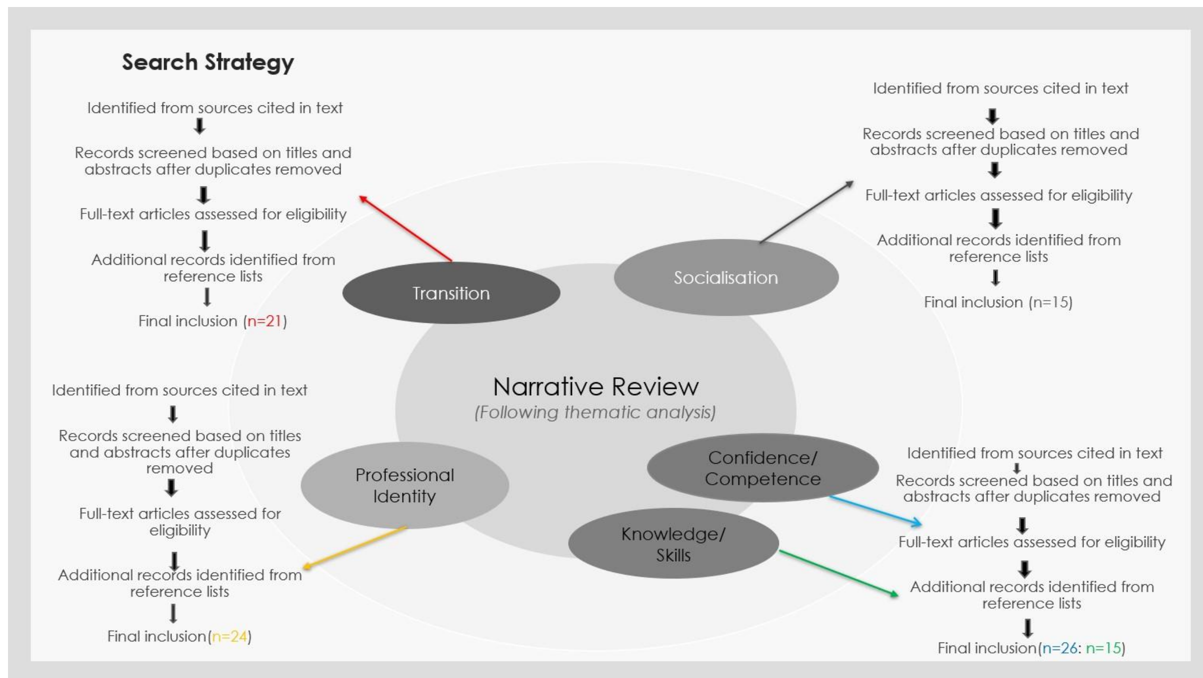

Figure 1: Detailed outline of Search Strategy.

The appraisal process was undertaken, screening of the titles and abstracts to exclude irrelevant studies and ensure the studies cited directly addressed the research question. A critical appraisal process was undertaken to assess the quality and validity of the studies collated and their applicability to the research question. Data was extracted, the themes and findings of the studies were presented to ensure all the relevant information was examined and analysed. A narrative synthesis was then presented in the themes cited in Figure 1.

2.3 Transition to Professional Practice

The concept of transition is an established notion, Meleis (1985, 2010) state the value of its role within nursing theory, it influences the individual, the organisation and society, defining transition as the '*passage from one life phase, condition or status to another*' (p. 238) over a fixed period of time. This transition encompasses changes in an individual's

behaviour in relation to ability, competence, identity, role, and relationship (Lindmark et al., 2019). The issues and terms of '*transition*' and '*socialisation*' are interrelated throughout the literature (Duchscher, 2009, Duchscher, 2012) and will be discussed in this study in turn. Transition demonstrates the acceptance of change and socialisation shows the process whereby individuals become integrated in an organisation. Jayne *et al* (2005) state clearly that transition involves three stages; the separation from academia, the transition into clinical practice and the formation of an identity within the new professional role. It involves the process of knowledge and skills acquisition (Barnes, 2015), embracing professional values and beliefs, as well as the development of role attitudes and norms related to the professional position (Paley et al., 2007).

The transition from student to registered nurse is described by Meleis (2010) and Lindmark et al (2019) as the phase from the security and comfort of the structured university learning environment and supervised clinical practice to the clinical setting as a registered professional practicing without direct supervision. This new role is complex, stressful and is interlinked with the changing personal and professional values and practices. The transition process is influenced by educational backgrounds, practice environments and peers (Maben et al., 2007). For example, the level of previous experience in the setting, the management structure with the setting itself, the staffing level and characters of the different personnel can affect how a NQN feels and settles into a clinical setting. In addition to programme structures, individuals' learning, and personal journeys can have a significant influence of how well a member of the team can settle into a workplace (Edwards et al., 2015, Brower et al., 2022).

The transition involves more than just a single individual, it refers to both the process and the outcome of a complex interaction between the individuals and the clinical environment (Meleis, 1985, Kralik et al., 2006, Thrysoe et al., 2012). These interactions have a significant impact on both the individual and the organisation, with the NQN entering the profession with the elation of achieving registration with the enormity of the practice reality (Lee et al., 2013, Caliskan, 2010). Additionally, the organisation itself experiences changes through the introduction of a new member of staff and the challenges that can bring. This emotional matrix results in the new professionals having conflictingly high expectations of themselves in their need to perform well, seeking an environment which can embrace and facilitate them and an organisation that has diverse

agendas competing for its focus (Child, 2015) and therefore causing conflict and possible instability for the NQN. This can lead to the NQN experiencing feelings of self-doubt and at times overwhelming stress (Delaney, 2003, Wieland et al., 2007, Walker et al., 2013).

This is widely referred to as '*transition shock'* (Duchscher, 2009) where the NQN moves from the security of the academic setting to the accountable environment of professional practice. Individuals enter with the euphoria of achieving their goal of registration with the academic merit and move into the turmoil of clinical practice with its uncertainty of today's healthcare (Jindal-Snape and Holmes, 2009). This introduces a different structure to their pre-registration life; this change can be present as discomfort and uncertainty which can affect all those experiencing difference in their work. However, there is a vast quantity of evidence which links to the NQN's experiences, finding that they do not always feel adequately prepared to make a successful transition (Draper et al., 2010). This requires a period of preceptorship and formal and structured support (Whitehead et al., 2013, Whitehead et al., 2016, Walker et al., 2013) and also finds that at times their expectations do not align to their own practices or their expectation (Randall Andrews, 2013). Additionally their level of knowledge and skills do not meet the requirements for the transition (Duchscher, 2008) and therefore the process of transition is hindered.

Literature has produced various theories that enhances our understanding of the complex and challenging experiences of the transitioning NQN (Kramer, 1975, Benner, 1984, Duchscher, 2009). Duchscher (2008) proposed three distinct phases of development toward transition, '*doing*' (initial phase), *'being'* (three to six months) and the '*knowing*' (six months onwards) where the individual having explored the complexities of professional practice and the interplay of the *'emotional, intellectual, physical, socio-cultural and developmental'* issues have successfully made their transition (p. 442). Linked closely to the stages of transition cited by Jayne *et al* (2005) who refers to stages which take the practitioner from academia, into clinical practice and forming a professional identity. These concepts link together and are relevant to the context of transition and has been applied to the conceptual framework presented in this thesis, the idea that when all these themes aspects come together, and meet a point or threshold and then the practitioner is 'ready' to move through transition (Burton and Ormrod, 2011, Duclos-Miller, 2011, Hampton et al., 2020, Powers et al., 2021). The cited authors confirm that it not a single aspect, such a knowledge and skills alone or confidence and

competence (Duchscher, 2009, Duchscher, 2008, Duchscher, 2012), but a combination and a convergence of multiple characteristics is what aids and facilitates transition into the role of a confident practitioner.

Duchscher's theory of transition and Benner's novice to expert theory differ in their focus and scope. Duchscher's theory is specifically centred on the transition experience of novice nurses during their first year of practice, with an emphasis on the emotional and psychological challenges they face during this initial period, particularly the first six months (Duchscher, 2012; Duchscher, 2008; Duchscher, 2009) which therefore became the focus of this research. Conversely, Benner's theory offered a broader perspective, describing the progression of a nurse's career from novice to expert over time and focusing on the development of clinical knowledge, skills, and expertise (Benner, 1984). Duchscher's theory zooms in on that intense transition period of new nurses, from 0 to six months, exploring the unique struggles and adjustments they encounter during this phase, Benner's theory provides a more comprehensive framework that encompasses the entire professional journey of a nurse, far beyond the initial phase including the acquisition of expertise and the evolution of clinical judgment and decision-making abilities.

2.4 Socialisation

Socialisation is a key aspect of the transition process, where individuals adjust to their environments, consolidate their skills, and become familiar with their new roles (Mackintosh, 2006, Wray et al., 2021). Scott et al (2008) developed a socialisation framework that utilised three vital stages: pre-work experience or anticipatory socialisation, actual work experience or organisational socialisation and work adjustment or socialisation outcomes. This can be linked not only to the graduate's path from the qualification at which they will have had some exposure to clinical practice during the educational programme, to consistent and maintained time in clinical practice on commencing their jobs to finally the consolidation of socialisation (Woodhams, 2014, Saghafi et al., 2022). Scott et al (2008) and Duchscher's (2008) frameworks cite the routes through this progression, establishing that socialisation as an influential component to the transition process undertaken by the qualifying practitioner (Duchscher, 2012). Employing frameworks can facilitate our understanding of a

successful transition by providing a structured approach to managing change. Frameworks offer a systematic way to comprehend goal setting, outline strategies, allocate resources, and measure progress within transition (Shipman, 2014). These frameworks help organisations and individuals navigate complexities, address challenges, and adapt to new environments effectively. Ultimately, frameworks help understand the transition process, fostering clarity, consistency, and ultimately successful socialisation can occur (Woodhams, 2014).

The literature suggests that becoming socialised in the clinical setting within an organisation is not easily facilitated until you feel confident and is essential for personal growth and professional success. This socialisation refers to the process of learning and adapting to the norms, values, and expectations of a particular social group or community, such as a hospital, a ward or a unit (Aldosari et al., 2021). In the context of any organisation, socialisation involves integrating into the culture of the setting, understanding the dynamics of the workplace, and building relationships with colleagues (AlMekkawi and El Khalil, 2020).

Every organisation has its unique culture, which includes shared values, beliefs, and behaviours. It can take time to observe and understand the company culture by paying attention to how people interact, communicate, and make decisions (Woodhams, 2014). This understanding develops over a varying amount of time and will depend on your personal situation and your history with or within that organisation. Initially, as part of an induction process building a strong network, gaining trust and respect from colleagues, or becoming an influential and useful member of the team is significant. Also building relationships with colleagues is crucial for socialisation, taking the initiative to introduce yourself, engage in conversations, and integrating within the team is key to successful socialisation. It is also beneficial to have a mentor within the organisation who can guide the socialisation process. A mentor provides valuable insights, advice, and support, helping the navigation of the organisational dynamics and building confidence in the role (Stacey et al., 2020, Wakefield et al., 2022), and is evident in all clinical settings.

Therefore, building a successful socialisation into an organisation until you feel capable requires understanding the hospital's culture, setting clear goals, building relationships,

seeking mentorship, being proactive and adaptable, communicating effectively, embracing feedback, to allow for transition (Wray et al., 2021). Walton et al (2018) outlined that transition occurs in a gradual progression, building smoothly over time and is presented in Figure 2 below, multiple authors suggest that this socialisation and transition occurs steadily during the first six month (Darvill et al., 2021, Duchscher, 2009, Hampton et al., 2020).

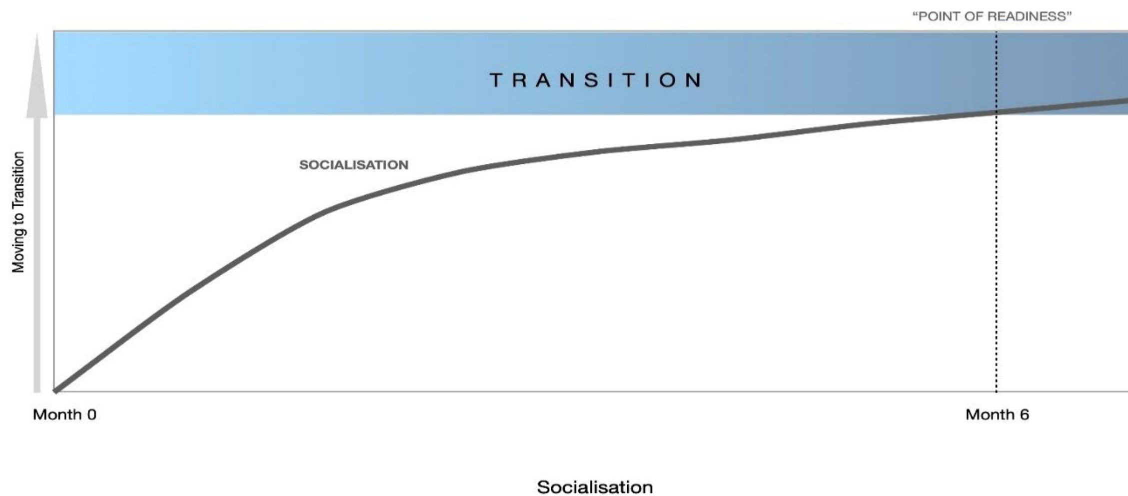

Figure 2: Visual representation of socialisation process

2.5 Competence and Confidence

There is a paradox between the competence and confidence required and the resulting capability desired to succeed in making the transition from student to qualified practitioner (Gardner et al., 2006). The issues with the competence model used in nurse education is that it can contribute to the development of professionalism, accountability and autonomy which are essential to developing into capable practitioner. Competence is defined as dynamic concept, going beyond simply possessing knowledge and skills but being able to apply this to real-world situations (Ulrich et al., 2010, Ma et al., 2023) and is therefore based on a proficiency in a task and can be measured and demonstrated through performance and outcomes. Confidence in clinical practice is also defined as a multifaceted concept that encompasses knowledge, skills, and competence to deliver safe and effective patient care (Pfaff et al., 2014, Ortiz, 2016), which refers to ones' own belief and feelings of certainty in undertaking a skill or task. Competence can lead to confidence and vica versa, one can be confident without competence and be competent but lack

confidence. These concepts will be discussed together, but it is acknowledged that they are not always entwined but a balance is desirable in practice.

In clinical practice, capability can be defined as the combination of confidence, knowledge, skills, experience, expertise, and array of competencies that practitioners possess to effectively assess, diagnose, treat, and care for patients. It encompasses the ability to apply evidence-based practices, critical thinking, ethical decision-making, and communication skills to provide high-quality, patient-centred care (Gardner et al., 2006). Capability is something beyond competence, it outlines the ability to work and utilise cognitive skills to analyse and synthesise information and perform complex tasks, and thus requires a higher educational level (Saghafi *et al.,* 2022). A person can be trained to undertake tasks and become competent in them after performing them repetitively and then becoming able to undertake them automatically; while you cannot 'train' a person to manage the unexpected, react to changing circumstances, this requires an advanced level of critical thinking and knowledge demonstrated by a graduate (O'Connell et al., 2014, Gardner et al., 2006, Cowan et al., 2005).

There is a clear link in much of the literature, between competence and confidence in clinical practice leading to the capability is established and ultimately a successful transition, the theoretical framework of critical pedagogy can be applied (Cowan et al., 2005). The Department of Health (2010) outlined that in the Preceptorship Framework, transition is best described as the refinement of knowledge and skills, professional behaviour and an increase in competence and confidence. Throughout the literature cited in O'Driscoll et al (2022) the notions of confidence and competence are discussed together, linked, and bound together resulting in successful transition to a capable practitioner.

The relationship between teaching and learning which purports to employ a continuous process of 'unlearning', 'learning', 'relearning', 'reflection' and 'evaluation' and the effects these actions have on the learner (Wilson-Thomas, 1995, Freire, 1998, Freire, 2000). Critical pedagogy influenced by Freire (2000, 1998) endorses the student's ability to think critically about their education and therefore recognises the influences of the individual, social context and experiences have of the process. Critical social theory can be applied as a framework for the development and advancement of nursing and nurses

through its education system (Ironside, 2003). It is a form of science and enquiry that seeks to liberate groups from conscious or unconscious constraints, interfering with balanced participation in social interactions (Wilson-Thomas, 1995, Mooney and Nolan, 2006).

Critical theory is one way of generating knowledge that is based on a critical reflection of society with its rules, habits, convictions and meaning. Freedom comes from the generation and the development of knowledge theory and research which will result in freedom from those controls. Adopting the principles of critical praxis, simultaneous reflection and action, the NQN can facilitate the examination of knowledge, and critically analyse the social structures and ideologies that exist to oppress and constrain the profession (Mooney and Nolan, 2006) securing the ability to critically practice and assimilate knowledge, leading to competence. Nursing and nurse education needs to demonstrate that it is a vibrant, rigorous, challenging professional capable of transforming lives through quality holistic care and leadership, gathering, and enquiring in the pursuit of excellence, this will depend on academic leadership and scholarly activity. Nurses of the future need to be 'thoughtful, courageous, inspirational and visionary' qualities that are vital but rare (Thompson, 2009) in order for the nurses of the future to meet the needs of patient care in a changing and challenging healthcare setting. These are the key characteristics of a graduate nurse and the hallmark of a professional (NMC, 2009; NMC, 2018; Willis 2012; Willis, 2015).

Benner (1984) states that nurses transition through a trajectory from 'novice to expert' when learning and engaging in clinical practice, the stages of novice to advanced beginner, to competent, to proficient ad finally to expert, allowing for the learners' development and level of participation to advance over time and experience. If clear to the learner the transition through the framework can be seamless, each clinical placement building on the previous on to manage learning and 'knowing' in nursing (Gardner, 2012). But at the point of registration, they need to be ready and able to 'perform' as a qualified nurse and develop the professional identity as a registrant. Benner (1984) makes no reference to the point of registration specifically, rather stating that the move from 'novice' to an 'advanced beginner' and 'competent' can coincide with the completion of a professional preparation programme, differing from Meleis (1985; 2010) and Jayne *et al* (2005) who

mark the end of a programme or the move from academia as a significant phase of transition, and therefore key to achieving competence and confidence in practice.

This identification of transition is fundamental to newly qualified nurses, competence and confidence in practice are key facets to enable proficient practitioners learning and transforming into their role (van Rooyen et al., 2018) and then feeling capable in that role. Thus, the development of the construction of their identity is essential to the successful transition from student to registered nurse (Baldwin et al., 2017). Firstly there is a need to 'learn' the formal processes, the key policies and common practice of a specific setting, the induction process and the 'every-day' workings of a setting and secondly the manner and perception of the member themselves within that organisation, 'the perception of self' (Handley et al., 2006, Malouf and West, 2011). The nurse therefore needs to negotiate and manage their identity as a participant in the specific clinical practice setting, establishing with other members their level of competency and also reflect on how their participation will foster and promote the transition, in the hope that their involvement and engagement will develop and advance their level of confidence and competence further (Gardner, 2012, Gardner et al., 2006, Farnsworth et al., 2016).

The literature surrounding confidence/ competence and knowledge/skills outlines a journey from the point of qualification to transition, also building slowly over time. Building competence and confidence to the point of being a capable practitioner is a journey that requires dedication, continuous learning, and self-belief. In the professional field, becoming a capable practitioner requires a combination of developing confidence and competence, as well as knowledge and skills (Garside and Nhemachena, 2013), leading to a successful transition.

Building competence and confidence requires self-belief, requiring practitioner to develop and trust the process of induction and support offered by the ward team (Gerrish, 2000) . Knowledge and skills are acquired gradually over time and allow the practitioner to grow and build a repertoire to consolidation what was learnt in their professional preparation programmes (Hoffart et al., 2011) Theory alone is not enough to become a capable practitioner, applying knowledge and skills in clinical situations allows practitioners to facilitate a successful transition (Shipman, 2014, Saghafi et al., 2022).

Accordingly, building competence/ confidence and knowledge and skills are explicitly linked together, they ebb and flow and develop slowly over time to the point of being a capable practitioner (Pullen and Ahchay, 2022), this is illustrated below in Figure 3, giving a visual representation of the peaks and troughs. This involves acquiring knowledge and skills, gaining experience, embracing continuous learning and development and practicing and refining your skills, in order to progress to transition (Murray et al., 2019).

2.6 Knowledge and Skills

Knowledge and skills are essential components of nursing practice. Nurses require a solid foundation of knowledge and a diverse set of skills in order to provide safe and effective care to their patients (Alteren, 2019, Cheung et al., 2013, Jacobs-Kramer and Chinn, 1988). Knowledge is the theoretical understanding of concepts, principles, and facts related to nursing practice (Eraut, 2000). It encompasses a wide range of subjects, including anatomy, physiology, pharmacology, psychology, , developing a therapeutic relationship, communication techniques and evidence informed decision making. Nurses must have a strong knowledge base to understand the underlying principles of patient care and make informed decisions in clinical practice.

Figure 3: Visual representation of confidence/ competence and knowledge /skills process

This knowledge is crucial in assessing patients, identifying abnormalities, and providing appropriate interventions. For example, nurses with a deep understanding of anatomy and physiology can identify signs and symptoms of respiratory distress and take prompt action to ensure the patient's airway is clear and they are receiving adequate oxygen. This fundamental knowledge allows the practitioner to function safely and competently in practice (AlMekkawi and El Khalil, 2020) and deliver quality patient care. Additionally, knowledge in nursing also includes an understanding of pharmacology. Alteren (2019) knowledge in nursing extends beyond the medical aspects of care and extends to the psychological and social policy. Nurses must also understand psychology and human behaviour to effectively communicate with patients and provide emotional support (Hart et al., 2013). This knowledge helps nurses establish rapport with patients, assess their mental health, and provide appropriate interventions. For example, a nurse with knowledge of therapeutic communication techniques can effectively communicate with a patient experiencing anxiety and help alleviate their distress (Nelson and Gordon, 2009).

While knowledge is crucial in nursing, it is not sufficient on its own. Nurses must also possess a diverse set of skills to apply their knowledge in a practical setting (Nelson and Gordon, 2009). Skills in nursing refer to the ability to perform specific tasks and procedures that are essential for patient care. One of the essential skills in nursing is assessment. Nurses must be skilled in conducting thorough assessments to gather relevant information about a patient's health status, including taking vital signs, performing physical examinations, and collecting patient histories. Accurate assessments are critical for identifying health problems and developing appropriate care plans (Pennbrant et al., 2013). In addition to activities such as assessment and medication administration and key practical skills such as wound dressing, nurses also require skills in communication, critical thinking, and problem-solving (Hampton et al., 2020). Effective communication skills are essential for building trust with patients, collaborating with healthcare team members, and providing patient education. Critical thinking and problem-solving skills enable nurses to analyse complex situations, make sound clinical judgments, and adapt their care plans as needed and facilitate the transition (Pennbrant et al., 2013, Nelson and Gordon, 2009, Rogers et al., 2021) to enhance clinical practice.

Therefore, knowledge and skills are indispensable in nursing practice. Nurses must possess a solid foundation of knowledge in various subjects to understand the principles of patient care. Additionally, they must acquire a diverse set of skills to apply this knowledge effectively in a practical setting. The literature supports the principle of combining their knowledge and skills, nurses can deliver high-quality care that meets the unique needs of each patient (Alteren, 2019, Jacobs-Kramer and Chinn, 1988). Continuous learning and professional development are crucial for nurses to stay updated with the latest knowledge and enhance their skills, ultimately improving patient outcomes (Rogers et al., 2021, AlMekkawi and El Khalil, 2020, Nelson and Gordon, 2009) and facilitating their transition into a competent and confident practitioner.

2.7 Professional Identity

Professional identity refers to the way an individual perceives and defines themselves within a specific professional context and is defined throughout the literature in multiple forms (Fitzgerald, 2020, Cruess et al., 2019, Hinkley et al., 2023). It encompasses the values, beliefs, attitudes, skills, and behaviours that individuals develop and exhibit when they move into their profession. It is a crucial aspect of one's professional life and professionalism as it influences how they approach their work, interact with colleagues and clients, and make decisions (Johnson et al., 2012, Landis, 2023, Maginnis, 2018). Professional identity is shaped through a combination of factors, Meyer and Faan (2022) suggest this includes education, training, work experiences, and personal values. It is also influenced by societal norms, cultural expectations, and the specific demands and requirements of a particular profession (Fitzgerald, 2020, Fitzgerald and Clukey, 2022). For example, a nurse may identify themselves as a healthcare professional committed to providing quality care and saving lives (Cruess et al., 2019).

An established professional identity is important as it helps individuals establish their credibility and reputation within their field, as well as consolidate their confidence and competence, knowledge, and skills, as well as facilitate their transition (AlMekkawi and El Khalil, 2020, Boud and Hager, 2012, Fitzgerald and Clukey, 2022). It provides a sense of purpose and direction, guiding individuals in their professional choices and decisions. Hinkley et al (2023) suggest the an established professional identity fosters a sense of

belonging and connection to a professional community, allowing individuals to network and collaborate with others who share similar values and goals. Professional identity is not static but evolves over time as individuals gain more experience and knowledge in their field. It can be influenced by external factors such as changes in the clinical settings or advancements in technology. Individuals may also redefine their professional identity as they grow and develop personally and professionally (Landis, 2023, Traynor and Buus, 2016, Wu et al., 2020). The recognition of the development of professional identity is seen by our professional body, the NMC as going hand in hand with continuing professional development (Landis, 2023).

The development of professional identity in nursing promotes a sense of belonging and pride. Nurses who identify strongly with their profession are more likely to feel a sense of pride in their work and take ownership of their role in patient care (Mackay, 2015, Meyer and Faan, 2022). This sense of belonging fosters a positive work environment and enhances job satisfaction (Missen et al., 2014). Goodyear (2021) outlines that nurses who have a strong professional identity are more likely to be motivated, engaged, and committed to providing high-quality care.

Professional identity in nursing influences the attitudes and behaviours of nurses. Nurses who have a strong professional identity are more likely to exhibit professionalism in their interactions with patients, colleagues, and other members of the healthcare team (Godfrey, 2022). They adhere to ethical standards, maintain confidentiality, and demonstrate respect and compassion towards patients (Hoeve et al., 2014, Hinkley et al., 2023). Professional identity confirms nurses' commitment to lifelong learning and professional development, as they recognise the importance of staying updated with the latest evidence-based practices and advancements in healthcare (Hinkley et al., 2023, Trede et al., 2012).

Additionally, professional identity in nursing contributes to the development of a positive professional image held by others (Sun et al., 2016). Nurses who have a positive professional identity are seen as competent, trustworthy, and reliable by patients, colleagues, and the community (Tan et al., 2016, Tan et al., 2017) and present a professional status. This positive professional image not only enhances the reputation of

the nursing profession but also improves the overall perception of healthcare as a whole (Hinkley et al., 2023). Nurses with a strong professional identity are more likely to be respected and valued for their contributions to patient care (Andrew et al., 2009).

Mentorship and role modelling have a significant impact on the development of professional identity in nursing (Baldwin et al., 2017). Experienced nurses who serve as mentors provide guidance, support, and encouragement to novice nurses, helping them navigate the challenges of the profession. Mentors serve as role models, demonstrating professionalism, compassion, and a commitment to lifelong learning. Wei et al (2021) confirmed that observing and learning from experienced nurses, novice nurses develop a sense of professional identity and allowed them to adopt positive professional behaviours.

Additionally, professional organisations and associations play a crucial role in fostering professional identity in nursing. These organisations provide resources, support, and networking opportunities for nurses online and via social media and social networks, allowing them to connect with colleagues and stay updated with the latest advancements in the field (Alharbi et al., 2020, Alharbi et al., 2022). Professional organisations also advocate for the rights and interests of nurses, promoting the value and importance of the nursing profession. By actively participating in professional organisations, nurses strengthen their professional identity and contribute to the advancement of the profession as a whole (Johnson et al., 2012).

Nurses who have a strong professional identity are more likely to exhibit professionalism, demonstrate a commitment to lifelong learning, and provide high-quality care (Boud and Hager, 2012). Factors such as education, mentorship, and involvement in professional organisations contribute to the development of professional identity in nursing (Hinkley et al., 2023). Fitzgerald (2020) and Fitzgerald and Clukey (2022) outlined that a strong professional identity builds in stages and consolidates gradually over time, culminating in transition to a capable and confident practitioner.

Professional identity is crucial in a professional setting as it helps individuals establish their reputation, credibility, and expertise. It involves developing a unique personal brand as a qualified nurse that showcases one's skills, values, and professional goals and allows

for the establishment of one own personal role. Building a strong professional identity not only enhances career prospects but also helps in gaining respect and recognition from colleagues and managers (MacIntosh, 2003). Building a professional identity also involves developing strong interpersonal skills encompassing effective communication, teamwork, and leadership abilities (Mazyck, 2023). By actively working on these skills, practitioners demonstrate their ability to work well with others and contribute positively to the workplace (Goodyear, 2021).

Additionally, building a professional identity requires continuous learning and development. Fitzgerald (2020) and Fitzgerald and Clukey (2022) confirm that professional identity involves maintaining a positive reputation and ethical conduct. Honesty, integrity, and professionalism are highly valued in the workplace (NMC, 2018). By consistently demonstrating these qualities, individuals can build trust and credibility among colleagues, clients, and superiors (Hinkley et al., 2023). This not only helps in building a positive professional image but also opens up opportunities for collaboration, mentorship, and leadership roles (Girot, 2000).

Thus, building a professional identity in a professional setting is crucial for career success and growth. It involves self-awareness, establishing a strong clinical presence, developing interpersonal skills, continuous learning, and maintaining a positive reputation (Hoeve et al., 2014). It builds slowly initially and gathers gradually over time and results once established, allows for a practitioner to arrive as a confident clinician, illustrated in Figure 4 below.

Figure 4: *Visual representation of professional identity process*

2.8 Development of the Conceptual Framework

The themes of socialisation, knowledge and skills, competence and confidence, and professional identity are interconnected and play a pivotal role in achieving successful transitions in various contexts as outlined in both the literature review and the visual presentation of the themes in Figure 5. I also took into consideration the possibility of using Benner's (1984) novice to expert theory to frame the enquiry instead of Duchscher's (2009) theory of transition because both theories can account for the process of nurses' transition from student nurses to confident nurses. However, it is important to note that Benner's theory specifically addresses the overall trajectory of a nurse's career and examines the transition in practice from novice to expert levels over an extended period of time, while Duchscher's theory is focused more narrowly on the first year of practice, and specifically the first six months for novice nurses. As this study is centred on the early stages of transitioning to practice, Duchscher's theory is better suited as it specifically aligns with the focus on the first six months of nursing rather than the broader transition from novice to expert.

Socialisation can be seen as a process through which individuals acquire the knowledge, skills, and norms necessary to function effectively within a specific social group or profession. It involves learning the values, attitudes, and behaviours that are expected and accepted within the professional community. Socialisation helps individuals develop a sense of belonging and identity within their professional field, as they learn to conform to the expectations and norms of their peers and mentors.

Competence and confidence, applied in conjunction, can be referred to as the ability to apply knowledge and skills effectively in practical situations leading to capability and successful transition (Saghafi *et al.,* 2022). It involves the integration of theoretical knowledge with practical experience and the development of problem-solving and critical thinking skills. Competence is crucial for successful professional transition as it enables individuals to perform their job tasks, make informed decisions, and adapt to new challenges and contexts. Competence is often assessed through evaluations, certifications, and performance reviews, which provide individuals with feedback on their abilities and areas for improvement.

Consequently, knowledge and skills presents itself as fundamental component of professional transition. It refers to the theoretical and practical understanding of a particular field or discipline. As individuals transition into a new professional role, they must acquire the necessary knowledge to perform their job effectively. This includes understanding the theories, concepts, and best practices relevant to their field. Knowledge and skill acquisition can occur through formal education, training programs, on-the-job experiences, and continuous professional development (Nelson and Gordon, 2009, van Rooyen et al., 2018). The acquisition of knowledge is essential for individuals to gain credibility and competence in their new professional role.
Professional identity is the sense of self and belonging that individuals develop within their professional field. It encompasses their values, beliefs, and attitudes towards their work and the professional community. Professional identity is shaped through socialisation, knowledge acquisition, and competence development. As individuals transition into a new professional role, they may undergo a process of identity formation, where they redefine their sense of self and align it with their new professional identity. This process involves internalising the values and norms of the profession, identifying with the goals and aspirations of the professional community, and developing a sense of purpose and meaning in their work.

To achieve a successful transition, individuals, together need to engage in intentional learning and reflection, seek guidance and mentorship, and actively participate in professional communities. They must be open to new experiences, willing to learn from others, and adaptable to changing circumstances. By combining socialisation, knowledge, competence, and professional identity, individuals can navigate the complexities of professional transition and thrive in their new roles.

By bringing together of the ideas of socialisation, competence and confidence, knowledge and skills and professional identity, a threshold or a 'point of readiness' or as Duchscher (2009) outlines the point of 'knowing' which signifies the time when the individual 'transitions' in practice; consolidating their clinical practice and moves on to embark on their future career can be illustrated in a conceptual framework presented below in Figure 4. This conceptual framework represents the combination of themes from the literature in a visual interpretation or research tool of how they merge to take the

individual over the threshold of 'transition' or the 'point of readiness' resulting in a capable confident practitioner.

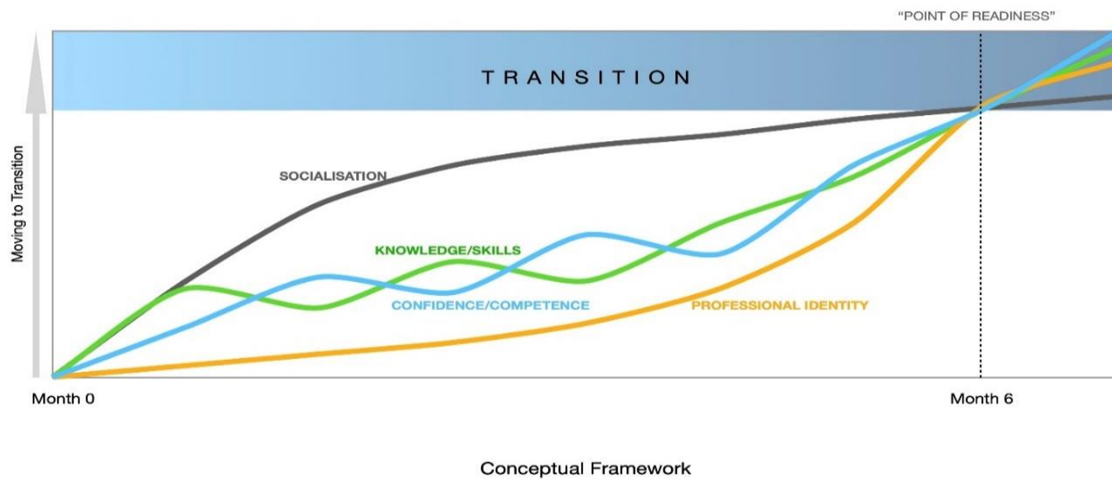

Figure 5: Conceptual framework- Adaptation combining themes.

2.9 Chapter Summary

This chapter has explored the concepts and literature supporting the themes of transition to professional practice, socialisation, confidence and competence, knowledge and skills, and professional identity in the form of a narrative review (Grant and Booth, 2009). The critical analysis highlights the common threads related to the existing research and the aim was to construct a conceptual framework to consolidate and summarise the literature in order to utilise this framework as a research tool. Combining the transition models, the literature surrounding the cited themes allows for the development of a conceptual framework to visually represent my interpretation of transition. I am interested in seeking an in-depth understanding of this transition from the NQN themselves, a holistic comprehension of their experiences of the first six months and their perceptions of the process, and this is the aim of the research. This chapter also focussed on the development of a conceptual framework or model to give a visual representation of transition of the practitioners from qualification /registration to the emergence of a confident professional.

As discussed in the Chapter 1, transition to professional practice refers to the process of moving from a student or trainee role into a professional or working role within a particular field or clinical setting. There are different stages or phases of transition, from

student to NQN, from NQN to confident practitioner, from NQN in a new setting and the NQN feeling part of a setting or feeling socialised in the clinical setting. The focus of the thesis is on the phase of transition from student to NQN, from NQN to confident practitioner and the transition to feeling socialised into a clinical setting.

The narrative review of the literature explored in this chapter explored these cited themes, in some studies they were explored separately and, in some studies, combined the different themes and explored them in combination. This thesis not only explored them together, but more specifically used them as a research tool. This is a gap in the existing body of knowledge; i) the combination of the themes, ii) the use of the conceptual framework as a research tool, iii) asking the participants in the thesis their views on the existing literature and iv) utilising this to pose questions to fully understanding the complexities of transition from the perspective of the individual practitioners in their first six months.

Therefore, the research aim: *To explore the complexities of transition from qualification to becoming a confident practitioner following a professional preparation programme.*

3. Methodology and Methods

In this chapter I will present outline the chosen methodology of social constructionism, the multiple case study approach and the use Braun and Clarke's (2006, 2022, 2017) thematic approach to the analysis. The chosen methodology allowed me to understand the phenomena fully and comprehend how transition occurred in reality, the multiple case studies provided detailed, contextual, and multifaceted understanding of how the reality of transition are constructed and maintained, and Braun and Clarke's (2006, 2022, 2017) approach provided a flexible, systematic, and sensitive approach to identifying and interpreting the patterns formed from the data collected. Social constructionism is a theoretical framework that emphasises how reality is created through social interactions and language (Bryman, 2016). It suggests that individuals and societies actively construct their understanding of the world. In this research, social constructionism can be utilised by examining how social phenomena, such as professional identity, confidence, and competence, are constructed and interpreted by individuals and groups. I explore how different social factors influence individuals' perceptions and behaviours, and how these constructions shape societal structures and relationships. This approach provides valuable insights into the subjective nature of reality and the influence of social processes on human experiences, such as transition to professional practice.

This in-depth enquiry utilises the methodology to explore the experiences and perceptions of newly qualified nurses to explore their ability to perform competently, the possible stresses and joys of their new professional positions as they navigate the transition to confident practitioners. A critical review of the research journey outlines the research development process and development of the researcher, focussing on reflexivity and the need to demonstrate cohesion and understanding of the participants' individual stories.

There will be a discussion of the social constructionist perspective, an analysis of the ontology and epistemology, emphasising the suitability of this paradigm to address the study's aims. The series of cases utilising an adapted case study design will be discussed, and the data collection tools will then be addressed, along with justification of the diaries and interviews as the most appropriate choice. This chapter will also include a critical

review of trustworthiness and rigour of the study, as well as ethical issues. Finally, positionality and reflexivity will be discussed in relation to the research aims.

3.1 Social Constructionist Perspective

The interpretive paradigm is an umbrella concept that encompasses a variety of methodological designs and approaches to enquiry (Bryman, 2016). They offer a distinctively different mechanisms of data generation from differing and specific lens, all follow a collection of common conceptual assumptions that they seek to enhance understanding rather than prove a hypothesis. The search and resulting choice of appropriate methodology were challenged by my desire for familiarity and a shared understanding of the development of the newly qualified nurses and their transition. The literature focussed on problem centric studies dominating the subject of transition, while a social constructionist approach provided the opportunity to enquire and explore transition facilitated through a cooperative and interactive mechanism involving participants and allowing for the study to be 'with' rather than 'on' the individuals involved (Bryman, 2016, Parahoo, 2014).

Social constructionism or the social constructionist perspective can be defined as a theory of knowledge that examines the development of a jointly constructed understanding of the world, which is formed on the premise that there is a shared assumption of reality. Social constructionism stems from an attempt to explore and examine the nature of reality and the assumption that 'truth' and 'facts' are not defined entities but that multiple 'truths' exists to explain and inform us about the world. Essentially it is an anti-realist, relativist stance (Hammersley, 1992) that seeks to understand an issue, shares the goal of understanding the world of lived experience from the perspective and viewpoint of those living and experiencing the world they live in. Interpretive, qualitative research states that its goals are to understand the meaning of social phenomena, valuing the subjective experience but seeking to develop an objective stance to study and describe it (Parahoo, 2014). This creates a clear tension between objective interpretation of subjective experiences, utilising the logical, scientific, empirical perspective to human enquiry (Polit and Beck, 2014).

The social constructionist viewpoint is therefore not based on the notion of 'reality,' objectivity, and value neutrality. Discussing the concept of 'truth' is elusive, and our

ability to describe and think about phenomena from different viewpoints detracts from objectivity and value neutrality and thus eventually enriches our understanding. Central to the views of the social constructionist is the discussion of knowledge and truth generation, Berger and Luckmann (1991) suggest that the nature and construction of knowledge is created by the interactions of individuals within society and emerges in complex forms as exchanges take place in all settings.

Qualitative research designed from a constructionist approach could lead to new methods of inquiry, or greater emphasis on storytelling and the participant-researcher relationship in narrative research (Bryman, 2016). This narrative or storytelling approach allowed me to explore and seek an understanding of the complexities of transition to professional practice from the newly qualified nurses' themselves and gain an in-depth insight into their experiences and perception of this transition.

An individual and a group of individuals create and define the reality that exist for them at that time and in that moment, and it is that reality that the social constructionist wishes to capture with the use of the individual narrative. The creation of knowledge from the interactions of individuals in society is an essential facet of the constructionist perspectives (Schwandt, 2003). This approach sought to discover what the individual newly qualified nurse thinks, feels, and experiences when they make the complex transition from a student nurse to a registered practitioner, enquiring about identity change, power relationships and the difficulties of taking on additional responsibilities of clinical management of patient care that can be stressful and required emotional resilience. In making these discoveries the professional preparation programme could be developed to address any omissions or adapted to reflect the needs of the nurses joining the professional register (Caliskan and Ergun, 2012) and assist in easing the transition and developing understanding which will be outlined in the conclusions and recommendations.

3.2 Ontology and Epistemology

Social constructionism challenges traditional notions of reality by emphasising the role of social interactions and language in shaping our understanding of the world. It suggests that reality is not fixed or objective, but rather constructed and interpreted through cultural and historical contexts (Bryman, 2016). This challenges the idea of a single,

universal truth, and instead highlights the diversity of perspectives and experiences. Social constructionism encourages a critical examination of how social forces and power dynamics influence what is considered to be real or true, ultimately questioning the stability and objectivity of traditional notions of reality.

The emergence of social constructionism stems from a response to quantitative methodology as it emphasises the subjective and context-dependent nature of reality rather than the objective fact-based nature of the positivist paradigm. It encourages a critical examination of the assumptions and perspectives embedded in quantitative research methods, such as surveys and experiments, and how these methods may shape and construct the phenomena they seek to measure. Social constructionism challenges the idea of objective, value-free data collection, and instead encourages researchers to consider the social and cultural influences on the research process. This approach promotes a nuanced understanding of the limitations and possibilities of quantitative methodology, highlighting the importance of contextualising findings within the broader social and historical landscape.

Guba and Lincoln (1994) outline key contrasts between the positivist and constructionist approaches to emphasise their differences. In terms of ontology, in constructionist research multiple realities are constructed by the actors in research, not that there is a single reality that is correct or 'true' and exist independently as an entity to be examined. On an epistemological level, the researcher embarking on a relationship with the participants and entering into a conversation as part of the data collection, where the 'knower' and the 'known' are inseparable, inextricably linked and the research is value bound; rather than observing them from a detached stance in an experimental or objective form of data collection where the enquirer is value free, culture blind and universalist, that social objects are real entities operating in causal relationships.

Ontology addresses assumptions about your view of the world and the nature and orientation of social entities:

> *'the question of whether social entities can and should be considered objective entities that have a reality external to social actors, or whether they can and should*

be considered social constructions built up from the perceptions and actions of social actors' (Bryman, 2016).

Therefore, it is essential when phrasing the necessary enquiry to be clear of focus and context. Epistemology is associated with our beliefs about how one might develop knowledge about the world. Bryman (2016) states that the enquiry *'raise the questions about the issues of how the social world should be studied*', (p. 4) and whether scientific approaches can answer key questions about individuals or social institutions. Hence, by selecting the epistemology as well as the ontology of a research paradigm it can further support the method, validity, scope, and distinction of the enquiry in question.

The objective of the study is to create a more informed and sophisticated construction of the transition to professional practice and therefore the subjectivity of researcher prevailed (Rashid et al., 2019) and is evident in the collection and emersion with the data. The diaries discussed in Section 3.4, allowed for the engagement of the participants, to read the entries as they were submitted, think about them, and analyse them as individual entries and in the context of the other entries, to read and re-read them, making notes, and keeping records of what was being discussed and what might require further explanation in the interview.

Finally in the relationship between theory and research, the constructionist emphasising inductive reasoning that is reliant on the data or research to develop theories and concepts to enhance understanding from the individual rather that the deductive perspectives that seeks to determine the collective view from facts and data to draw conclusions (Guba and Lincoln, 1994, Haslanger, 2012). The constructionist approach could use the newly qualified nurses' individual voices to articulate their experiences to seek an understanding of the issues of transition to practice, in an iterative manner as the data generation and analysis is guided by the theories around transition not to generate the theory itself.

3.3 Study Design

The multiple case study research design can be used in social constructionist research to explore the complexities and nuances of social phenomena within specific contexts. Each one of the case studies outlines the transition of the participants, the narrative of each individual qualifying nurses. Therefore, by employing in-depth, qualitative methods, such as diaries and semi-structured interviews, this research can focus on understanding the construction of reality within the particular case or setting. Social constructionism encourages researchers to examine the multiple perspectives, language, and social interactions that shape the phenomenon under exploration in the study. Through this multiple case study approach, I am able to uncover the diverse meanings and interpretations attributed to the phenomenon of transition, revealing the influence of socialisation, on its construction. This methodology allows for a rich and detailed exploration of the social construction of reality within specific cases, contributing to a deeper understanding of the subjective nature of the social phenomena of transitioning to a confident practitioner.

Using multiple case studies and applying a social constructionist approach enabled the research to generate an in-depth, multi-faceted understanding of a complex issue in a real-life setting (Crowe et al., 2011, Houghton et al., 2013, Yin, 2018). This research design, used extensively in a variety of disciplines, including social sciences, with '*the central tenet being the need to explore an event or phenomenon in depth and in its natural context*' (Crowe et al., 2011). The series of cases can be described as either explanatory, exploratory, and descriptive examples; exploratory cases are undertaken to learn about a phenomenon. An instrumental story or case uses a particular case to gain a broader appreciation of an issue, whereas a multiple case approach involves exploring several cases simultaneously or sequentially to explain and explore the phenomenon (Yin, 2018, Yin, 2015) therefore understand and generate a broader awareness and comprehension of the issue under review (Wynn and Williams, 2012). Yin's perspective offers a systematic process for understanding specific events within the context in which they occur and therefore offers valuable insights from a social constructionist paradigm (Yin, 2018) exploring and expanding my understanding of the process of transition. The application of the multiple case study approach using a social constructionist approach focusses on the how the social construct shapes our understanding of the phenomena

under investigation and acknowledges the likely exceptions and commonalities in this approach (Wynn and Williams, 2012) ensuring an in-depth comprehension of the transition.

The key characteristics of a multiple case study approach include an in-depth exploration, case study research involves a thorough and detailed examination of a specific case or series of cases exploring a phenomenon within its real-life context. This qualitative approach typically employs qualitative research methods such as interviews, document analysis, such as diaries to gather rich and contextual data. Case study research emphasises understanding the unique context and intricate details surrounding the case or cases under investigation allowing for contextual understanding (Anthony and Jack, 2009). Researchers often use multiple sources of data to triangulate and validate findings, and I choose to include diaries and interviews as the multiple sources of data. It frequently involves an inductive approach to data analysis, allowing themes and patterns to emerge from the data rather than being predetermined by theory. There is an emphasis on holistic perspective, this case study research aims to provide a holistic view of the transition, considering various factors and perspectives that contribute to the phenomenon under study. This approach is well-suited for examining complex and multifaceted issues, allowing for a deep understanding of the intricacies involved. These case studies often focus on unique or uncommon cases, aiming to uncover detailed insights rather than generalisable findings (Gillham, 2000, Hancock and Algozzine, 2017). These characteristics make case study research an effective methodology for exploring the richness and complexities of specific cases and phenomena within their natural context (Yin, 2015, Yin, 2018) and therefore gaining comprehensive awareness and knowledge of the transition process.

While the multiple case study approach offers an in-depth exploration of transition, other qualitative approaches could have been applied to investigate the phenomena, such as phenomenology, narrative inquiry, or grounded theory. Phenomenology would allow for an understanding of the lived experience of individuals by focussing on their subjective perception (Bryman, 2016) and interpretation of transition but would not encompass the whole picture of the participants and their journey, which was vital to this inquiry. This approach would not include the real-time diaries that were so informative to this research

Grounded theory depends on theory to be developed by the data, useful for exploring new phenomena to build a new theoretical framework, (Woodhams, 2014) which was not applicable as multiple theoretical frameworks exist surrounding transition. Narrative inquiry focusses on collecting and analysing the stories to understand individuals and collective experiences (Mooney, 2007) and could have been applicable to this inquiry. It utilises interviews, personal narratives to explore how individuals to construct meaning through their stories of an issue but the multiple case study approach allowed for the study of an expansive, complex social issue such as transition.

A multiple case study approach was undertaken, a series of three cases were collected and analysed followed by a further three cases, which were then analysed and compared the first series, to ensure the understanding of the subject area. The participants were selected from their respective qualifying cohort, three were recruited in the first groups and a further three were recruited in the next qualifying cohort. On commencing recruitment, no definitive numbers were pre-determined, I did not have a sample target number. The timings were dictated by when the cohorts qualified and when they registered with the NMC. The samples came from the two qualifying cohorts, which fell six months apart, aligning with the phases of data collection, the diary entries, and the subsequent interviews.

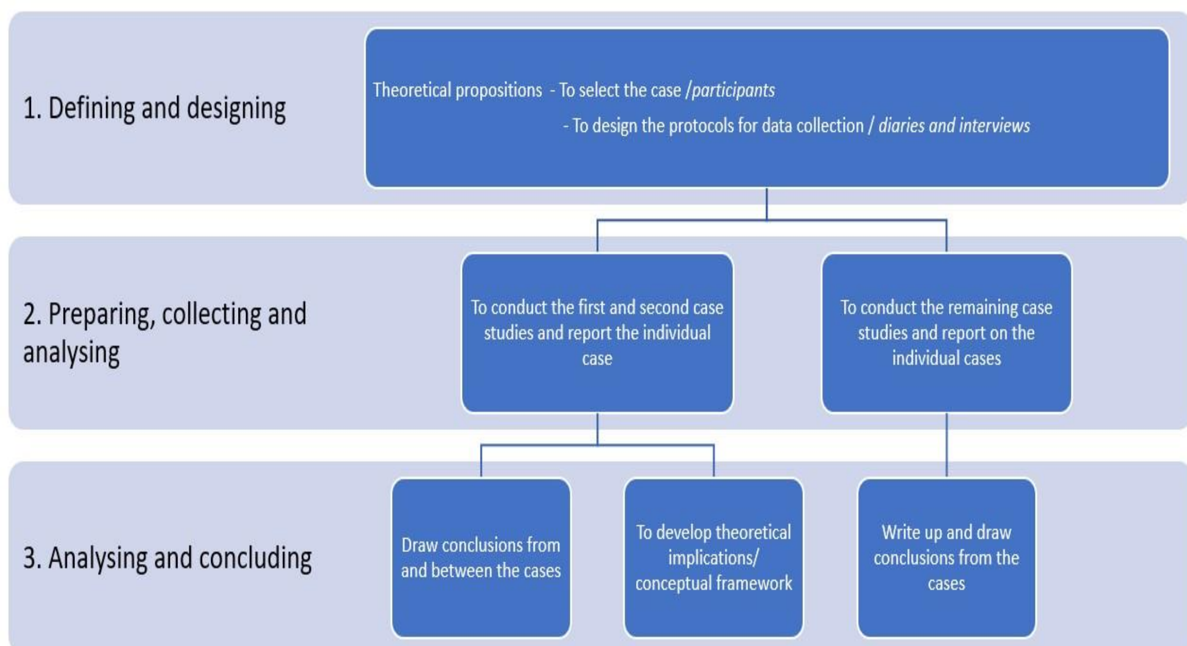

Table 1: Adapted from the Steps of the Case Study Design by Yin (2015)

Following successful completion of a professional preparation programme the nurses will register with the NMC, at this point they were approached and invited to participate and form the first series of case studies. A brief presentation was given to the completing cohort on their final teaching event, an information sheet was shared both in person and on the Digital Learning Environment (DLE) to inform potential participants. The researcher was then contacted by interested participants and they were given further information and asked to consent to participate in the research. Once this registration occurred the nurse can practice as a qualified professional; undertaking all the tasks and responsibilities of a qualified nurse (NMC, 2004, NMC, 2009, NMC, 2010, NMC, 2015). On completion of the programme, there can be a delay between finishing the professional preparation programme and receiving their NMC registration. This delay can be anything from days to a few weeks. It is not until they receive their registration number can they undertake certain tasks, such as drug delivery and signing communications. Following recruitment, the newly qualified nurses were asked to keep a reflective diary to record critical incidents and events over the next 6 months focussing on experiences that demonstrate personal developments related to competence, capability, and role identity.

3.4 Methods

The methods are the systematic approach or procedures utilised to generate and then analyse the data. The methods provides the framework for collecting rigorous information, in the form of diaries and interviews, to ensure valid and credible findings (Bryman, 2016). The methods section outline the sampling strategy, the data collection techniques, and the method of analysis.

Purposive sampling was utilised as it offered a way for the participant to be selected in a strategic way, and those that were sampled were relevant to the research aims (Bryman, 2016, Parahoo, 2014). Purposive sampling is a non-probability sampling technique used to select participants based on specific characteristics or criteria that are relevant to the research question. In purposive sampling, researchers intentionally select individuals or cases that possess the desired qualities or knowledge to provide valuable insights into the research topic. This sampling method allows researchers to target specific groups or individuals who are most likely to provide rich and relevant data, enhancing the validity and depth of the research findings. This is outlined in section 3.5.

Reflection, and the use of reflective accounts are an integral part of Professional Preparation Programmes, and form part of the ongoing assessment in nurse education, therefore the invited participant will be familiar with this activity. Reflective diaries are a valuable and flexible method of data collection that offers the potential to record accounts that are ordered, sequential and 'true to life' (Bolger et al., 2003, Williamson et al., 2015, Hewitt, 2015, Thille et al., 2022), the diary can capture the events authentically, allowing for an accurate record of events. Hewitt (2015) states '*a diary can be considered a systematic records with discrete entries arranged by order of date; type of report and commentary upon events, experiences thoughts and feelings' (p. 347),* this will be invaluable to record the events as they occur with the newly qualified nurses. The participants recorded the data without the researcher being present, allowing them to elaborate their own personal thoughts and feelings without influence. Although they were writing their diaries for the purpose of this research, it was not monitored or checked, it was simply received and analysed, therefore it was hoped that the participants were honest and candid. This will be of particular benefit as the reflections were of a personal nature. The diary provided the nurses with the reflective 'space' to think and capture the experiences and events of everyday clinical practice, their thoughts and feelings from the participants' own perspective (Hewitt, 2015).

Diaries can take several varied forms, written and oral formats following a structured format, but technological advances have created new and innovative methods of diary keeping from video 'selfies,' verbal recordings to online blogs, all methods were evaluated to assess their feasibility, accessibility and participant ease, and the use of online written diary was selected. All the participants were familiar with online platform as they had been utilising it throughout their programmes and so were at ease with the technology. The platform, the DLE allowed the participant the ability to open their diaries wherever they were able, and whenever they had the time to add to their diaries. This convenience, it was hoped would facilitate the participants and aid data collection.

Although audio blogs or diaries were considered, the written format was selected as it offered the participants the opportunity to record the events in a timely fashion, not simply verbalise the events, which might result in the recording of un-edited or under curated accounts that were not representative of a critical reflection. The written account, in an online format allowed the participant the opportunity to record and reflect on the

events of the shift/ week in a critical manner and allowed them time to read the entry prior to adding the entry to the online platform. The online functionality offers me as the researcher the ability to monitor and review the entries as there were submitted, analysing them for themes to be developed into the interview schedule. The limitations of this method of data collection were cited in section 3.12.2.

The phases of data collection will reflect the points of registration, a February 2019 cohort and then a September 2019 cohort. In each cohort three participants volunteered and were subsequently recruited, a further two came forward but withdrew after the initial discussion. With six participants over the course of the study there was sufficient data collected from the reflective diary to inform the structure of the interview (Bryman, 2016). As the second group were completing their diaries and the interviews were undertaken the data was found to have resonance, themes were emerging, and I was gaining a comprehensive understanding from my participants of the transition. None of the participants withdrew during data collection and went on to be interviewed.

Case series from Cohort A was recruited in February 2019 following registration, the diary entries ran from then to September 2019, with interviews held during October and November of that year. Case series from Cohort B were recruited in July 2019, completing their programme in September, the diary entries ran from then to February 2020 with interviews following that date. The first three participants were recruited and introduced to the online platform in a recruitment meeting. They were able to log in and add to the diary accounts at a time convenient to them. When diary entries were made and submitted online, I was alerted with an email. This allowed me to read and review the entries as they came in. The following three participants were introduced to the system in the same way, and entries commenced.

Following the diary collection phase, the participants were invited for a semi-structured interview. The combination of research tools allows the research to fully address the proposed aims. The diaries allowed for the collection of data directly from the participants about the first six month of clinical practice ensuring there was a full understanding about what was happening. The interviews subsequently allowed for the participants to share their opinions on the literature presented as a conceptual

framework and get a further understanding of the significant events recorded in the diaries.

This diary-interview method is often used the participants are asked to record their experiences, thought and behaviours rather than simply recording times and dates and then followed by a semi-structured interview that responds to themes drawn out of the diary entries (Bryman, 2016, Kenten, 2010, Thille et al., 2022). A semi structured interview can be defined as a broad open-ended conversation covering several evolving sets of questions. These will have been developed following an analysis of the diaries and will be good at obtaining rich data that offers clarity to the issues that unfolded in the reflective diaries, exploring what is meant, how decisions were made, how the participants felt and reacted to the situations and events cited. The interviews took place at a time and place that was mutually agreed and lasted approx. one hour. The interviews were recorded and transcribed using voice activated software[3], an audio recording was also kept validating the transcription for accuracy. This allowed for thematic analysis to be undertaken, the interview guide was flexible and reflected themes drawn out of the reflective diaries accounts but focussing on competence and capability and the development of role identity. There were key questions to focus the participants to expand on events recounted in the diary entries (see Appendix iv). This gave the researcher the opportunity to seek clarity on any entries that required or needed further insight and allowed for the presentation of the conceptual framework and ask for any comments or 'correction' to the framework to better reflect their experiences.

The plan for the data collection portion of the study was cited in a Gantt chart (see Appendix v), following the phases of data collection from the point of registration and recruitment, through six months of diary entries and finishing with the interview. The research process is potentially 'messy' and therefore a pragmatic approach was taken to the cited plan, slippage will occur and I needed to flexible and responsive to the process, building in extra time for all phases, from ethics approval, to data collection, analysis, and the final writing up stage (Dunleavy, 2003).

[3] Otter for Education.

3.5 Participant Selection

The social constructionist approach requires the participants to shape the process, and as such the participants were invited to be involved in the study. The invitation was issued through a presentation at the point of completion of the programme and removed the need or opportunity to use a randomised approach to sampling. This supports the methodology as the selection process is flexible and collaborative process.

The purposive sampling of newly qualified nurses directly following a Professional Preparation Programme followed this set of inclusion and exclusion criteria, (*see Table 2*).

Inclusion	Exclusion
Completed a BSc (Hons) Nursing- Adult Completed within the last 2 months. Working in a non-rotational post in Secondary care Ward or Unit	Multiple Registrations Working agency/bank Working in Primary care OPD/Clinics

Table 2: Inclusion and Exclusion Criteria

The rationale for selecting nurses who are working in wards and unit within the secondary care setting is due to the fact they will be working in diverse teams with multiple professionals and undertaking the roles that are clearly defined whereas those working in primary care and Outpatient Departments (OPD) have autonomous roles and working independently and therefore will have very different experiences of the transition following registration.

The timeframe of the first six months was chosen from the point of registration to explore the concept of transition and is based on the Duchscher's (2008, 2009) model of the stages of transition. This model cites the stages of 'doing,' 'being' and 'knowing,' and suggests the 'knowing' stage occurred at approximately six months demonstrating the 'point of readiness' at which the NQNs moves from dependant/ supported student to independent/ established practitioner and transition had occurred. I looked at the timeframe of six months allied with Duchschner as that aligned with local practice

recommendations that a NQN's first post should be a minimum of six months. I wanted to capture the initial stages, the series of 'firsts' as they occurred. After the first six month it is accepted practice locally to start to think about moving to another post or setting at this point. This is in contradiction to the national recommendations cited in policy statements (O'Driscoll et al., 2022) and other theorist. I also wanted to establish whether my participants felt that transition had occurred at this stage, and whether they felt ready or capable in their role within the six-month timeframe. It also aligns with when the cohorts reach the point of qualification and were recruited.

3.6 Context and Programme Information

As previously stated, the study was undertaken within the nursing faculty of a UK university which followed the Nursing and Midwifery Council (NMC) validated programme for the professional preparation of all nurses who wish to join the NMC register. Without this qualification it is not possible to gain employment in the UK as a registered nurse. The programme has three branches or fields, adult, mental health, and child, and at the time of the study the faculty had two intakes per year, in February and September. The February cohorts has only an adult and a mental health field and is smaller in number, while the September cohorts has all three fields and is considerably larger. The ratios of male to females in the cohorts was within a similar range to the eventual sample in the study, and therefore representative of the gender make up in the cohorts.

Cohort	Total	Adult No	Ratio - Male: Female
Sept 2018	466	259	1 : 7
Feb 2019*	**169**	**114**	**1 : 5**
Sept 2019*	**439**	**251**	**1 : 8**
Feb 2020	147	97	1 : 6

Table 3: Cohort Breakdown, numbers, and ratios

The purpose of the research was to investigate transition of adult nurses after registration and the aims were to explore this transition. Following registration, newly qualified nurse (NQN) takes up posts in clinical settings of their own choice. They can choose to work in any setting or geographical location. All the research participants had

trained in National Health Services (NHS) clinical settings in the region and could choose to remain in those settings, those familiar to them or choose to accept employment in any other setting. The study recruited the participants at the point of registration, those who fulfilled the inclusion criteria set out in Table 2, from both the February and the September cohorts.

3.7 Participant Demographics

Six participants volunteered and were then recruited, three from the February cohort and three from the September cohort highlighted in Table 3 and identified as Cohort A and Cohort B. At the point of registration and the start of their employment, each participant started a diary and then were interviewed at approximately six months, the timing of the interview was governed by the participant's availability and ranged from twenty-four to thirty-two weeks post registration.

In Cohort A there were two females and one male, whereas Cohort B was all female, a ratio of 1:5 - male to female falls with the representative range of previous cohorts.

The participants were aged between twenty-three and forty-four years at the point of registration with a mean age of 30.6 years and falls within the representative ranges for the previous cohorts.

Cohorts	Age Range	Mean Age	Participant Age Range	Participant Mean Age
Feb 2019	21-47	31.2	23-37	28.7
Sept 2019	21-40	27.5	21-39	27.3
Overall	**21-47**	**28.4**	**21-38**	**28**

Table 4: Participant age range and means.

Details of personal and professional information was anonymised, and all the participants and personnel cited were given pseudonyms and anonymised to ensure their individual identities were protected and places of work were generalised.

3.8 Method of Analysis

The data was analysis in accordance with the social constructionist methodology (Bryman, 2016). There was a breadth and richness to the raw data, and the process of analysis needed to allow for the description of emerging concepts and phenomena providing explanations of data as it became apparent.

The data comprised of the diaries which contained the narrative account of events as they transpired and the interviews transcripts which were the recorded conversation structured by the interview guide (see Appendix iii), that was combined with the notes taken in my reflective journal, to form part of the reflexivity of my study (Louis and Barton, 2002). I utilised the online platform and annotated my own thought and analysis on the texts as they came in. This allowed me to start the process of analysis, making notes and simple term 'colour coding' the entries, identifying themes relating to the conceptual framework highlighted in the literature review. This exploration of multiple sources and meanings allowed for the development of the relationship with the participant, this ensured I remained truthful and honest to the data while still viewing the data without prejudice.

Thematic analysis was the chosen approach to undertake the analysis of the data collected, to structure the process of analysis, Braun and Clarke's (2006) guidance was utilised, allowing the data to be identified, refined and review to find emerging 'patterns of meaning', and to enable the initial themes and sub themes to become evident (Braun and Clarke, 2022) and therefore form an accurate picture of the phenomena.

Thematic analysis is a commonly utilised approach in qualitative research; it allows the synthesis of diverse, nuanced, and complex data (Braun and Clarke, 2006, Bryman, 2016, Braun and Clarke, 2022). Boyatzis (1998) suggests it is not a specific method but rather a tool that can be used to manage and review qualitative data in a robust and valid manner, it is flexible in its approach which allows for analysis of research data. It provided a systematic approach to the generation and coding of themes from raw qualitative data, generated by the diary entries and the interview transcripts by the reading, examining, and re-reading of the data. Each discreet piece of data was examined and coded to allow me to consider all data sources and enhance the overall analysis (Holloway and Fulbrook, 2001).

Braun and Clarke (2022, 2006) and Clarke and Braun (2017) support the principles and phases of thematic analysis to allow the generation of themes from the data that can be flexible, not just theoretical but actually flexible in terms of the sample, research aim and data collection method. This is essential to reflect the social constructionist paradigm and is different to the more positivist emphasis from the Boyatzis (1998) who focusses on the systematic coding of data to form the analysis (Nowell et al., 2017).

Certain phases and words form the smallest unit of data that capture interesting features such as word or phases, which are then built up into themes or larger units which produce patterns (Clarke and Braun, 2017). Themes then provide a framework for organising, reporting, and generating findings from the data. While flexibility is useful and inductive it still requires a clear set of guidelines and for this the six-stage process advocated by Braun and Clark (2006), and allowing for the generation of themes to appropriately address the research aim..

Phase	**Description of the Process**
1. Familiarizing yourself with your data	Transcribing data (if necessary), reading and re-reading the data, noting down initial ideas.
2. Generating initial codes	Coding interesting features of the data in a systematic fashion across the entire data set, collating data relevant to each code.
3. Searching for themes	Collating codes into potential themes, gathering all data relevant to each potential theme.
4. Reviewing themes	Checking if the themes work in relation to the coded extracts and the entire data set, generating a thematic 'map' of the analysis.
5. Defining and naming themes	Ongoing analysis to refine the specifics of each theme, and the overall story the analysis tells, generating clear definitions and names for each theme.
6. Producing the report	The final opportunity for analysis. Selection of vivid, compelling extract examples, final analysis of selected extracts, relating back of the analysis to the research question and literature, producing a scholarly report of the analysis.

Table 5: Phases of Thematic analysis taken from Braun and Clarke (2006)

Phase 1 – The data collected in the online platform was read and re-read the diary entries were reviewed and examined as there were submitted and catalogued and note down the initial ideas and themes as they emerged. This was in order to familiarise oneself to the data. Throughout this process the participants were thanked for the contribution, and at the 3 month point an email was sent to maintain motivation and keep the diary entries 'on track'. The interviews were recorded and transcribed using voice activated software (*Otter for Education*), audio recordings were also kept checking for accuracy and the online annotations were also written up and underwent a process of thematic analysis. Braun and Clarke (2006) suggest that there is no single way to undertake this however *'thematic analysis is a method of identifying, analysing and reporting patterns (themes) within the data'* (p. 79), nonetheless this guide outlines a clear strategy for undertaking the process.

The constant and consistent review of the data and the engagement with the material allows for familiarisation to develop and patterns to form, and as they did, they were noted and recorded. In order to establish trustworthiness my engagement in the data as well as reflexivity was documented, engaging in self-questioning and self-understanding was prominent (Patton, 2002), enabling me to develop my thinking and enhance my awareness of the themes as they emerged. Holloway and Wheeler (2013) suggest it is this immersion in the data that invokes and promotes trustworthiness and the essence of the various truths evident in the participant own experiences.

The text was also put through a Qualitative Data Analysis Software (NVIVO 10) at this stage and the preliminary codes were allocated and compared. This management system was invaluable to organise, check and re-consider the information stored, but it was not necessary to efficiently manage all the data on this system, as the DLE was able to catalogue and manage the data already. The DLE was therefore used and allowed for the data to be managed with ease. I and the participant were very familiar with this platform and so an additional data management system was unnecessary. As a researcher there was a temptation to become pre-occupied with mastering the NVIVO 10 software, which became a distraction, therefore manual data analysis was employed.

Phase 2 – Initial codes with similar features and properties were grouped together to form themes. The digital versions of the diaries and interview transcripts were at this

stage highlighted in assorted colours to aid in the identification of codes and potential themes. The diaries, field notes and interview transcripts were reviewed. Digital copies of the diary entries and the interview transcripts were saved, any meaningful quotes were virtually highlighted, and colour coded to align with the colour identified from the conceptual framework. This allowed for themes to start to emerge during data collection, allowing commonalities to be grouped together as they emerged. There was a manual line-by-line analysis of all the data, the diary entries, interview transcripts and annotation notes (Clarke and Braun, 2017). Once the highlighted quotes were allocated with appropriate colour coding, aligned to the colours from the conceptual framework, interesting features or patterns were also grouped together. This visual representation aided in the ability to review and verify the codes and themes. The different sections were electronically cut up and placed in different virtual folders and stored.

Data Extract: Case Study 1- Participant 1a- 'Bob'

Diary- *'Induction was a process, I was the only new member of staff this week, ... so, I went to all the Trust stuff alone and was shown around. .... Went to Manual Handling etc, just a tick box exercise. This first week has been OK, met other staff, some I knew before but mainly new people... also got my shifts for the 8 weeks, which feels weird and a bit scary now, all seems very real now.' (P1a- Bob)*

Interview- '*Gosh, induction was a long time ago now. It was fine, I think. I mean, it was what I expected., but I am yeah induction was all right did all the normal things did the…had a nice tour, had some updates, all those normal things and that was fine. I suppose. (P1a- Bob)*

Coded as: 1. settling in/induction.

Phase 3 – A spreadsheet was created mapping initial thoughts, identifying themes, and trying to establish patterns. The preliminary ideas and thoughts were captured and grouped together forming four major themes. The themes that emerged during the diary entries were collated and presented to the participants; each participant was asked whether they were happy with diary entries. Whether or not they wished to change or revise any sections or entries on reflection. This was so the participant felt reassured that their data was valuable and respected. This enabled me to confirm my initial analysis and allowed me to ask questions and seek clarity on the different areas and allowed me to establish the validity of the data. The confirmation of the collated themes by the participants contributed to the rigour and trustworthiness of the data analysis.

Phase 4 - To further review and confirm the narrative (Braun and Clarke, 2006) and ensure the accuracy of the process, extract from the transcript, with themes was written up. Re-reading and confirming the themes from the diary entries and the interviews transcripts in order to establish a coherent storyline for analysis. This ensures that clear definitions are reached, and each theme is appropriately identified.

Phase 5 – The final stage of the thematic analysis process was to develop a thematic map and produce a checklist and ensure I had truly aligned my analysis to the principles of Braun and Clarke's (2006) process.

The generation of themes and sub-themes is an inductive process where patterns, ideas, and categorisations emerge from the data itself rather than being imposed beforehand. Then comparing and contrasting these codes across the dataset, broader categories or themes will become apparent. Themes are patterns or concepts that recur within the data and represent some level of significance in the context of the research question. Subthemes, on the other hand, are more specific categories that fall under the umbrella of a broader theme, helping to nuance and refine the analysis (Braun and Clarke, 2022). The development and refinement of themes and subthemes continued until a coherent narrative emerges that faithfully represented the participants' experiences and the research context. Throughout the process, I remained attentive to my own biases and interpretations to ensure the construction of themes accurately mirrors the participants' perspectives and the social realities being investigated (Haslanger, 2012) and not just what I expected or wanted to discover.

3.9 Rigour in Social Constructionist Enquiry

The constructionist or qualitative researcher seeks rigour and trustworthiness through a process of transferability, credibility, confirmability, and dependability in their enquiry (Polit and Beck, 2014, Rolfe, 2006). In the constructionist example to explore the complexities experienced by newly qualified nurses when making the transition to a registered practitioner following a professional preparation programme the measure of quality and rigour will stem from the cited methodological principles to form the trustworthiness of the study (Koch, 2006, Rolfe, 2006, Houghton et al., 2013). The approach in this research utilised multiple methods of data collection to support the

measures of quality, the use of in-depth interviews, annotated notes, and reflective diaries from both the researcher and the participants was appropriate.

Transferability concerns itself with issues of whether the research findings can be transferred and are applicable to other contexts, meaning in similar circumstances, to similar populations and related to similar phenomena. This similarity or 'fittingness' must be outlined in the research by providing adequate contextual information, Sandelowski (1986) states that '*a study meets the criterion of fittingness when its findings can 'fit' into contexts outside the study situation and when its audience views its findings as meaningful and applicable in terms of their own experiences*' (p. 27). The use of rich description from the participants can demonstrate that the research findings can be applicable to multiple contexts, the detailed narratives from the newly qualified nurse resonated with all newly qualified nurses, many other professional groups who move from a training/education role to a qualified autonomous role in professional practice such as teachers, paramedics and doctors which is supported by evidence (Klein and Fowles, 2009, Gerrish, 2000, Redfern et al., 2002).

Credibility relates to issues of the level of confidence that the research findings are true and accurate, Guba and Lincoln (1989) describes the '*truth value*' of the research. The use of triangulation of method of data collection can enhance the credibility of the study, and in the use of in-depth interviews, annotated notes and reflective diaries from the participants and the researcher then quality could be ensured. The reflective accounts from the researcher and annotated notes also increased the self-awareness of the investigator which is essential in generating credibility (Koch, 2006). The credibility was also established by the participants believing in me the researcher and my 'presentation of self' (Child, 2015) who explored the transition and emphasised the significance of the being a real and credible as a nurse. The participant knew me, knew my background and recognising I had insight into the transition for student to qualified practitioner.

Confirmability focuses on the level of neutrality in the research study's findings, the findings should be based on participants' responses and not any potential bias or personal motivations of the researchers themselves. This involved ensuring that researcher bias does not manipulate the interpretation of what the research participants stated in their individual narratives. To establish confirmability, researchers can

document an audit trail in a reflective diary or notes, which outlines every step of data collection and analysis that was undertaken to provide a rationale for the decisions made in the research (Cope, 2014). The researcher described how the conclusions and interpretations were reached, how the findings had been drawn out from the data. This was achieved by using 'rich quotes' directly from the diaries and interview to confirm what is being reported.

Trustworthiness also includes the issues of both transferability and/ or applicability (Koch, 2006) and refers to *'the extent to which findings can be transferred to other settings or groups' (Polit and Hungler, 1999).* Although this research was small, as with other qualitative studies, it was not designed to make generalisation, but to inform and develop future practice and educational developments in relation to programmes for preparation for professional practice.

The use of differing and supporting methods to establish the research findings accurately portray participants' true responses and in the presentation of results the use of direct quotes to reiterate what was found. Dependability concerns itself with the extent that the study could be repeated by other researchers and that the findings would be dependable rather than consistent (Koch, 2006). Therefore, if another researcher wished to repeat the study, following a review of the research process, data collection and data analysis then there would be adequate information from for it to be replicated. Guba and Lincoln (1989) makes the recommendation that this decision trail is essential in establishing rigour, leaving clear and explicit information that outlines the theoretical, methodological and analytical choices throughout the study (Koch, 2006). This took the form of an audit trail or supporting field notes that document the journey of the researcher, stressing the importance of self-awareness, managing personal biases, knowledge, and experiences.

3.10 Ethical Considerations

The research aim was to explore the complexities of transition to professional practice and conducting an in-depth exploration of that journey, and as such possible ethical challenges were anticipated. Ethical approval were sought and given by the Education Research Ethics and Integrity Sub-committee (See Appendix i). All research undertaken needs to consider the ethical implications and follow the principles of autonomy, beneficence and justice which underpin the conduct of research (Parahoo, 2014,

Beauchamp and Childress, 2013, Bryman, 2016, Endacott, 2007). The way these principles were addressed by ensuring the participants were fully informed, gave consent and have full knowledge of the risks and benefits of the study. An information sheet was provided to the potential participants in advance of the recruitment meeting to explain the study's requirements (See Appendix ii), this outlined the privacy and confidentiality measures, debriefing requirements, and the support available during and after the data collection.

At the recruitment meeting the participant discussed the study's requirements and then consent was gained by the signing of a consent form (See Appendix iii). The ethical principles of honesty and trust between the participants and researcher are implicit to the informed consent process, the implications, and risks for the participants in divulging information that may be emotionally challenging, and potential unsafe practice need to be sensitively managed. The participants were informed that if any unsafe practice was identified, whether in the diaries or the interviews, then they would be contacted, and the incident discussed. If required this would also be discussed with the participant's line manager, who were aware of the research. Any critical incidents would prompt further action to ensure the well-being of the participants.

Autonomy needs to made clear to the participants, outlining that they have the right to refuse or withdraw from the study at any time without it affecting their professional role, professional status, or their relationship with the university. It is good practice to seek written consent, but also to check verbally during the data collection phase that the information given can still be included in the study, this will ensure that the participant is fully aware and safeguards against any accidental disclosures(Endacott, 2007).

Ensuring the study's data remains confidential, only accessible to the research team which will include me as the primary researcher and my supervisory team, and completely anonymous. The participants will not be identifiable in the thesis or in any subsequent publications, the diary and interviews were paired together with a code that ensure the right diary entries are followed up in the interview, this code will be known to only the research team. Formal ethical consent was sought and approved by the Education Research Ethics and Integrity Sub-committee (see Appendix i). The research was put through the NHS Health Research Authority (HRA) Assessment tool and was not

required to seek full Integrated Research Application System (IRAS) approval. All provision and protection were taken to ensure adherence to ethical principles for the participants.

When addressing the ethics, the requirements of access, gatekeepers and positionality were addressed. Access to the newly qualified nurses was sought through the Programme Lead, a presentation was made at the end of both the February and September programmes and invitations were issued in person and via email. The study commenced once the students had finished their programme, the newly qualified nurses then started their transition jobs and the local managers were informed of their participation, this is to ensure support was in place in case there were any issues of patient and professional competence raised in the data collection process.

During the ethical permission stage this was an issue of paramount concern for both me, the supervisory team, and the ethics committee, to ensure any issues of poor practice, potential participant or patient harm could be highlighted and managed appropriately. If any breaches occurred, then the participants would have been contacted directly by the me outside the diary entries, via email, in order to discuss the entry of concern. If the entry of concern were related to an issue of patient safety, potential harm, or poor practice then a meeting would be required, and the participant's local manager would have been informed. This process was clearly outlined and agreed in the recruitment meeting.

3.11 Positionality and Reflexivity

Positionality is a key issue in terms of the authenticity of the research, I am a nurse as well as a nurse educator and I am bound by the same code of professional conduct as the participants and therefore could be considered an 'insider' as well as a researcher (Louis and Barton, 2002, Guillemin and Gillam, 2004). Reflecting on my own positionality, I acknowledge that I have a specific insight into the experiences of these newly qualified nurses as I have gone through this process and as such will draw upon these experiences when examining their diaries extracts and developing the interview guide. During and following data collection I will also need to explore the issue of subjectivity and assumptions made to ensure the findings are robust. An awareness of subjectivity and self-reflection of my own positionality and a clear presentation of the participant's voice

will ensure there is a 'bridge' between personal and participant's experiences and the academic discourse (Louis and Barton, 2002).

As a qualified nurse myself, I have made the transition from student to qualified nurse and have undergone the similar process and therefore have a unique insight into the changes. Although some years ago, I made the transition from student to qualified practitioner and it seems to me that it remains relatively unchanged, the environment may have changed with modernisation but the thoughts and feelings of complexity navigating the journey resonated with me as I read the diaries and undertook the interviews. As the researcher and a nurse, I had an insider-outsider position that influenced what the participants divulged in both their diaries and interviews, allowing them to be honest and disclose the reality of clinical practice, knowing that I would understand what was being shared (Baldwin et al., 2017) and be able to recognise and make assumptions about the findings.

Reflexivity is a critical element in qualitative research, acting as a means for me to reflect on my own positionality, biases, and preconceptions throughout the research process. By acknowledging and addressing the role of the researcher's subjectivity, reflexivity contributes to the overall rigor, trustworthiness, and credibility of the research (Lazard and McAvoy, 2020, Dodgson, 2019). It allowed me to critically examine how my own personal experiences, cultural background, and social context may shape my interpretations of participants' experiences and the data collected. Furthermore, reflexivity fosters transparency and ethical conduct in qualitative research (Dodgson, 2019). It requires the researchers to continuously question their own assumptions and perspectives, allowing for a more comprehensive and nuanced understanding of the phenomena under investigation. This self-awareness prompted me to approach data collection and analysis with a critical lens, thereby reducing the potential for confirmation bias and enhancing the validity of the research findings. Additionally, reflexivity encourages a more inclusive and open-minded approach, and enabled me to consider diverse viewpoints and interpretations.

In addition, reflexivity facilitates the establishment of trust and rapport with research participants. By acknowledging my own positionality, I create a more equitable and respectful dialogue with the participants, leading to a richer and more authentic portrayal

of their experiences, they know my background and knew I was a qualified nurse myself. Ultimately, reflexivity contributes to the robustness and integrity of this research, ensuring that the findings are grounded in a thoughtful and introspective approach (Dodgson, 2019), increasing the credibility of the findings, deepening my understanding of the phenomena, and resonating with the lived experiences of the participants.

3.12 Strengths and Limitations

This thesis utilised qualitative research methods, a case study approach using diaries and semi-structured interviews in order to offer unique presentation, the strengths and limitations in gathering rich and in-depth data, this allowed for multiple viewpoints supporting a social constructionist perspective (Bryman, 2016).

3.12.1 Strengths

The strengths of the case study research are that it allowed me to undertake in-depth analysis, case studies allow researchers to gather detailed and comprehensive data about a particular phenomenon or individual, therefore this provided a rich understanding of the topic of transition. Case studies are conducted in real-life settings, allowing researchers to examine the phenomenon in its natural environment and consider the influence of various contextual factors and the collection of data from multiple sources, such as diaries, semi structured interviews, documents, which enhanced the validity and reliability of the findings (Silva and Mercês, 2018). Case studies can contribute to the development of new theories or provide support for existing theories by providing evidence and identifying patterns and relationships (Boblin et al., 2013). They are flexible in terms of research design and data collection methods, allowing researchers to adapt their approach based on the specific research question and context (Hancock and Algozzine, 2017, Houghton et al., 2013), the diary entries with the annotated notes led to the adaptions to the interview guide to ensure the appropriate themes were further explored.

The diaries provide a means for the individuals to record their thoughts, experiences, and reflections over a period of time. One of the key strengths of using diaries in research is the ability to capture real-time data (Day and Thatcher, 2009). Participants can document

their experiences as they occur, allowing for a more authentic and detailed account of their thoughts and emotions. This method also provides a level of privacy and confidentiality, as participants have control over what they choose to write and share with me online. This led to a greater level of honesty and openness in the data collected, the participants were able to share and outline exactly what was occurring as it occurred (Hewitt, 2015).

Additionally, diaries allow for a longitudinal perspective, as participants could record their experiences over the six-month period. This enabled me to gain insights into the development and changes into my participants' thoughts, feelings, and behaviours over this time. It also allows for the exploration of complex and nuanced issues that may not be fully captured in a single interview or survey. Diaries also offer flexibility in terms of data collection. Participants can choose when and where to write, which can enhance their comfort and willingness to share personal experiences. This flexibility also allows participants to document the events or experiences that may be difficult to recall accurately in an interview setting (Hewitt, 2015, Kenten, 2010).

Semi-structured interviews provided an interactive and dynamic approach to qualitative research. These interviews involved a set of predetermined questions, but also allowed for flexibility and exploration of emergent themes. One of the strengths of this method is the ability to probe deeper into a participants' responses and gain a more nuanced understanding of their experiences (Jindal-Snape and Holmes, 2009). The interactive nature of the interview allows for clarification and elaboration, which can lead to richer and more detailed data.

Semi-structured interviews also provide an opportunity for a rapport to be built and establish a trusting relationship with the participants (Houghton et al., 2013). This can enhance the quality of the data collected, as the participants would feel more comfortable sharing personal and sensitive information with me (Botti and Endacott, 2008, Endacott, 2008). Additionally, the interview setting allows for non-verbal cues and body language to be observed, providing additional insights into participants' experiences and emotions. The semi-structured interviews allowed for the exploration of diverse perspectives and experiences. I was able to adapt the questions and prompts based on the individual

characteristics and backgrounds of the participants, allowing for a more inclusive and comprehensive understanding of their transition.

3.12.2 Limitations

The limitations of case study research can be limited generalisability, due to the small sample size and specific context of case studies, the findings may not be easily generalised to other populations or settings. Case studies heavily rely on one's own interpretation and judgment, which introduces the potential for bias and subjectivity in data collection, analysis, and reporting (Sandelowski, 2011). Case studies often require significant time, resources, and effort to conduct, including extensive data collection, analysis, and interpretation, which can limit the feasibility of conducting multiple case studies (Silva and Mercês, 2018). Case studies involve studying phenomena as they naturally occur, which means researchers have limited control over variables and cannot manipulate or control them as in experimental studies. Researchers must carefully consider and address ethical concerns, such as privacy, confidentiality, and informed consent, when conducting case studies involving human participants (Houghton et al., 2013, Kohlbacher, 2006).
The limitations of using diaries as a method of data collection, the potential for selective reporting or bias. The participants may choose to omit or over-emphasise certain experiences or emotions based on their own perceptions or desires. This can introduce a level of subjectivity and may impact the reliability and validity of the data collected. Participants may forget to write in their diaries or may lose interest over time, leading to missing or incomplete data. This can impact the overall quality and comprehensiveness of the findings.

There are limitations to using semi-structured interviews as a research method. One limitation is the potential for social desirability bias. Participants may alter their responses to align with societal norms or what they perceive to be the expectations of the researcher. This can impact the accuracy and authenticity of the data collected. Another limitation is the potential for researcher bias or influence. The presence of the researcher during the interview can influence participants' responses, consciously or unconsciously. This can impact the objectivity and reliability of the data collected. Additionally, the

interpretation of the data collected in interviews is subjective and dependent on the skills and biases of the researcher.

Qualitative research methods, using a case study approach using diaries and semi-structured interviews, offer unique strengths and limitations. Diaries provide real-time and longitudinal perspectives, allowing for a more authentic and detailed account of participants' experiences. However, they may be subject to selective reporting and low response rates. Semi-structured interviews allow for interactive and dynamic exploration of participants' experiences but may be influenced by social desirability bias and researcher bias. Researchers should carefully consider these strengths and limitations when selecting and utilising these methods in their research (Mills et al., 2016, Rashid et al., 2019).

3.13 Chapter Summary

This chapter commenced by introducing the social constructionist paradigm and how this emphasises that research is undertaken 'with' and for people rather than 'on' them (Reed, 2009). This approach recognises the collaborative nature of research with the research recognised as an active part, facilitating data generation. The study design, data collection, analysis and ethics were addressed, and the strengths and limitations of the thesis were outlined.

4. Series of Cases

This chapter will present the series of cases, presenting excerpts from the participant's diary entries to illustrate the journey from the start to the end of the first six months, and subsequently their interviews allowed for the expansion on key events and their personal development. Then, it explores the emerging themes and sub-themes that arose through the data collection phases both with the diaries and the interviews. The themes and sub-themes from the diaries and the interview were reviewed together. These emerging themes form the discussion provided by crucial data exploring and illuminating the area of study.

4.1 Presentation of the Cases

An outline of the participants, a brief background to give some contextual information, a selection of the key diary entries and interview content was presented. Each of the participants was given a name, the alpha- numerical identification system was not used as it was felt that it de-humanised them for the research. A random name generator was not used, but neutral names without cultural or ethnic bias, or ageism were chosen. It was hoped that each name did not give away any identifying attributes of the selected participants, with regard to age, race or ethnicity. Gender was the only differentiated name and denoted the only male participant.

4.1.1 Study Cohort A – Participant 1a

Background

'Bob' was a 38-year-old, he had come to nursing as a second career having been in the military since school. He was married and his wife was expecting their first child. He had undertaken all his placements in one trust but had chosen to take a post in another trust when qualified. This choice was driven by wanting to work closer to where he and his wife lived.

Additional info: Bob is a 38-year-old, he undertook all his placements in Trust A, but took his first post in Trust B. This was a completely new clinical setting for him, he had personal reasons for taking this job.

He is married and expecting his first child in June 2019. Bob was on his second career, having been in the military for some years. His diary entries were methodical and clear, with clear mention of specific details of competencies such as venesection, venepuncture, IVs. Incredibly determined and clear about what needed to be achieved.

He took a job in the 30 bedded Medical Assessment Unit at a local District General Hospital. This is a busy unit that took acutely unwell patients from the Emergency Department, the patients would be assessed, managed for 24-48 hours and then either discharged or transferred to the appropriate ward or unit.

4.1.2 Diary Entries

An excerpt from Bob's diary can be found below that focus on the initial stages of transition and how he settled into the clinical placement started to develop as a practitioner.

I have completed my first week, it has not been that tough or busy. Induction was a process, I was the only new member of staff this week, SN[1] who was on my course will start in a month or so, she is travelling before she starts, so, I went to all the Trust stuff alone and was shown around. There was a whole series of things to attend, went to the Manual Handling etc, just a tick box exercise. It felt like I had to get through these to then get started properly. This first week has been OK, met other staff, some I knew before but mainly new people. I know I am not going to remember everyone or what they do, but I will get used to it. I also got my shifts for the 8 weeks, which feels weird and a bit scary now, all seems very real now.

I am going to have to get used to long days though, I have not done them since the first year. I am not sure if I don't prefer short days, but anyway. Looking forward to getting started now. I chose this place because of where it is, and I thought an MAU would be a great place to learn and get settle in the job.

Done my first set of long days- 3 shifts is a lot, I am really tired. The daily plan is different from what I used to, we have a brief bed to bed handover, a really quick run-down and then get allocated patients, which seem weird as we don't know everything about them. Most of the night shift then goes home, the nurse in charge stays then and goes into the office with the nurse in charge of the day shift and has a detailed handover. We get on with jobs, like the drug round and getting the washes etc started and working out what needs to be done. The nurse in charge then comes and finds you and gives you the details of your patients only. The problem with that is you do not know what is going on with everyone else. Fine most of the time but sometimes people come and ask you stuff and you can't answer it.

I am not sure I realised how busy this place was going to be, you have no idea what is going to come in. We take the patients from majors or direct from the GP referral unit, they are usually very unwell and need a proper bed on the ward, have lots of investigation booked and are being seen by different teams. That bit is taking some time to get my head around, different teams are on take and then they pass to others, and it does not seem to make sense. I am sure it will, one thing is clear is I need to get some extra stuff sorted, like the training for bloods end venflons.

Analysis:

The excerpt highlights the process of induction and attending various training sessions, such as manual handling. Bob mentions that these activities felt like a tick-box exercise before getting started properly. He refers to being the only new member of staff during his first week and having to navigate the workplace alone. He also mentions meeting new colleagues and trying to remember everyone and their roles.

Bob remarks on adjusting to long workdays after not having done them in a while and expresses uncertainty about whether he prefer shorter shifts but are looking forward to getting started in their new role. The section discusses the daily routine and communication process at work. He references a brief bed-to-bed handover, receiving patient details from the nurse in charge, and the challenge of not knowing what is happening with other patients or teams.

Bob expresses surprise at the busyness of the workplace and the unpredictable nature of the patients coming in, stating that receiving patients from different sources and being involved in various investigations and teams. The excerpt concludes with that he acknowledges the need for additional training, specifically for being able to take bloods and 'do' venflons.

Overall, the common themes in this paragraph revolve around Bob's experience of starting a new job- settling in, adjusting to the work environment, and facing the challenges of a busy and unpredictable workload. It also highlight the importance of training and communication in their role.

Early Entries: excerpts of entries from months 2/3

A month or so in now, not looking forward to next week, have my first set of nights. I haven't done that many nights, like practical none. And certainly, none qualified, so I am nervous.

I have been getting used to the ward. One of the issues for me is that if your patient has to go to scan you can spend ages off the ward and then you get back and nothing has been done for the rest of your patients and you are really behind, you then don't get a break because you need to catch up and then you get told off for not taking your break when it was allocated. Just want to get used to it and plan how I work in a shift and how to organise myself. I don't think I have ever been taught that or shown how that can work. I don't remember if we have ever had a session on organising chaos. I don't like it, I don't like the lack of order, I find it really difficult to make it work and plan my day. One thing I do now realise is I have to get some addition training quickly; it would be so much easier to organise care if I had my cannulation stuff done. Things are starting to make sense, I am settling in, knowing what to do when and knowing who to ask what and stuff.

I have met everyone now. WM[4] is back from leave and have had a sit down with her. She was on leave for the first couple of weeks, she is back now although we never see her on the ward she is always at meetings and stuff. She has a very clear handle on what is going on, she runs the place pretty much from a distance, she seems to know what is going on even though she is very rarely on the ward. She does occasionally clinical although when she is she tend to stay in the office.

Ok so nights – that was my first 3 on my own. I am so tired but sort of enjoyed it. It was a little calmer overnight. There are lots of people coming in and out, being admitted etc and I am not sure anyone gets any sleep. There was a real difference to the organisation of the ward. At the start of the night, we all hear the handover unlike the day shift, we all sit in the office and the nurse in charge of the day shift goes through all the patients on the ward, and all the patients waiting in ED for admission although we don't have the space. We then have a collective conversation about what needs to be done. It is really weird that at night we are completely task organised, you do drug, you do Obs etc and we are manging the whole rather than the individual. At some point at the night, we divvy out the notes and write them together. It feels like a proper team because we all muck in, everyone does everything there is no 'he is not my patient' or 'I don't work on this side,' but it still busy. Also, there are a lot less others on the ward which make life easier. I don't mean that in a bad way, but the physios and docs are just there for what they need and what they want to do and do not think about us and what we need to do. I am not saying what they want is more or less important, but you always need to step aside when they arrive even if it is not a great time for you or your patient.

Seem to be settling in now- I have gone a whole set of days without having to ask someone where something is, without asking someone how to do something. I have sorted the drug competencies and can now do a drug round without any supervision, which makes a huge difference, done the cannulation venesection study days, and am working on those competencies. Getting sign off is a bit of a pain- need an F1 or someone like that to watch me and there never seems to be anyone around when I need it. I think will make such a difference when I can do these things without having to waste so much time trying to find someone to give a drug or start an IV.

<u>Analysis</u>

The excerpt highlights the Bob's process of getting used to the ward and the challenges he faces in organising their work and planning their day. He expresses a desire to learn how to handle chaos and mention the need for additional training, such as cannulation.

The participant expresses frustration with the lack of order and organisation on the ward. He mentioned feeling behind when their patient is away for a scan and struggling to catch up on their tasks or the patient. He also mentions not being taught how to work in a shift or how to plan his day effectively. The excerpt briefly mentions WM, who is back from leave and seems to have a clear handle on what is going on in the ward. He describes her as running the place from a distance and being knowledgeable about the ward's activities. However, he notes that she is rarely seen on the ward and tends to stay in the office.

Bob reflects on his first set of night shifts and mentions that it was calmer compared to the day shift. He describes a different organisational approach during the night, with a

[4] Replaced the name of the Ward Manager

collective conversation about tasks and a focus on managing the whole rather than individual patients. He also mention that there are fewer staff members on the ward during the night.

The section emphasises the sense of teamwork and collaboration during the night shifts. Bob mentions that everyone mucks in and does everything, without the distinction of "not my patient" or "I don't work on this side." He also mention the challenges of working with other healthcare professionals, such as physios and doctors, who may not always consider the needs of the nursing staff.

Bob reflects on their progress and growth in their role. He mentions going a whole set of days without needing assistance, completing drug competencies, and working on cannulation and venesection competencies. He expresses frustration with the process of getting sign-off from a higher-level staff member for these competencies.

Overall, the common themes in this excerpt revolve around Bob's learning and adjustment process, the challenges of organisation and lack of order, the dynamics of leadership and management, the experiences and differences of night shifts, the importance of teamwork and collaboration, and his progress and development in his role.

Mid-Point Entries: excerpts of entries from months 4/5

*Just had a couple of days which were interesting and difficult. So, on Monday, I was on a long day with really poor staffing, it was meant to be me and 3 other qualified, plus couple of HCAs and I think 2 students, one of which is a 3rd year so useful. Anyway, SSN[5] and SN[6] went off sick so just me and one other qualified, and SN[7] is always really difficult to work with, she is ok with her patients but when you ask her to help or do something to help then she is really ****, she was supposed to be in charge, SN has been qualified a lot longer than me, we were waiting for agency, one pitched up at 10, and the other came at 1, it was bedlam in the morning. Had to send the student to CT, which was a bit mean, but she was ok, I think, I hope. I was completely taken up with this 'bleeder,' hardly managed to see any of my other patient. HCA[8] was on the case though, he tends to be good. If he worried about things he will come and find you or one of the docs if they are around. But this patient I was with was a nightmare- we were really struggling to get it sorted, he really needed to go to theatre or GI but there was no-one available to take him. The 'take' team hadn't phoned overnight and we were waiting for ages to get the b****** medic to come and review him and take him over. This meant he wasn't reviewed for ages, and he was really poorly, he should have gone first thing, the ITU Reg came eventually and then things started to change. I felt really sorry for him and his family, he was vomiting and bleeding all morning, his obs were all over the place and his bloods were tanking. I had to really dig deep. We were giving bloods and fluid as quickly as we could, he was in*

[5] Replaced name of senior staff nurse
[6] Replaced name of staff nurse
[7] Replaced name of staff nurse
[8] Replaced name of HCA

bed 2 so close to the desk and we had the monitor and everything, for the first time I was organised, methodical, I had it under control, just about. I knew what was going on the and what to do but was frustrated by the lack of action from the medics. But I was on it, I had the obs going, the bloods and IVs running. It really helpful that I could now do the cannulation, the bloods and stuff, so I was on it. I have really worked on my handover skills and felt confident talking to the ITU Reg, the medics and the 'take' team. We got him through, and he eventually went to GI at 4ish, should have been quicker but at least he went.

That was the Monday and then the following day it was as bad- still short staffed and had really poorly people. We had a lady who should have gone straight to the stroke unit but came to us as there were no beds. I think we managed her ok, but again it took ages for the right docs to get to her and sort her out. Again, I was able to get things done, and get through to the right docs and give them an ok handover. I think I made a difference I think because I can do things now like venflons and stuff I get things done quicker.

Things got a little better, on Wednesday, staffing was better, I mean we had people from the start of the shift, some agency but people we had had before. But the patients transferred overnight were a real mess. We had one post MI who should have gone to the cath lab and then to ward but came back to us for some reason. We had him on a monitor right by the desk, we had a lady down the end with only the agency and a student who was fitting, and we had a bloke with a head injury on ½ hourly obs. I was given the MI guy, which was fine, and we were getting on OK, but the HI went off and it was chaos. It took ages for the Neuros to get involved and then we had to get him ready for transfer. The cardio team eventually got a bed for the MI, and he went to the ward. I was completely knackered after 3 long days but for the first time I really felt in control, I knew what I was doing and why, don't get me wrong things still went wrong but I was able to handle things and cope. Even with everything and no real help we got it done.

Analysis

The excerpt highlights the difficulties faced due to poor staffing. Bob mentions the ward being short-staffed and having colleagues go off sick, which puts additional pressure on the remaining staff members. He also mentions relying on agency staff to fill in the gaps.

The excerpts describes encounters with challenging patients who require immediate attention and specialised care. He mentions struggling to find appropriate resources or specialists to handle these patients, leading to delays in treatment. Despite the challenges, Bob expresses a sense of taking charge and making a difference in patient care. He mentions being organised, methodical, and confident in their abilities to handle tasks such as cannulation and venflons. He also highlights the importance of effective handover skills in communicating with other healthcare professionals.

The excerpt mentions specific cases, such as a patient with bleeding and vomiting, a patient who should have gone to the stroke unit, and a patient with a head injury. He describes the chaos and the efforts made to manage these critical situations, including monitoring vital signs, coordinating with specialists, and preparing patients for transfer.

The passage reflects Bob's personal growth and development in his role. He mentions feeling more in control, knowing what he is doing and why, and being able to handle difficult situations. He attributes the increased confidence and effectiveness to acquiring new skills, such as venflons, and improving their handover skills.

The excerpt acknowledges the physical and mental exhaustion experienced after consecutive long days. Despite this fatigue, Bob expresses resilience and determination to get the job done, even without much help.

Overall, the common themes in this section revolves around the challenges of staffing shortages, the complexities of handling complex patients, the sense of taking charge and making a difference in patient care, the growth and development of Bob in his role, the importance of effective communication and coordination with other healthcare professionals, and the resilience and determination demonstrated in the face of fatigue and workplace adversity.

<u>End of Enquiry Entries:</u> excerpts of entries from month 6

Just finished a set of nights, people said it would calm down in the summer- that is a joke, it has been busier than ever. Not helped of course by people being on holiday and bed closures. Getting bed on the wards and transferring patients out is so slow, we had patient in with us for days. They should be upstairs in the proper place, looked after by the right team, but they are here under the Take team. It is fine looking after them, but we don't have everything we need. We are not used to have patients, washing etc for days they aren't meant to stay for 4 days. I had a couple of patients in for all my nights, that 3 on the trot. I suppose I was in charge, there was a couple agency who had been qualified for ages, but I was the only permanent qualified. It was ok, I didn't know until I got there, I am not if I would have been nervous if we had known. I have never been on my own during the day, never done a proper in charge shift before, I mean I have sort of done an in charge during the day, but had other people around like SSN[9], who is great and let me get on with it, but I knew she was there. This time I was completely on my own, well sort of, AN[10] was on and I know her and have worked with her before. I did the drugs and sorted everything; things went quite smoothly. Certain people took me seriously for the first time I think even some of the docs were really nice and did what I asked, which was weird. Fortunately, the patients were not too sick, there were stable, and we got everything done- I suppose one of the benefits of only having 3 beds at the beginning of the night means you can only get 3 admissions. But when I was handing over, I felt really great- WM was on in the morning and we had a chat in the office before I went home, she was impressed and gave me a really great feedback, I think this is the very first time anyone has ever said – 'good job' to me at work or at the end of a shift.

[9] Replaced name of Senior Staff Nurse
[10] Replaced name of the Agency Nurse

Analysis

This excerpt highlights the increased workload and busyness experienced during the night shifts, despite expectations that it would calm down in the summer. Bob mentions the challenges caused by staff holidays and bed closures, resulting in delays in transferring patients to the appropriate wards.

This passage discusses the challenges of caring for patients who are meant to be in a different ward but are staying under the take team. Bob mentions the lack of necessary resources and the difficulty of providing long-term care when patients are not meant to stay for extended periods. The paragraph describes Bob taking on the role of being in charge during the night shifts. He mentions being the only permanent qualified staff member and having agency staff who have been qualified for a long time. Despite initial uncertainty, he manages the responsibilities well and receives positive feedback from colleagues, including doctors.

This excerpt highlights Bob's sense of accomplishment and validation in his role. He mentions feeling great during the handover and receiving positive feedback from WM. This positive feedback is significant to Bob as it is the first time someone has acknowledged his work with a "good job" at the end of a shift.

The section mentions the support and collaboration with colleagues, such as SSN and AN, who aid and allows Bob to take charge. He also notes the cooperation of some doctors, which he found surprising and positive. He also reflects the personal growth and development of the professional role. He mentions handling responsibilities independently and receiving positive feedback, indicating recognition for his abilities and contributions.

Overall, the common themes in this section revolve around the increased workload and busyness during night shifts, the challenges of patient care and resource limitations. The experience of taking on responsibility and receiving positive feedback, the importance of collaboration and support from colleagues, and the personal growth and recognition, or confidence and competence.

4.1.3 Sections from the Interview

Excerpts from the interview with Bob- September 2019

Bob was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

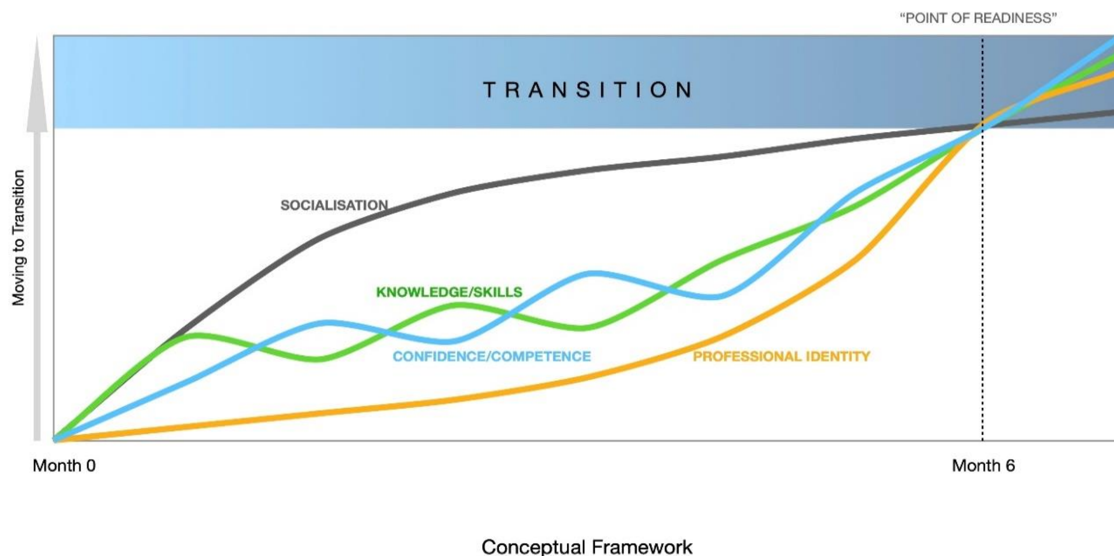

Figure 5: Conceptual Framework

I would say the 'socialisation' line is much steeper than the picture, I think I was socialised, although I am not completely sure what that means. I think I fitted in much quicker, than the graph suggests. If socialisation means to belong and so on, I think I was a member of the team pretty quickly.

I am not sure why that was, the team were pretty good- I think I got on with everyone. I didn't upset anyone I suppose and being completely new helped I think as no-one knew me as a student or anything. Don't know whether it made a difference but being older…well old and a bloke, at the beginning docs and others thought I was the new band 6 or 7, some would be really surprised that I was newly qualified. They would sort of smile and go....'really?' …'oh, right,' which was ok but sometimes I would find it really annoying, expecting me to know what I am doing, but it was ok.

You look at the lines about confidence and competence and like they track together, but I am not sure they always do, just like knowledge and skills, like they are not always linked. I mean I think they could but not always so closely. I don't think that they just track each other…

What do you mean?

Sort of like, sort of further apart from each other.

The professional identity thing was much more of a slow burn. I have always struggled with a title or being able to describe myself as something, being actually something. I would laugh and think when I could carry the keys then I would be a proper nurse, but then when it actually happened, I felt such a fraud. How I could actually be a qualified nurse, it happened so quickly. But the uniform changes and then everyone treats you like you know what you are doing. I think when I started knowing what I was doing and others around me assumed I knew what I was doing then I started to think of myself as a nurse, I mean a qualified staff nurse. It came from the patients too, I started to feel like they trusted me.

You mentioned 'things started to make sense' and 'things settling now'– what did that mean?

I don't know I suppose when you don't have to think about every little thing you do, and they start falling in line- like you do things like the obs and thinking about what is next and what they mean and it just comes without thinking, I mean I am not saying I don't think! But you know, it is automatic.

You highlighted a series of shifts in the middle of the diary that were particularly difficult or tough- why were they so important?

*It was a combination of things really, I mean 3 long days is a lot, they are always tough but there were a number of things that went '**** up' on these days. I suppose staffing was the biggest issue- when you get to work and realise there is nobody there, I mean SN X was on too, but she can be hopeless. She doesn't like dealing with the docs so after handover she just gets on with stuff and doesn't share information and so you don't always know what is going on with everyone which is stressful. Don't get me wrong she is great with the patients but ...not with the staff! On those days, the patients were really sick too- a couple really should have not been with us they should have been upstairs, getting things done was difficult. The medics were... well, not **** but not on the unit so no help. I was pleased that I had sorted the extra stuff, the cannulation and stuff, being able to just get on with things and not have to wait was great. The biggest pain etc was the fact we couldn't get beds, they shouldn't have to stay with us, they were too sick for us, we needed to get them out.*

Asked about the statement – 'good job' and the positive feedback at the end of the diary.

That was quite a set of night, same old same old…. no beds, no staff, but I actually really enjoyed those nights, I was in charge and could organise things and get things done just as I wanted. I actually really like that, and to get WM saying 'good job' was quite something, I am not sure she has ever said that to anyone else and I have certainly never been told that. I mean you get some nice comments from your mentors and such when you are a student, but for her to call me into the office and make a point of saying it was ...well I felt really great. I have to say I really felt I knew what I was doing, like really did. After those nights and so on, I felt 'ready in my skins,' I felt ok, sort of done, that sounds weird I know but after those nights, I really started thinking what's next. I am not going to leave quite yet but I have started looking, I think it is time. I need to think what is next, sort of career wise. I was thinking a Band 6 upstairs or maybe into ED.

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

Yes, definitely… most definitely. I really feel like a staff nurse and have done for some time.

When do think it occurred?

Certainly, before my nights, about 4 to 5 months in, when things started making sense, I started do things automatically….

Summary

Bob reflects on their transition from being a student to a qualified staff nurse. He mentions feeling a sense of belonging and quickly fitting into the team- ‘finding his feet.’ He attributes this to getting along with everyone and being perceived as experienced due to his age and gender. He also discuss the relationship between confidence, competence, knowledge, and skills, noting that they are not **always** closely linked.

The development of a professional identity was a gradual process for Bob. He initially struggled with feeling like a fraud but started to see himself as a nurse when he began to know what they were doing and gained the trust of patients. He describes a sense of things falling into place or ‘coming together’ and becoming automatic in their practice.

Bob highlights a series of challenging shifts that were important because they tested their abilities and resilience. Staffing issues, difficult patients, and lack of support from doctors made these shifts particularly tough. However, he found satisfaction in being able to handle tasks independently, thanks to his additional training in cannulation and other skills.

Receiving positive feedback, such as being told "good job" by a senior colleague, was a significant moment. It boosted his confidence and made him feel recognised for his abilities. This positive experience, along with feeling in control during a set of night shifts, led Bob to consider their next career steps, such as pursuing a Band 6 position or applying for a position in the Emergency Department.

Bob believes he has successfully transitioned from student to qualified nurse, feeling like a staff nurse for several months. He attributes this transition to a growing understanding of their role and the ability to perform tasks automatically.

4.2.1 Study Cohort A – Participant 1b

Background

‘Susie’ was a 25-year-old, she struggled at school, undertook a local access course at college and then started the programme. She did all her student placements in the same large hospital, a tertiary referral centre with a busy Emergency Department. She was

placed on a busy 28 bedded acute medical ward for her final third year placement as a student and opted to stay there for her first job.

Additional Info: Susie, 25 years old, stayed in the same Trust, and on the same ward she had been in her final placement. She made this specific choice, she had other job offers, but thought it would be 'easier' for her, she stated at recruitment 'one day I was a student, and the very next shift I came back as a staff nurse.'

Susie really struggling to settle, although she knew the ward and the staff her development was slow, and her diary entries were sparse. Stated that she felt like and was treated like a student for months, referred to her colleagues as 'mentors,' took ages to stop using the language of a student.

Her diary was full of comments about her lack of confidence, stating she 'always felt on the verge of being out of my depth.' But intentionally avoided being in situations that were going to challenge her.

4.2.2 Diary Entries

Excerpts of entries from the first month

Started this week, I am not sure how different it is, I know it should be, but it does not feel that different. I went to work in a different uniform and that was it. I was even looking after the same patients, as I was last week. I went home on Friday after a long day and have come back this week as a Staff Nurse. I don't know if everyone even noticed, the SN induction stuff is next month I missed the dates this month. I forgot to book so there were no spaces. I think WM[11] was a little annoyed, he had reminded me a couple of times, but I don't know really why I have to, I know my way around etc so do I need an induction?

Been on six long days now, over the last couple of weeks, and it really depends on who is on as to how it goes. So, if I am on with SSNa[12] or SSNb[13] then I will be treated just like I was last month, sometime not even given my own patients…... it does not seem to matter what I say. SSNa simply ignores me and says I need to earn it, but I am not sure how to do that, I mean what is absolutely laughable she is the one who signed off my practice assessment document! They were my mentors when I was a student, and they still supervise me in the same way.

I went back in this week, I did the induction session, tour, key numbers and so on, I really did not need to be in there. There were only 6 of us, I have to say I did not learn anything new- but I can tick that box and WM is now off my back! Now I have done that I should start feeling like part of the team, even have a locker now.

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[11] Replaced name of Ward Manager
[12] Replaced name of senior staff nurse a
[13] Replaced name of senior staff nurse b

Analysis

Susie expresses a sense of not feeling much different after transitioning from a student to a staff nurse. She mentions that her work and patient assignments remain the same, and the only noticeable change is wearing a different uniform. She questions the necessity of an induction process, as she feels familiar with the work environment and believed she does not need additional training. She missed the initial induction sessions but eventually attended one to fulfil the requirement and appease her manager.

She describes challenges with certain colleagues, particularly SSNa and SSNb, who continue to treat her as she did when she was a student. Susie expresses frustration at not being given her own patients and feeling ignored by SSNa. She finds it ironic that SSNa was her mentor during her student days but still supervises her in the same manner.

Susie mentions that attending the induction session and having a locker makes her feel more like part of the team, ensuring she has settled in. She believes that completing these formalities will contribute to her sense of belonging and integration into the staff nurse role.

Overall, the common themes in this section revolve around Susie's perception of the lack of differentiation between her student and staff nurse roles, questioning the necessity of an induction process, challenges with certain colleagues, and the desire to feel like a valued member of the team.

Early Entries: excerpts of entries from months 2/3

*Couple of months now, we do 2 on, 2 off – or 3 on 2 off. I am quite tired, the only thing that seems to be different is that I am getting paid! I do not seem to have any different responsibilities. The Ward is so busy, we get allocated the section or side at handover and then it just bedlam from then, I don't seem to be getting any better at it, any quicker, or that anything is any clearer. It sounds weird but I thought it would be easier. I really hate doing the drugs it takes ages and everyone get so cross I take so long. SSNa sometimes just takes over because I am taking so long, but I am not going to get better or quicker if 'they'[14] just take over every time. It is s*** really, I am just the same as I was a couple months ago. Nothing is getting easier.*

*Me and HCA[15] got allocated the end bay on my last shift, we were having a bit of a laugh, I mean we weren't mucking around or anything, but SSNa was on, and she really didn't like it, G** forbid we enjoy work! Our patients were relatively stable, we had 8 in the bay and 4 in the side rooms. I would be allocated about the same when I was a student, I mean it is quite a lot to do but the far end of the ward tends to be slightly easier to manage. I was sort of starting to feel like somethings were starting*

[14] Replaced 2 names.

[15] Replaced name of HCA

to make sense, for the first time I sort of knew what to do most of the time. We had 12 patients to look after but SSNa was down our end all the time checking up on me and HCA. She does not need to countersign everything or anything actually; she does need to look over my shoulder all the time, but she does. It is like she doesn't remember I am qualified. I even have my PIN and can sign for everything now. It was different before and needed to have things signed off, but now I don't….

Analysis

Susie expresses a sense of disappointment and frustration at not feeling any different in her role as a staff nurse compared to when she was a student. She mentions that the only noticeable change is getting paid, but her responsibilities and the challenges she faces remain the same.

Susie mentions struggling with administering medications, finding it time-consuming and receiving criticism from others for taking too long. She expresses a desire to improve and become more efficient but feel hindered when others take over the task instead of allowing her to learn and improve and gain a sense of salience in her work.

She describes a busy and chaotic ward, where she is allocated a section or side during handover and face difficulties in managing her workload. She expresses frustration at not feeling any improvement or clarity in her work, despite the passage of time. She mentions a specific incident where she and an HCA were having a light-hearted moment, but their senior colleague, SSNa, disapproved. This highlights potential tensions and differences in the workplace culture and dynamics.

Susie expresses frustration at SSNa's constant oversight and micromanagement, despite being qualified and having her PIN. She feels that SSNa does not recognise her professional status and constantly checks up on her, which undermines her confidence, competence, and autonomy.

Overall, the common themes in this excerpt revolves around Susie's disappointment at the lack of differentiation between her student and staff nurse roles. The challenges with medication administration, the difficulty of managing a busy ward, interactions with colleagues, and the frustration of not being given the autonomy and recognition she feels she deserves as a qualified nurse.

<u>Mid-Point Entries:</u> excerpts of entries from months 4/5

Came back from annual leave, had a great holiday but feel like I am back to square one, I don't feel confident or competent about anything. It really didn't help that I was on the last 2 long days with SSNa, which meant she was checking on everything I do. It is starting to annoy me.

I was looking after a group of patients that were quite unwell, I mean not too bad. But one particular was really worrying, there was nothing specific, I was doing her obs regularly and nothing was that bad, I mean nothing to put your finger on, just 'off.' I mentioned it to SSNa, she dismissed it. I am sure she does not trust me. So, I kept checking, I had a feeling he was not well, anyway, just before handover, he completely crashed. He vomited blood everywhere, and completely went off, it was carnage…. I was completely useless; I had no idea what to do. All I did was call for help; I had no clue.

*SSNa was a complete *****, I mean she was so cross with me and HCA, for not telling her there was something wrong, but I had been all day, she completely ignored me all day, and then, in front of everyone, asked why I had not told her that I was worried, or that he was unstable. I was so ******* cross, I mean I had told her. I mean I know I was useless, but I had warned her. We got him off the ward and to Endo, but after that he crashed and he went to ICU, but he did not make it.*

Following receipt of the diary entry, Susie was contacted to ensure that she had received a debriefing, support from her colleague and line manager, as per the Participant Information Sheet. Also discussed with Susie whether some organisational learning had taken place. I also followed up at the interview.

Analysis

Susie expresses a lack of confidence and competence upon returning from annual leave. She feels like she is back at the beginning and is unsure about her abilities. This volatile level of confidence is exacerbated by the presence of SSNa, who constantly checks her work and undermines her self-assurance.

Susie describes a patient who was unwell but did not show any specific signs or symptoms. She had a feeling that something was wrong and expressed her concerns to SSNa, who dismissed them. Eventually, the patient deteriorated and experienced a medical emergency. She feels guilty and useless for not knowing what to do in that situation. Susie expresses frustration and anger towards SSNa for not taking her concerns seriously and for blaming her in front of others. She believes that SSNa did not trust her and ignores her warnings about the patient's condition. She feels that SSNa's actions were unfair and disrespectful. The section ends with the tragic outcome of the patient's condition. Susie expresses sadness and regret that despite her efforts, the patient did not survive. This event likely has a significant emotional impact on her, contributing to her feelings of incompetence and self-doubt.

Overall, the common themes in this section revolve around Susie's lack of confidence and competence, concerns about patient care, frustration with a colleague who undermines her abilities, and the emotional impact of a patient's deteriorating condition and subsequent death.

End of Enquiry Entries: excerpts of entries from month 6

The Ward is busy, we have got through the winter, and I thought things might start to calm down… it has been bedlam all week. I was thinking about it this week as I know I have been qualified for a while now and I was hoping it would all start making sense. I always feel that I am 'out of my depth,' I even listen to handover, and sometimes it felt just like my first day, and sort of need a translation! I remember being lost then and I am just as lost now. I can remember thinking 'oh what are they talking about' and I listen now and feel exactly the same… Work today was just like that. I actually googled a diagnosis!

Analysis

Susie describes the ongoing busyness of the ward, even after the winter season. Despite the hope for things to calm down, the workload remains hectic and overwhelming. She expresses a persistent feeling of being "out of their depth" despite having been qualified for a while. She feels lost and in need of guidance, comparing her current experience to her first day as a qualified nurse. She mentions struggling to understand handover conversations, feeling the need for translation or clarification. Susie recalls feeling lost and confused during her early days as a nurse and still experiencing the same confusion now. Susie admits to resorting to using Google to search for a diagnosis. This suggests a lack of confidence in her own knowledge and a desire for additional information or guidance.

Overall, the common themes in this passage revolves around the ongoing busyness of the ward, Susie's persistent feeling of being out of her depth despite her time on the ward, difficulty understanding handover conversations, and seeking external sources of information to compensate for her perceived lack of knowledge.

4.2.3 Sections from the Interview

Excerpts from the interview with Susie- September 2019

Susie was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

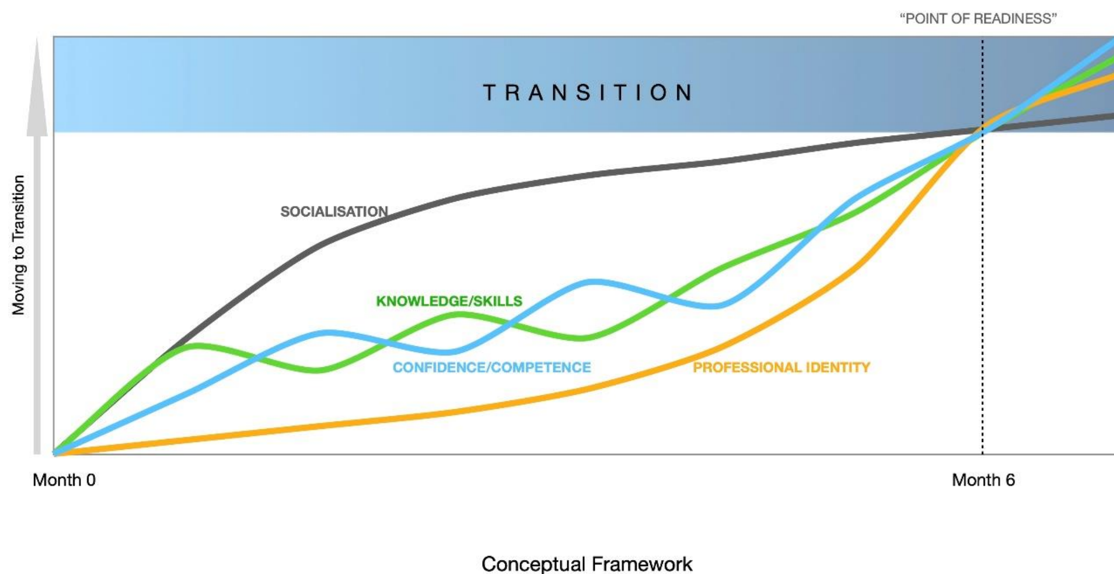

Figure 5: Conceptual Framework

Socialisation, like settling in... I mean I was already socialised then before I qualified, so when I started as a staff nurse, I had worked there for 12 weeks and so I never needed socialising as such! Took me ages to feel part the team properly, some of them have been friends for ages so it is quite difficult to get in with them. We do not go out together at all.

But confidence, competence etc it was much slower than that, I am not sure I am even there yet, wherever there is. I certainly do not feel skilled or anything yet, it will take a lot longer, I think. They sort of flow like the picture, but not always closely, sometimes a little bit further apart. I am really not sure they tracked each other- not together….

Professional identity is interesting, I mean I still answer the phone a 'Student Nurse,' can't quite remember I am actually qualified.

In your diary you talked about settling in, can you expand on that:

I think the really difficult thing was nothing changed, I thought it would be easier, I thought it would make my life easier to stay, to be in the same place with the same people. I thought if I stayed there and just changed my uniform, it would be simpler. I mean I knew everyone and knew how the ward worked. I was really happy there as a student, the WM was great at interview, he said lots about my development and becoming a valuable member of the team, blah blah…. None of that was true, he just wants a pair of hands, who can just get on with it. I suppose that is how it felt, we do not go out together, like out of work. It might have been better to go somewhere else and start again, but I don't think I was brave enough.

Tell me a little bit more about your early weeks:

You mean the fact that SSNa did not leave me alone… I think she would supervise everything I did if she could. She is always looking over my shoulder. I am not sure it is me or her. She doubts me, doubts

whether I can do it, but so do I…I don't think I can do it most of the time. I am completely out of my depth…

I think I am getting it all sorted, working out how to get the job done, but then I just go back to being a student… need to be told, need to help, even HCA, who is great, she tells me what to do, tells me what to do next. Am I waiting to be told or are they telling before I can work it out for myself? I mean I might if people would just give me a little bit of time… thinking back maybe I should have gone somewhere else. It is like the drug stuff, I can do it, but just not quick enough!

An event when a patient crashed, tell me more:

*Oh, you are talking about when I was completely useless. Yeah, that was really ****, I mean I was rubbish. I knew something was off, but nobody would listen, I knew there was a problem. I had never seen anything like it, there was blood everywhere. He had been ok, all day, I mean not ok but not really bad… I was just not sure… his BP was going up and down, nothing terrible, but he wasn't hungry, and he really didn't want a drink and he was usually a bit of a laugh to chat to, but nothing that day. Nobody would take any notice; I even told the Reg, and she dismissed it. I think what I was more annoyed about, was how ***** SSNa was, she was cross I hadn't said anything when I had mentioned it all day. When he crashed, I was hopeless, I just stood there, called the crash team, but did nothing helpful and she just got cross. I felt like such a fool, and nobody talked to us, 'talked' us through it, what went well and what went badly… I mean he died, and I really would have liked to find out if there was anything I could do, was it my fault or not. I mean I don't think it was but, could I have done something else….*

You talk about being lost and feeling 'out of your depth,' what do you mean?

Well, I suppose, I thought it would start making sense by now! I mean when I qualified, I thought it start being easier or not easier just the pieces would come together and if I did it every day, I might find it easier to understand what was going on. But it isn't. I mean some of the conditions and patients are the same or similar, but even then, I don't seem to be able to predict or work out what to do. I even still have to look stuff up!

Why do you think that is?

I don't know, I thought when I started, I would have a mentor, like when I was a student, someone to help and guide. And the WM did say I would at interview, but that didn't happen. They just wanted a pair of hands...

SSNa always checked on me and did not trust me to do anything, I do think she liked me. But that isn't the same I just wanted a mentor, someone who could show me the ropes and what to do. I just feel like I come to work, do stuff, and then leave. I do not feel any more confident or competent than I did when I started. I suppose it is the people who make a place or something.

And what now?

*I don't know, I mean I will stay for a while here but might look for something else, in the trust, maybe a specialist ward… I thought I might go to ******, I was always like haematology…*

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

No, not yet I mean I think I am nearly there… it comes in waves. One day I think this is great, this is fine…. I am doing it and then something will happen, or someone will say something, and I will go straight back to being a clueless student!

Summary

The interview reflects on her experience of socialisation and settling into her role as a staff nurse. She mentions struggling to feel like part of the team and not going out socially with her colleagues. The themes of confidence and competence emerge as Susie feels that progress in these areas has been slower than expected. She expresses doubts about her abilities and questions whether they are being given enough guidance and support.

She recalls an event where a patient experienced a medical emergency, and she felt helpless and unsure of what to do. She expresses frustration at not receiving feedback or guidance after the incident, leaving her uncertain about her performance and whether they could have done something differently.

Feeling 'lost' and out of her depth is a recurring theme for 'Susie.' She expected that with time and experience, things would start to make more sense, but she still finds herself needing to look up information and lacking confidence in her decision-making abilities. She expresses a desire for a mentor to guide her and help her navigate the role more effectively.

Looking ahead, Susie is unsure of her future plans. While she intends to stay in her current position for a while, she is considering seeking opportunities in a specialist ward or another area within the same healthcare trust. She acknowledges that she has not yet fully transitioned from being a student to a qualified nurse and still experience moments of feeling like a clueless student.

Overall, Susie's reflections highlight ongoing challenges in her transition to the role of a staff nurse, including difficulties with socialisation, confidence, competence, and finding adequate support and guidance.

4.3.1 Study Cohort A – Participant 1c

Background

'Charlie' was a 23-year-old who moved to the Southwest to undertake the programme and stayed in the city; she had all her placement in the city at the many hospitals. She then took her first job in the largest hospital in the city on the surgical ward, a 30 bedded

general surgical ward with 8 ENT (Ear, Nose and Throat) beds. She had worked in the hospital but not on that specific ward. One of the main reasons she took the job was she liked the ward manager when she had her interview.

Additional Info: Charlie, 23 years old, she had all her placements in a single Trust, and remained there for her first job, although she had never worked on this specific ward as a student. The diary entries were quite sparse and seemed like a list of jobs, like a handover document. After several entries, I prompted her via email to try and include a little more detail.

This resulted in more detail, but still a superficial approach. Nothing phased her, she was a happy bubbly girl, younger than her years.

At the time of her interview, Charlie had just got engaged, her reflections of the previous 6 months were incredibly happy, her personal life had certainly an impact on her reflection of her development and her transition. After a significant dip in her confidence and competence, caused by a critical incident, she took a while to successfully recover. Were the external influencing factors a large part of her 'successful' transition?

4.3.2 Diary Entries

Initial Entries: excerpts of entries from the first month

Review of the first week, I went for Induction- and was introduced to the Trust. I have worked in this hospital before at the end of my second year so some of the information I already knew.

Did 4 shifts this week, was allocated the same patients all week and looked after them pretty much alone- they all were pre or post op and I think I managed them all- Some clinical details excluded- I feel I have settled well. I am getting on with everyone and am enjoying it.

Reviewing my first weeks, they have gone rather well. The Ward is busy but really well organised and everyone seem to know what to do and when. It can depend on who is on but if WM[16] is in charge the place runs very smoothly. I feel very supported and look after, the team are great, and I am enjoying actually doing the job.

Analysis

Charlie mentions going through an induction process and being introduced to the trust. She notes that she has previously worked at the hospital during her second year, which suggests a level of familiarity with the environment. This theme highlights the

[16] Replaced name of ward manager

importance of orientation and the advantage of prior knowledge in settling into a new role.

She states that she was allocated the same patients throughout her first week and felt capable of managing them independently. This suggests a level of trust and autonomy given to the Charlie, allowing her to take responsibility for the patients. The theme of patient allocation and independence highlights her growing confidence in her abilities.

Charlie describes the ward as busy but well-organised, with a supportive and knowledgeable team. She mentions that the smooth running of the ward can depend on the presence of WM, indicating the impact of effective leadership on the work environment. This theme emphasises the importance of a positive and supportive work culture in facilitating a successful transition.

Charlie expresses enjoyment and satisfaction in her first weeks as a staff nurse. She mentions getting along with everyone and enjoying the actual work. This theme highlights her positive attitude and sense of fulfilment in her new role.

Overall, the common themes in this excerpt revolves around her familiarity with the hospital, her autonomy and responsibility in patient care, the positive work environment, and her enjoyment and satisfaction in her role as a staff nurse. These themes contribute to a sense of confidence and contentment in her first weeks of work.

<u>Early Entries:</u> excerpts of entries from months 2/3

The shift pattern and the ward routine are very set and organised. There are certain lists on certain days and so you can pretty much predict what will happen on the specific days. Like on a Monday it is a plastics list, those patients will come in on Sunday night, some short cases but some longer, so the short cases might go home on Tuesday and the longer one's home on Thursday or Friday. Then the Tuesday lists, come in on Monday night and theatre on Tuesday, those are ENT and some Breast surgery. This means that if you are on a 'late' on a Sunday/ Monday you know you will be doing admission and some post op obs. The weeks can be quite predictable or organised, which I quite like that.

I have done a set of mixed day shift, early and lates, I have done a weekend, which was quite quiet, and have just finished my first set of nights, I only did 4 nights. I thought I would struggle but they were fine. The Ward was well managed, I was on with SN[17], she has been qualified a while and I think we worked quite well together. She really knows what she is doing. There was a very clear plan from the start of shift. We had handover, got the drug done, did all the post op obs and got everything

[17] Replaced name of staff nurse

settled. We only had one patient we were worried about, just because we could not get her pain under control. The F1 came up and helped us out, once we had her settled, we had quite calm nights.

Analysis

The passage highlights the set shift pattern and routine in the ward, which allows for predictability and organisation. She mentions specific lists for certain days and describes how she can anticipate the types of cases and tasks she will be handling. This theme emphasises the structured nature of the work environment and Charlie's appreciation for it.

She mentions working with an experienced staff nurse (SN) and describes a positive working relationship, highlighting the SN's competence and knowledge, indicating effective teamwork. The theme of collaboration underscores the importance of working together to provide efficient and effective patient care.

Charlie reflects on her first set of night shifts and expresses initial concerns that were ultimately unfounded. She describes the ward as well-managed during the night shifts and mention a clear plan from the beginning of the shift. This theme highlights Charlie's successful adaptation to working nights and her overall positive experience during this period. She mentions a patient whose pain they struggled to control. She highlights the collaboration with a foundation year 1 doctor (F1) to address the issue and ultimately achieve a settled state for the patient. This theme underlines the challenges that can arise in patient care and the importance of teamwork and seeking assistance when needed.

Overall, the common themes in this section revolve around the predictability and organisation of the shift pattern and ward routine, the positive experience of collaboration and teamwork, the successful adaptation to night shifts, and the challenges encountered in patient care. These themes contribute to a sense of order and efficiency in Charlie's work environment and highlights the importance of effective teamwork in providing quality patient care.

<u>Mid-Point Entries:</u> excerpts of entries from months 4/5

We had a nightmare on Thursday- so we had 2 patients we were concerned about; both were post op. I say we were concerned but that is not really true. One of them we thought was fine. We had handover at the beginning of a late shift, went out to start the shift, all was going well, we had a lot back from theatre a few going to scan etc and things were plodding along, did the evening drugs and was helping to give out the teas. Anyway, Mr A was not stable, and his BP was all over the place, we

called the F1, she came up and was helping, he was in a lot of pain, and it was not really that clear what was going on. He had a hemi the day before and his abdo was distended and they were talking about taking him back to theatre, we were really taken up with him. That was the issue, Mrs B was meant to be OK, she was my patient, and I should have been keeping an eye on her, she was probably going to be discharged Friday/ Saturday. I saw her at the beginning of the shift and then I did not see her again until we found her. I did the evening drugs, and she was not due anything, I asked the other in the bay if they had seen her, assumed she was in the loo. Anyway, about an hour later we found her in the bathroom, she had collapsed, StN[18] called for help. The crash team and everything, but we never got her back.

I have spent so much time since this filling in forms, Datex forms, statements with the WM, the Docs. It seems she had a PE, and there was nothing we could do. But it was my fault we took so long to find her.

Following receipt of the diary entry, Charlie was contacted to ensure that she had received a debriefing, support from her colleague and line manager, as per the Participant Information Sheet. Following review of the Datex and statements, Charlie discussed the organisational learning that had taken place, including documenting regular reviews. I also followed up at the interview.

Analysis

Charlie mentions two postoperative patients about which she was concerned. She describes the situation with Mr. A, who had unstable vital signs and was in pain, requiring intervention from a foundation year 1 doctor. Charlie then reveals that she neglected to keep an eye on Mrs. B, their assigned patient, who later collapsed and did not survive. This theme highlights the challenges and responsibilities of postoperative care and the consequences of overlooking patient monitoring.

Charlie emphasises the involvement of the foundation year 1 doctor and the assistance provided by StN in calling for help when Mrs. B collapsed. This theme underscores the importance of effective communication and teamwork, linked to confidence and competence in responding to critical situations and seeking appropriate assistance.

Charlie expresses a sense of guilt and responsibility for the delay in finding Mrs. B and the subsequent outcome. She describes the emotional toll of the incident and the subsequent involvement in filling out forms and providing statements. This theme highlights the emotional impact of adverse events and the need for accountability in patient care. The section describes a medical emergency involving Mrs. B, who was later found to have a pulmonary embolism (PE). Despite efforts to resuscitate her, she could

[18] Replaced name of student nurse

not be revived. This theme highlights the gravity of medical emergencies and the potential for adverse patient outcomes.

Overall, the common themes in this piece revolve around patient concerns and postoperative care, the importance of communication and teamwork in critical situations, the emotional impact and accountability following adverse events, and the potential for adverse patient outcomes during medical emergencies. These themes shed light on the challenges and responsibilities of providing patient care and the need for vigilance and effective communication in ensuring patient safety.

<u>End of Enquiry Entries:</u> excerpts of entries from month 6

I am enjoying work and life again. The Ward is busy, but I am starting to enjoy it again. This week I even was in charge for a shift. I have not been in charge since Mrs B, I mean I really felt terrible about that. Everyone was great but I still think it was my fault she had to die in a loo.

I think things are good- I am hoping to do a leadership course next month and a think I will stay here for a little bit longer.

<u>Analysis</u>

The common themes in this statement revolve around work, personal growth, and a sense of responsibility. Charlie expresses a renewed enjoyment in both work and life, indicating a positive shift in their overall well-being. She mentions being in charge of a shift, which suggests a desire for leadership and taking on more responsibility. The mention of feeling terrible about someone's death implies a sense of guilt or remorse, highlighting the importance of personal accountability. She also expresses future aspirations, such as taking a leadership course and considering staying in her current position longer, indicating a desire for personal and professional growth.

4.3.3 Sections from the Interview

Excerpts from the interview with Charlie- late September 2019

Charlie was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

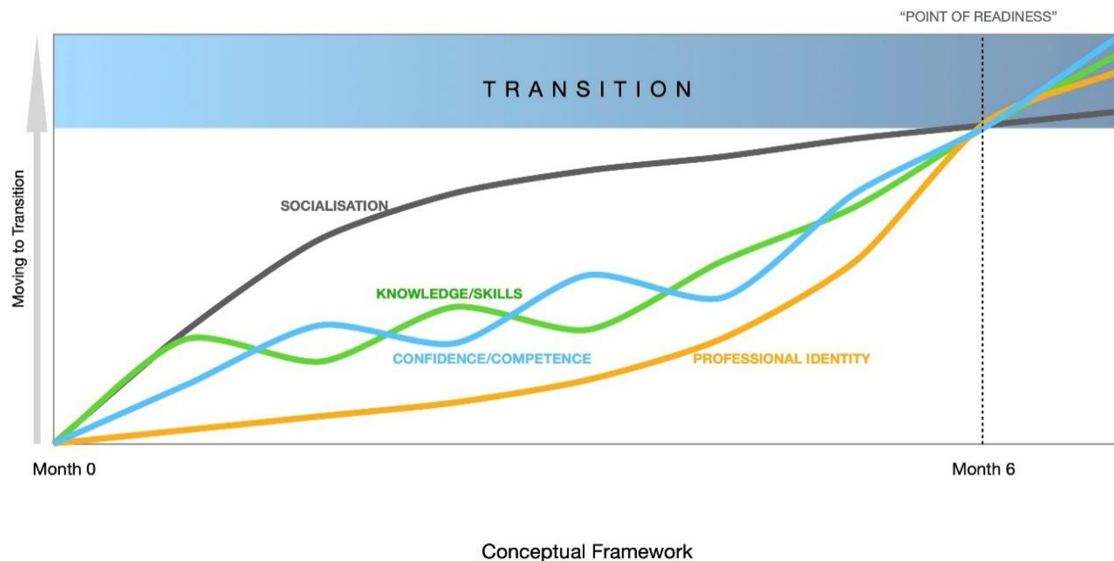

Figure 5: Conceptual Framework

I am looking at these and think, well, it is about right, although I think all the lines are a little slower than that. I mean socialisation was a very steady line, I think I settled in very well, and the professional identity is something I never thought about it, I mean I am a staff nurse now and I like being qualified. I did not really think about it that much, I like the status and the role and that sort of stuff.

The confidence and competence thing, I am not sure I can judge, isn't that something others judge. I mean I think I am competent now, but maybe you should ask the team. I think my confidence, and everything took a significant knock after Mrs B. they are not always the same, I think sometimes they are different and much further apart, the picture suggest they are always tracking and are linked …. I don't think they are. The knowledge/ skills things are quite different, I thought that went up much quicker…

Shall we talk about that now- tell me about the event?

*Well, it was awful. I mean, it was my first arrest, like proper arrest, and the circumstance were really ****. She was fine, I saw her after handover and thought 'she is ok' and with everything that was going on, I have to admit I did not even give her a second thought and that is what I feel so awful about. I mean it was not until after tea that I even noticed she was missing, and then we found her in the loo. She had collapsed, she was on the floor, and she wasn't breathing. I, well we tried, the team were there quickly, and we started. Looking back should we have got her back to bed or done thing differently, but we did it all on the floor of the bathroom. We did resus for ages, well it felt like ages, I think looking back it was only half an hour! Never got her back, I did chest compression for the first time…*

How was it?

Nothing like the sim! I knew it wouldn't…. It just was not what I expected, it was very messy, chaotic and I think the worst thing… in the bathroom. So undignified for her and when her husband came in, I just couldn't look at him I felt really terrible, I mean you can't say, she died, and we found her on the toilet floor, and she was already dead, and we tried to resus her, and it didn't work. I mean we did loads, shocking and drugs etc but we never got her back.

The WM was good, she spent quite a bit of time with me, to discuss and chat the whole thing through. She was great- I had to admit to felt really guilty, people keep telling me I have nothing to feel guilty about but that is easier said than done. I just think if I had kept an eye on her and not been busy with everything else to realise that she was not in bed, or on the ward, or in any distress. Later, a couple of weeks later, the Reg told me that she had a massive PE and even if I had been with her at the time, it would not have made any difference… but you just do not know. That sort of made me feel better, but sort of was a little late...

It really does not matter… it did not make me feel any better. I still spent time, I mean lots of time, thinking about her. I just wish it hadn't happened like that, or at all… in a way I wish I had seen an arrest as a student, when I had nothing proper to do…

Proper? What do you mean?

I mean responsible for her, like accountable for in a way. As a student I would have had someone there and helping, supervising… but I was on my own, there were people there, but she was my patient, she was in my care, and I was responsible for her- and she died. I know people will die, that is the job I suppose, I didn't want it to happen to me and then.

So, going back to settling in- did that go well?

*Oh- I settled in really quickly, everyone was really nice and welcoming. I had worked in the trust for ages, so working on ******* ward was easy. I mean I knew the Trust and the place and even some of the staff, so it felt pretty much at home from the start. I got stuck in pretty quickly.*

The Ward is really well organised, the WM is great, I mean she sort of supports you, but lets you get on with things and is sort of in the background... just there and present and sort of supportive. I don't know what else to say….

*I thought everything was going really well, I got used to working and life was great I suppose everything is going great… as you know I met J***** a while ago- any we are getting married and got engaged just after my birthday. I don't know what I would have done without him. After the whole Mrs B stuff, he was great, I mean I really struggled to manage the whole thing. I cried lots, I was shattered, I mean I hated going in for a while and just couldn't do it for a bit. But got back into it after a while and felt OK after a while.*

And what now?

Well, I am getting married next year- I am so excited. I can't think about anything else at the moment…. I am staying on the ward.

You mentioned a leadership course in your diary- are you still going for that?

*Oh that- it was WM idea, she is really keen to get us to do things, sort of fell off my radar. I mean I might, I might enjoy it or something, I think I want to stay for the time being. Things have been a little hectic since we got engaged. I don't know what will happen with J*****'s job, he is not just based in *******, so if we stay, I might… but we will see.*

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

*Yes, I think I am there now. Lots of things happened, some good, some a little s***. But I now feel like a staff nurse, properly qualified now.*

Summary

In this statement, Charlie reflects on their transition from being a student nurse to a qualified staff nurse. She expresses satisfaction with her socialisation into the nursing role, feeling settled and comfortable in her work environment. She also mentions enjoying the status and role of being a qualified nurse. However, she questions her own confidence and competence, suggesting that she may rely on others' judgment to assess these qualities. Charlie recounts a traumatic event involving a patient's death, expressing guilt and remorse for not noticing the patient's distress sooner. She describes the chaotic and undignified nature of the resuscitation attempt and share her struggles to cope with the emotional aftermath. She finds support from her ward manager, who helps her process her feelings of guilt. Despite this event, Charlie felt that she has settled well into her role and appreciates the organised and supportive environment of her ward. She also mentions her upcoming wedding and express excitement about her personal life. Charlie briefly mentions a leadership course suggested by her ward manager but admits that it has fallen off her radar due to other priorities. She concludes by affirming her feelings of being a qualified staff nurse and their intention to stay in her current position for the time being, considering the uncertainties surrounding her partner's job.

4.4.1 Study Cohort B – Participant 2a

Background

'Helen' was a 36-year-old, she had 3 grown up children. She had worked in the large University hospital in the city for many years as a Health Care Assistant (HCA) while her children were growing up. She had undertaken all her student placement in a nearby town with two small hospitals but had returned to the large University hospital for her first job. She had taken a job on a 28 bedded medical ward that specialised in gastro-intestinal medicine.

Additional info: Helen, 36 years old, return to the Trust where she had been a health care assistant. She had undertaken all her clinical placements as a student in a different Trust. Something she requested but did at times regret her decision not to stay in the trust she

knew. Her first job was back in the trust of her background and was on her first-choice Ward.

Despite this she took a long time to settle, struggling with the different role. Her diary entries were methodical and very ordered. Felt that she was telling what I wanted and what I expected! Talked endlessly about challenges and barriers, people that were being difficult. The loss of the significant management team was a large factor in the slow development, two senior SNs left leaving the management team in disarray.

She found the transition exceedingly difficult, felt very unsure of herself, now qualified. She has grown up children, one doing paeds course at university.

She had a delayed her career in nursing to bring her children up and worked extremely hard during the programme. One of her children was also undertaking her nursing degree specialising in paediatrics and was due to qualify in a year after her mother.

4.4.2 Diary Entries

Initial Entries: excerpts of entries from the first month

*Started on the Ward *** last week, went to the induction session on Day one- it was quite funny to be back. The induction session was almost the same as it was when I started in 2*** as an HCA. They went through all the usual stuff, and then I started on Ward *** with a couple of supervised shifts. I did a late and then an early before I start normally. I feel a little weird to be back.*

Starting as a staff nurse is different, as expected. I have been allocated to a team; we work in teams on this ward- I am not sure why. The team are blue and red and there seems to be an element of competition, how quickly we can get things done, who has the best paperwork and stuff. There is a wall chart in the office and each team gets stars on the chart… like children. I did charts like that when the kids were being potty trained. The 'winning' team at the end of the month get a treat, like a box of biscuits. I am not sure why or what the purpose of this is. I am a blue.

Analysis

This excerpt starts with a theme of familiarity and nostalgia. Helen mentions that the induction session on day one is almost the same as when she started as a healthcare assistant (HCA) in the past. She suggests that there are certain routines and procedures that remain consistent in her workplace. Additionally, she expresses feeling weird to be back, indicating a sense of returning to a familiar environment but with a new role.

Helen mentions that starting as a staff nurse is different, as expected. She has been allocated to a team and notes that working in teams is a unique aspect of this ward. This

suggests that the transition from being an HCA to a staff nurse involves adapting to new dynamics and responsibilities. She describes the teams on the ward being divided into blue and red, with an element of competition in terms of efficiency and paperwork. The teams receive stars on a wall chart, and the winning team at the end of the month receives a treat. This theme of competition and reward adds a sense of motivation and camaraderie among the staff.

Helen expresses confusion about the purpose of the competition and reward system. She mentions having done similar charts when her children were being potty trained, suggesting a sense of scepticism or questioning towards treating adult professionals in a similar manner. This theme of questioning adds a layer of reflection and curiosity to the narrative.

Overall, this passage highlights themes of familiarity and nostalgia, adjustment and transition, competition, and reward, and questioning and uncertainty. These themes contribute to the exploration of Helen's experiences as she starts her new role as a staff nurse.

<u>Early Entries:</u> excerpts of entries from months 2/3

I have worked on the ward for a couple of weeks now. The shift pattern is fine although as a new member of staff I have no chance to make request which is annoying. I have put in my requests for the next few months.

The Ward is busy and a challenge, I was expecting some supervision or support from the qualified. I have been on shift and just got on with things. The patients are quite complicated and different to what I have had experience of. The other staff have very set ways of doing things, there are a number of questions I have but the response is that the way we do things. The Ward is quite tight knit- I really wanted to work here for that reason. The Ward is known for its strong team, they have been together for some time.

In the blue team, we work OK together, but you never seem to work with somebody. I mean they are on shift, but you do not actually work with them. I mean you are working with someone, but nobody wants to share information, you always have to go and ask. I don't mind asking questions, but you continually have to go after people to get information. As a student nurse you never minded asking questions, I have to keep checking myself and remembering I am actually qualified.

<u>Analysis</u>

Helen mentions that as a new member of staff, she has no chance to make any shift requests, which she finds annoying. This suggest a sense of frustration with the lack of control or flexibility in their work schedule. Additionally, Helen expresses

disappointment in the lack of supervision or support from qualified staff. This theme of adjustment highlights the challenges and difficulties that comes with starting a new job.

She notes that the patients on the ward are quite complicated and different from her previous experience. This suggests a sense of unfamiliarity and the need to adapt to new situations and patient needs. Helen also mentions having questions about certain procedures or practices, but the response she receives is that it is just the way things are done. This idea of complexity and unfamiliarity adds a layer of learning and growth to facilitate her confidence and competence.

There is a discussion of teamwork and communication in the passage. Helen mentions that the ward is known for its strong team, but she also expresses frustration with the lack of information sharing among colleagues. She notes that they have to continually go after people to get information, which can be difficult. This excerpt highlights the importance of effective communication and collaboration within a team.

Lastly, there is a theme of self-reflection and professional identity. Helen mentions that as a student nurse, she did not mind asking questions, but now as a qualified nurse, she has to keep reminding herself of her new role. This suggests a sense of navigating her professional identity and adjusting to the responsibilities and expectations that come with being a qualified nurse.

Overall, this passage explores themes of adjustment and frustration, complexity and unfamiliarity, teamwork and communication, and self-reflection and professional identity. These themes contribute to the narrative's depiction of Helen's experience as she navigates the challenges and dynamics of her new role on the ward.

<u>Mid-Point Entries:</u> excerpts of entries from months 4/5

I was on night last week, which were OK, I mean I never like doing nights. I quite like the fact that nobody really bothers you. You can get on with the patients and get the work done without lots of other people getting involved.

I returned to the ward after a few days off to discover that SSNa[19] and SSNb[20] are not at work- one has resigned and the other is off sick, with WM[21] going on maternity leave in a few weeks I do not know how the place will be OK. I mean the whole team thing will need to be reviewed. We don't even have a rota for next month, they have pulled the students off the ward and yesterday at work we

[19] Replaced name of the senior staff nurse
[20] Replaced name of the senior staff nurse
[21] Replaced the name of the ward manager.

only had agency on shift. Fortunately, SN[22] *was on with me for all of the nights so I did not need to be there on my own.*

I hate working over Christmas and New Year- it has been busy; I miss the girls. I only saw them on Christmas eve, which was miserable. I would have been pretty bad anyway- at handover so much has been missed. I am not even sure some people even noticed…. I never thought I would say it, but I miss SSNa and SSNb, they would have noticed that things were missed… like dressing changes, IVs etc. On the ward round the DrA[23] *got quite cross with us, I was a little embarrassed, it is not that I could not be bothered or something, I just didn't know things needed to be done. Where is the guide or whatever, it is not like you get a sort of thing to tell you what to do SSNa and SSNb had been qualified for decades… and with WM gone as well, that is 30 year of knowledge and experience, just gone and there is no one taking over. The stuff they know and know how to do and what to do in certain circumstances, has just walked out the door and nobody seems to be concerned about this. When we say, 'who is in charge, who is or might be coming to join us' – like management people so not have an answer or a clue. I am not sure if there is anybody joining or coming to help and support. I don't know of it is just me, but I don't think the ward is working well at the moment.*

Analysis

There is a discussion of autonomy and independence. Helen expresses a liking for working nights because it allows them to focus on the patients and get work done without interference. This suggests a sense of independence and self-reliance in her work as she builds confidence and competence.

Helen discovers that two staff members have left, one is on sick leave, and another will be going on maternity leave soon. This creates a sense of uncertainty about the future of the team and the ward's operations. The absence of a rota for the next month and the reliance on agency staff further contributes to the feeling of change and uncertainty.

Helen expresses missing the presence of certain staff members who had extensive knowledge and experience. She mentions that important tasks were missed during handover and that there is a lack of guidance or support in knowing what needs to be done. This highlights the importance of experienced staff and the impact her absence can have on the functioning of the ward.

She mentions feeling embarrassed during a ward round when the doctor expressed frustration with the team. She also expresses concerns about the lack of management support and the uncertainty about whether anyone will be joining or helping the team.

[22] Replaced the name of the staff nurse.
[23] Replaced the name of the Consultant.

This theme of frustration and concern adds a layer of tension and unease to the narrative, discussing the impact of events on a successful transition.

Overall, this section explores themes of autonomy and independence, change and uncertainty, missing support and knowledge, and frustration and concern. These ideas contribute to Helen's depiction of the challenges and disruptions faced by her and the overall functioning of the ward.

End of Enquiry Entries: excerpts of entries from month 6

*People said that the ward get quieter after the winter, and it really hasn't. I don't think we have had an empty bed since I started. I took a job on Ward *** because of the people, the staff, especially the senior lot. When I was interviewed and when I was back as an HCA, I really liked the team, thought the place would be good for me, like I would fit in and be great, supported etc. the patients are ok, some are really sick, complicated and take some getting used to, we are meant to medical with GI, but actually we are just general, lots of respiratory, which I don't really like. So not quite what I expected, and now with all the staff gone. I mean we have been on our own for months…. like completely on our own. I mean I not sure I will stay here, I'll see. Finding things really difficult with SSNa and SSNb gone and WM still on mat leave, things might get better when she is back!*

Analysis

Firstly, there is a theme of unmet expectations. Helen mentions that she took the job on Ward *** because of the people and the senior staff, expecting to fit in and be supported. However, she expresses that the reality has not matched her expectations, particularly in terms of the patient population and the lack of support from senior staff. This theme highlights the disconnect between what Helen anticipated and what she has experienced.

She mentions finding things difficult without certain staff members and expresses a preference for a different type of medical specialty. This suggests that she is facing challenges in adapting to the patient population and the working environment. This highlights a layer of struggle and frustration to the narrative.

There is a discussion of uncertainty and potential change. Helen mentions that she is unsure if she will stay in her current position and expresses hope that things might improve when a staff member returns from maternity leave. This section reflects a sense of uncertainty about the future and the possibility of seeking different opportunities.

Overall, this passage explores themes of unmet expectations, challenges and difficulty, and uncertainty and potential change. These themes contribute to the narrative's

depiction of Helen's experience on Ward *** and her contemplation of her future in the role.

4.4.3 Sections from the Interview

Excerpts from the interview with Helen- March 2020

Helen was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

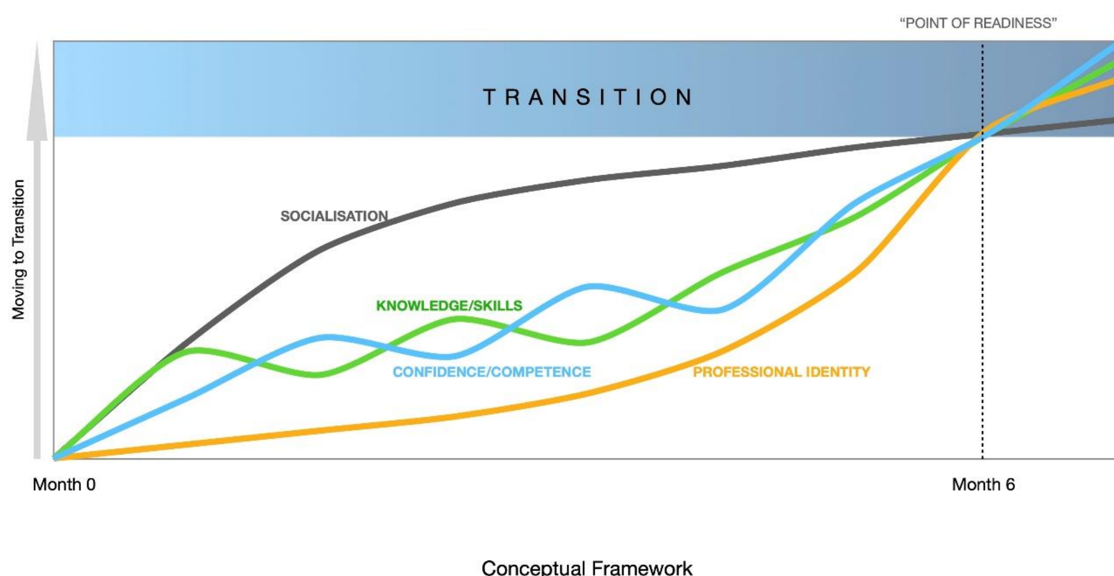

Figure 5: Conceptual Framework

Those lines seem to go up quite quickly. I mean confidence/competence were much slower than that, and in terms of knowledge and skills, not together, they have gone up a little but not much I don't think. I mean I think I might know a little more, but I don't know. The stuff we do, I suppose I am getting better at it, but nothing is automatic yet… nowhere near…

Socialisation was fine really; I knew the place already. I had worked in the hospital for year, on the ward even as an HCA etc, so I don't think I really needed to be 'socialised' as such. I went back as a qualified, nothing different!

It didn't feel different going back as a qualified staff nurse.

No not really, just doing the same sort of thing with a different uniform. I suppose that is what you mean about professional identity. I didn't really feel different. Did people treat me differently? I don't think so, but maybe, I felt a little weird about being back, probably.

Tell me a bit more about settling in.

I settled in quickly; the team thing was a little unusual. The reds and blues, even now I don't really get what that was about. But it worked well for a while. The thing was that if you were in the blues you knew about your patient and your staff, and worked with them, but knew nothing about the reds, so if anyone asked or the phone rang you would have to go and find a red. Anyway, that all stopped when SSNa and SSNb went, it sort of didn't work anymore. I never quite worked out how it worked or why, but they really like the element of competition but after they went it sort of died!

You mentioned significant members of staff leaving, tell me more about that?

*Yeah- well when they went things really went to ****. They were such fab SSNs, they really knew their stuff… I mean the ward just worked better with them around. And with WM went on mat leave the whole place as well was ****. Rotas were not done; stuff was missed the doc got really p****** with us sometimes….*

What do you mean?

The Ward was not quite what I expected, even before. I took the job because I thought I would know what to do and how things were but when I started things just were not like that. I am not really sure why. I thought things would be different, I don't easier. I had worked there as an HCA, I liked it, but as a staff nurse it was not what I expected. There was no support or care or, I don't know, they just wanted me to get on with it and just do the job…

You say it is not what you expected, what do you mean?

Um…I don't know. I suppose I expected that when I started, I would work with some experienced and senior and really learn how to do it. The job I mean, on a day-to-day basis. Nothing complicated just what to do when you get handover, and then what to do first, like obs or referrals. I am not sure… people just expect you to know like it is automatic, but I don't know. I just needed to learn the job, like as a student or an HCA, you did certain things, and I knew what to do and then when I qualified, I just didn't. I thought I suppose that if I shadowed someone fab, I would be able to do the job really well….

So, what now?

I don't know…. I am going to wait until WM is back before I plan. I don't think I can stay on this ward forever. We will see…

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

Yeah- I think I have now but definitely only recently… it may have just all come together.

Summary

The section from the interview reflects on Helen experiences transitioning from a student nurse to a qualified staff nurse. Several key points emerge from their reflection. She discusses her development of confidence and competence. She notes that her confidence and competence has not increased as quickly as she expected. While she feels she may have gained some knowledge and skills, but she did not feel that she has reached a level of automaticity in her practice.

Helen also discusses the process of socialisation. She mentions that she did not feel the need to be socialised as she was already familiar with the hospital and the ward from her previous experience as a healthcare assistant (HCA). She did not feel that her professional identity has significantly changed.

Regarding settling in, Helen reveals that she quickly adapted to the team structure on the ward, which involved dividing the staff into red and blue teams. However, she expresses confusion about the purpose and functioning of this structure. She notes that the competition element within the teams stopped when significant staff members, SSNa and SSNb, left the ward.

The departure of these staff members is described as having a negative impact on the ward. Helen praises the expertise and knowledge of SSNa and SSNb, and their absence led to a decline in the ward's functioning. She also cites that the absence of WM, who went on maternity leave, further contributed to the difficulties faced by the ward.

Helen expresses that her experience on the ward was not what she expected. She anticipated working with experienced and senior staff members who would guide her in her day-to-day tasks. However, she feels that she was expected to know everything automatically without proper support or guidance.

As for the future, she is uncertain about her plans. Helen mentions waiting for WM to return from maternity leave before making any decisions. She expresses a desire to explore other options and suggests that they may not stay on this ward indefinitely.

In conclusion, Helen's transition from student nurse to qualified staff nurse has been a challenging and uncertain journey. She encountered difficulties with confidence, socialisation, team structure, and the absence of key staff members. Nonetheless, she believes that she has recently made progress in her transition. Her future plans remains uncertain, and she is considering alternative options.

4.5.1 Study Cohort B - Participant 2b

Background

'Zoe' was a 21-year-old, who undertook all her placements in a small district general hospital and took her first job in the 16 bedded Intensive Care Unit which cared for level 2 and 3 patients. She described herself as extremely committed to the programme and to her nursing career. She was excited to get her first job on the ICU and planned to move to the 'big' city after a period getting experience.

Additional info: Zoe, 21 years old, took her first job in an intensive care unit, at the same trust she had been as student but in a specialised setting. She was incredibly happy and confident person, thrilled to have been given the opportunity to work in ICU, her 'dream job.' Her diary entries were thorough and detailed , comprehensive about her skills, her development and how she was having a wonderful time, really enjoying herself.

Comments on the positives of working in a close-knit team and how supportive they were, how welcoming, especially in relation to critical incidents and stressful situations.

4.5.2 Diary Entries

Initial Entries: excerpts of entries from the first month

Oh, this is terrifying… I start on ICU tomorrow!

Week one has been great- started on ICU with a Trust induction, I mean I have been here as a student for a while, but it was lovely to be welcomed back as a staff nurse. It feels fantastic to have started.

Then I started on the ward, I was allocated to SSN[24], we will work together for the next month. We are doing all our shifts together. We are on long days this week and next then 3 nights and then back on days. The Ward is pretty quiet at the moment, couple of level 3 but mostly level 2. We get allocated 2 patients together next to each other and look after them together.

During the last week we have also done the manual handling, the BLS, the IVs…. Everything… WM[25] is absolutely great- he sorted everything. He sat me down at the beginning of the week, mapped out the next few weeks. It is all planned, allocated me to SSN who I really like…she is great, really chilled and so happy to chat and teach and stuff.

The staff are all so great, and the know so much, I mean listening in handover, freeked me out a little. They talk about ventilators, inotropes and I think, OMG I am never going to know all this stuff.

[24] Replaced the name of senior staff nurse.
[25] Replaced the name of the ward manager.

Analysis

This section starts with a discussion of excitement and anticipation. Zoe expresses her excitement about starting on the ICU and feeling welcomed back as a staff nurse. This highlights her enthusiasm for the new role and the sense of anticipation for what lies ahead. There was then a narrative of teamwork and collaboration. Zoe states being allocated to work with a senior staff nurse (SSN) for the next month. She describes how she will be working together on shifts and looking after patients as a team. This emphasises the importance of collaboration and support in the ICU setting.

Then the narrative focusses on learning, knowledge, and skill acquisition. Zoe cites undergoing various training sessions, such as manual handling, basic life support (BLS), and intravenous (IV) procedures. She also expresses a sense of being overwhelmed by the knowledge and expertise of the staff during handover. This theme highlights the continuous learning process and the need to acquire new skills and knowledge in the ICU.

There is a discussion of admiration and respect for the experienced staff. She describes the staff as great and knowledgeable, and she expresses a sense of awe when hearing them discuss complex medical concepts. This underscores the importance of experienced mentors and the admiration that new staff members have for her expertise.

Overall, this portion explores themes of excitement and anticipation, teamwork, and collaboration, learning and skill acquisition, and admiration for experienced staff. These themes contribute to the narrative's depiction of the Zoe's initial experiences in the ICU and her journey of growth and development in her new role.

Early Entries: excerpts of entries from months 2/3

So, I have been here a month, I have shadowed SSN, we have been working together. She has been great- now she lets me take the lead on one of our patients and is just there, sort of at arm's length. It is really great to have her there, I don't worry about anything at work. She is always there and if I have a daft question, she never makes me feel stupid, but to be fair…even if she is not there any other member of staff is just as helpful. SSN was on a study day for her masters last week and I worked with the WM. He was unbelievable, the stuff he knows, and what is fab he always has a story or an anecdote to go with it… I have never laughed so much.

The patients vary quite a bit, we can have a real mix, level 2 and 3. If we have more level 3s, then it can be really busy… so much to do. I have learnt so much, stuff I never thought I would be able to do. I can put someone on a filter, do an art line, manage a ventilator…. loads of things I never thought I could do.

Analysis

Then Zoe comments on working closely with a senior staff nurse (SSN) who has been great in guiding and supporting her. She feels comfortable asking questions and appreciate the presence of the SSN, as well as other helpful staff members. This highlights the importance of mentorship and a supportive work environment.

She indicates that shadowing the SSN and gradually taking the lead on one of her patients. She expresses excitement at the opportunity to learn and develop new skills. She remarks on being able to perform tasks she never thought she could do, such as managing a ventilator or putting someone on a filter. This emphasises the continuous learning process and personal growth in the ICU setting.

There is a theme of teamwork and camaraderie, she mentions working with different staff members, such as the SSN and WM. Zoe appreciates the knowledge and expertise of her colleagues and enjoys the supportive and friendly atmosphere. This highlights the importance of collaboration and a positive team dynamic in providing quality patient care.

Zoe says the WM's ability to share stories and anecdotes, which she finds entertaining. She expresses laughter and enjoyment in their interactions with colleagues. This adds a sense of positivity and enjoyment to the narrative, highlighting the importance of a positive work environment.

This section explores ideas of mentorship and support, growth and learning, teamwork and camaraderie, and humour and enjoyment. These themes contribute to the depiction of Zoe's experiences in the ICU, highlighting the positive aspects of her work and the continuous learning and development she undergoes in her role.

Mid-Point Entries: excerpts of entries from months 4/5

I have just done my first shifts solo. SSN told WM that I could manage without her, and I no longer have to be supervised. Well, I say that but to be honest SSN has had me at arm's length for some time, but to be honest now there are lots of people who I can ask.

I had a really unstable level 3 patient; it was not like he just had one thing wrong with him. His kidneys were going, he was on full inotropes, ventilated etc. I mean I had him all day and manged really well, was titrating NORAD, changing his setting, doing his filters, did gases regularly and changed his I:E ratio…obviously went through the Reg and everything but did it on my own. WM was in the background, there and everything but did not intervene…. It felt great.

At the end of the day, WM called me and SSN into the office, just after handover and said, 'well done.' It felt great, they said how well I had done, and how proud they were of me and how I had coped and developed, WM said he had been watching and keeping a close eye on things and would have stepped in if required, but he did not need to so let me get on with it. WM suggested that I start thinking about doing the course and how he would look at dates and put forward….

Analysis

Zoe cites that they have recently completed her first shifts solo, without the need for direct supervision. She expresses a sense of accomplishment and confidence in being able to manage patients on her own. This highlights her growing independence and ability to make decisions and take responsibility in her role.

She states that she has been gradually given more independence by the senior staff nurse (SSN) and have been able to handle challenging situations on her own. She describes managing a complex and unstable level 3 patient and successfully performing various tasks and interventions. This emphasises her growth and development in her skills and knowledge as a nurse.

She indicates that she received positive feedback from the WM and SSN, who expressed pride in her progress and acknowledged her capabilities. This highlights the importance of recognition and validation in fostering confidence and motivation in the workplace.

The WM suggests that she start thinking about taking a course and offers to assist with arranging dates. This suggests that Zoe's potential for further professional development and advancement in her career.

This explores the themes of independence and autonomy, growth and development, recognition and praise, and future planning and advancement. This contributes to the ideas that this depiction of progress and achievements in her role as a nurse, highlighting her increasing confidence and competence in managing patients and her potential for further professional growth.

End of Enquiry Entries: excerpts of entries from month 6

Christmas, New Year, and the winter were really busy we did not really have enough staff, and we had some real sickies…. but we got through. We actually had a good time, CL[26], DR[27] and WM got loads of food and drink on the ward, we had Secret Santa etc party hats and all that stuff…

I have been on a series of long days, and I am really tired this week. I am so chuffed- I have a place on the ITU course starting next month. I have even started the CCN competencies, SSN shared her portfolio with me so I can start. When I look back since I qualified, I can't believe how much I have changed and how much I can now do.

Analysis

Zoe states that the Christmas, New Year, and winter period was busy, and that the unit faced staffing shortages. She also mention dealing with very sick patients. This highlights the demanding nature of the work and the challenges faced during this time. She describes the festive atmosphere on the ward during Christmas and New Year. She mentions activities like Secret Santa, parties, and sharing food and drink with colleagues. This emphasises the importance of building relationships and finding moments of joy and celebration in a demanding work environment.

Zoe expresses pride in securing a place on the ITU course starting the following month. She mentions starting the CCN (Critical Care Nurse) competencies and being able to access a senior staff nurse's portfolio for guidance. This highlights her progress and development since qualifying as a nurse, showcasing their increased knowledge, skills, and confidence.

This section explores busyness and challenges, camaraderie and celebration, and personal growth and achievement. These ideas contribute to Zoe's depiction of her experiences during a busy period, her sense of camaraderie with colleagues, and her personal growth and accomplishments in her nursing career.

[26] Replaced name of the Clinical Lead
[27] Replaced name of the Consultant

4.5.3 Sections from the Interview

Excerpts from the interview with Zoe- March 2020

Zoe was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

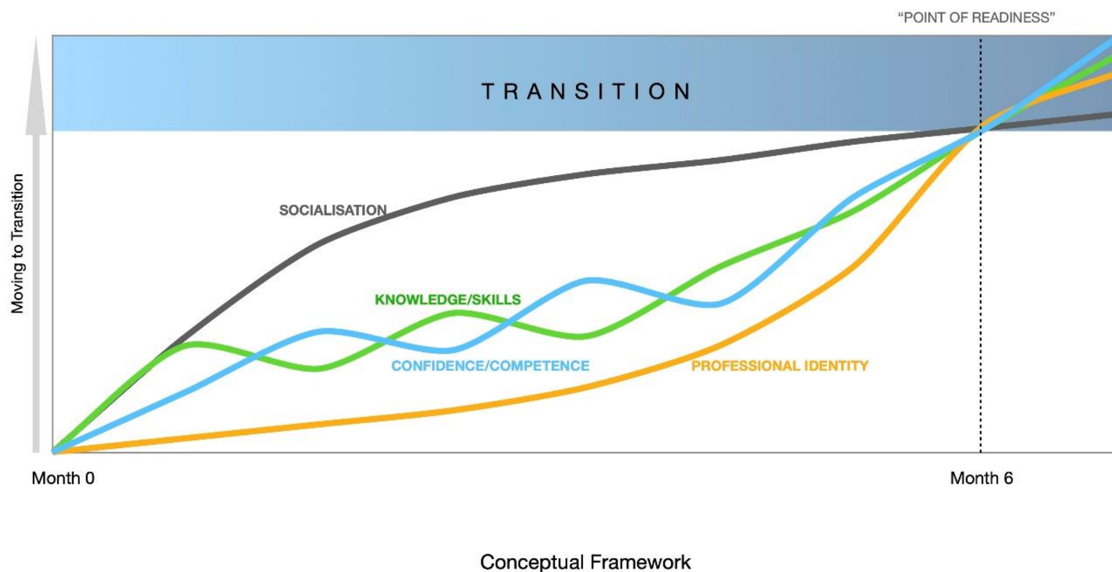

Figure 5: Conceptual Framework

OMG…. Those lines need to go up so much more….

Knowledge and skills were a vertical line…like straight up… I learnt so much so quickly. Like every day I learnt something, learnt how to do something, a skill, a thing, something…. I felt quite overwhelmed initially, but it has settle now, but it was a very steep learning curve...

Confidence and competence were slower I suppose, I was supported and helped, I mean really supported, I had someone there the whole time at the beginning, so I felt pretty confident, competence was something that followed especially when SSN told me how well I was doing…

WM made sure I had all the induction/ orientation stuff… so I was socialised really well and quite quickly. I was really well welcomed and looked after, I had someone with me all along, so I felt like one of the team from the moment I arrived…

Professional identity, that an interesting one, I felt like a staff nurse from the moment I put on scrubs and went on the unit… that was the good thing… in scrubs on the unit!

Explain that?

Well, it is scrubs…. You never wear them as a student, and it just feels really special. I was nervous of going straight into the unit, but it was the best thing I did.

Tell me more about the start, why the best thing?

Going into the unit as a newly qualified, so many people told me I was mad. I mean I really loved critical care as a student, so I knew I like the setting. But so many people, like my friends said…ITU as a first job, you are mad. But when I started, I was supported and helped, I mean I had a senior ITU colleague working right with me from the moment I started. WM was there, interested in me and cared about everyone. So, I have friend who went to medical, surgical, and other wards and they never get to work with anyone, they never have the support, they just have to get on with it. I worked with SSN on ever shift at the beginning, like every single shift…. I was literally taught the job, what to do, what to look for….

But more than that, every single day, I was taught… like actually taught something, either a skill or we went through the gas or …. I mean not a single day went by without me learning something…

What do think was the most significant thing to help you to settle?

The support, I mean not just SSN who was great, but the whole team. Everybody was so supportive and so invested. I was the only newly qualified on the unit at that time, another has just started… and they are the same with him… I don't whether it is because it is such a specialist area and there is so much to learn and do but when you start, you have ***so much*** *to learn. It felt a little overwhelming to be fair… at the beginning but the team are always there… supporting teaching etc… they teach all the time, there isn't a day that goes by when you don't learn something new… WM always says, 'every day is a school day!' and he is not wrong, but the really great thing is that it is the same for everyone. Even the Consultants say…. 'Oh, that is interesting' 'didn't know that' and 'I have to look that up' and there is nothing wrong with that. Nobody makes you feel dumb if you don't know the answer…*

What is next?

*Well, the course, do that, then a Band 6 and then I don't know… I think I would like to go and work in L****** or B******, like a really big unit, a trauma centre or maybe neuro… that all gets transferred from here. We are quite a small unit and so the really big stuff goes elsewhere. But I love ITU, so wherever I go I will stay in Critical Care!*

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

Oh yes- I think when I started being able to manage a patient on my own. There are still things I am learning, like every day, but I think I can manage most things now and really feel part of a team…. That make such a difference… because you know that if you can't manage or don't know what to do…then there is someone there to help, or advise, sort of support, so you feel like a proper staff nurse.

Summary

These insights reflects on their transition from being a student nurse to a qualified staff nurse in the critical care unit. Several key points emerge from their reflection. Zoe first discusses her rapid acquisition of knowledge and skills. She describes a steep learning curve and feeling overwhelmed initially, but with support and guidance, her confidence and competence gradually improved. She highlights the importance of having a senior

ITU colleague working closely with her from the beginning, which allowed her to learn the job and develop her skills.

The support and investment from the entire team was emphasised as a significant factor in helping Zoe to settle into her role. She expresses gratitude for the continuous support, teaching, and learning opportunities provided by the team. She also mentions the positive culture of learning within the unit, where even Consultants admit to not knowing everything and are open to learning from others.

Looking ahead, Zoe mentions her plans to pursue further professional development, such as taking a course and eventually aiming for a Band 6 position. She expresses a desire to work in larger critical care units or specialised areas like trauma or neuro, as she has a passion for critical care and want to continue working in that field.

In terms of her transition to being a qualified nurse, she believes they have been successful. She highlights her ability to manage patients independently and feeling like a valued member of the team. Zoe appreciated the support and knowledge-sharing culture that exists within the unit, which contributes to her confidence and sense of being a proper staff nurse, and in turn her development of her professional identity.

Zoe's reflection showcases her growth, development, and positive experiences during her transition from student to staff nurse. She highlights the importance of support, continuous learning, and being part of a supportive team in facilitating a successful transition and fostering their professional identity as a qualified nurse.

4.6.1 Study Cohort B – Participant 2c

Background

'Vicky' was a 25-year-old, she had undertaken all her placements in Cornwall. She took her first job in a large District General Hospital on a 28 bedded elective Orthopaedic ward, she moved to the city to 'follow her man'. This was a mistake! as she clearly stated. When she started her job, she was single and very unhappy about it.

Additional Info: She had her placements in several trust and chose the job rather than the trust. She wanted elective ortho, so chose her first job accordingly.

In her diary entries she was quite descriptive, she repeatedly stated that things were not what she expected. Due to winter bed pressure and the time of year that the diary took place, the ward beds were taken up with extremely sick medical patients, and in some case elective list were cancelled because of this. Unfortunately, this meant the acuity and nursing care requirements were vastly different to that of an elective orthopaedic ward and she was very unhappy with that, stating 'this is not what I signed up for.'

Very unhappy, , her diary was full of complaints, challenges, and negatives, about people, staff, patients. Remarked that everybody was stressed, all the time.

4.6.2 Diary Entries

Initial Entries: excerpts of entries from the first month

*I have moved into a new flat, moved all the way to E***** and started on Ward **** at the beginning of the week. I had my interview months ago, and I got the feeling when I arrived that they had forgotten about me. WM[28] was there and had a 'welcome pack' for me, I got a tour, and a locker and got my shifts for the next month.*

The Ward is fine, busy and I have never done Orthopaedic before, so I have a lot to learn about the surgeries and the investigation, but I have always been interested in the speciality. The Ward is newly re-furbished, really clean and fancy- which is quite nice, organised and the staff seem friendly. There is another new member of staff as well and we are doing our induction stuff together. We seem to be on the same shifts, just working on opposite sides of the ward.

Being new and being introduced to all the new things, and new people is really tough and really difficult. I seem to be explaining who I am and what I am doing all the time. I feel like I am going round in circles all the time.

Analysis

Firstly, Vicky remarks on moving to a new flat and starting a new job on Ward ****. She describes feeling like she was forgotten about initially but received a welcome pack and a tour from the WM. This highlights the challenges and adjustments that come with starting a new job and settling into a new environment.

Vicky cites being new to the field of Orthopaedics and having a lot to learn about surgeries and investigations in that specialty. She expresses her interest in the specialty and her willingness to acquire new knowledge and skills. This emphasises the continuous learning process and the need to adapt to a specialised area of practice.

[28] Replaced the name of the ward manager.

She describes the newly refurbished ward as clean, fancy, and organised. She mentions the staff being friendly and the positive atmosphere on the ward. This highlights the importance of a well-maintained and supportive work environment in facilitating a smooth transition and fostering a positive experience for new staff members.

Also outlined were the challenges of being new and adjusting to a new role. Vicky mentions the difficulty of constantly explaining who she was and what she was doing, feeling like she was going in circles. This underscores the challenges and frustrations that can arise when starting a new job and the need for support and understanding during this transition period.

Overall, this section explores new beginnings and adjustment, learning and specialisation, organisation and cleanliness, and the challenges of being new in a role. This contributes to the narrative of the Vicky's experiences in her new job and her journey of adapting to a new environment and acquiring specialised knowledge and skills.

Early Entries: excerpts of entries from months 2/3

Trying to get to grip with the ward and the running of the place. The work is fine I suppose, the patients are more challenging than I thought, and they are not all ortho which I really did not expect. It is a little annoying as you think you will be doing one thing and actually you are doing quite another. I don't mind but I would prefer to know what will be on the ward, sometimes you go into handover and there is a bit of everything from the 'take' before. If I had wanted a bit of everything, I would have taken a job on the medical admissions ward. I took this job specifically because I wanted to look after surgical patients- pre and post op, and have some order, having everything planned and organised. I don't really like the constant changing and moving.

We have had the busiest of shifts over the past week, I have not been looking after a single ortho patient. I have had respiratory, a confused old lady, a? heart attack lady and nothing I was expecting. There seems to be no sense to what is on the ward, and I really don't like not knowing about the patients, not knowing what will be there and having to look everything up.

Analysis

This passage focusses on expectations versus reality. Vicky outlines that the patients on the ward are more challenging than they initially thought. She expresses frustration at not having all orthopaedic patients as expected and feeling annoyed by the constant changing and moving of patients. This highlights the disconnect between her expectations and the reality of the work on the ward.

She mentions that she took the job specifically to look after surgical patients and have a sense of order and organisation. She expresses dissatisfaction with the lack of sense and

unpredictability in the patient assignments and the need to constantly look up information. This emphasises the preference for a structured and planned work environment.

She mentions the busiest shifts she has had, where she has not been looking after orthopaedic patients as expected and expresses frustration at not knowing about the patients and having to constantly look up information. This stresses the challenges of adapting to a new patient population and the need to quickly acquire knowledge and skills in unfamiliar areas.

This explores themes of expectations versus reality, desire for order and organisation, and adaptation and challenges. These contribute to the interpretation of Vicky's experiences in her new job and her struggle to adjust to the different patient assignments and the unpredictability of the work. It emphasises the need for flexibility and the ability to adapt in a dynamic healthcare environment.

Mid-Point Entries: excerpts of entries from months 4/5

I am struggling with the work; we are coming up to Christmas now and the ward is full of crumbly medical patient and all the ortho lists have been cancelled. It has been like this for weeks and now I am getting a little fed up with the ward. Everyone seems to just accept that the ward has changed into something it is not meant to be. I was chatting with WM, and she was just 'well that is how its is' and was sort of is resigned to that. There is not a single ortho admission, but the ortho emergencies do not come with us.

I worked Christmas and have had New Year off; in a way I wish I had done it the other way round. Working on Christmas Day and Boxing Day was really tough, the ward was so busy, we had been told we would close 6-8 beds over the Christmas period because the elective ortho had been cancelled, I mean we stopped doing elective stuff over a month ago and we have been chocker with poorly medical patients ever since. I am getting quite good at looking after respiratory patients, all I seem to do is prep nebulisers and do obs, this really isn't what I thought I would be doing.

I have finally got my IV certificate, it has taken a really long time to get sign off, but at least I have done it now. It gives so much more freedom to get things done if you can do the IVs, and the others were nagging me to get it done as well. It has been really difficult to get things done or finished in terms of my own development because of the workload, you get to work and just need to get your head down, the patients take up so much time and caring from them is so much tougher than I thought it would be.

Analysis

There was a discussion of frustration and dissatisfaction with the current work situation. Vicky outlines struggling with the ward being full of medical patients instead of orthopaedic ones. She expresses frustration at the cancellation of orthopaedic lists and feeling fed up with the ward's current state. She highlights the acceptance of this situation by others, including the WM. This emphasises her discontentment with the change in the ward's focus and the impact it has on her work experience.

Vicky also mentions working on Christmas Day and Boxing Day, finding it tough due to the high workload and busy ward. She expresses a desire to have had New Year off instead. This highlights the difficulties of working during a busy period and the impact it can have on her well-being and work-life balance.

There was a discussion of professional development and the struggle to find time for it. Vicky reveals finally obtaining their IV certificate after a long process of getting sign-off. She highlights the benefits of having this certification and the encouragement she received from others to complete it. However, she also mentions the challenges of finding time for personal development due to the workload and the demanding nature of caring for patients. This underscores the importance of ongoing professional development and the obstacles that can arise in pursuing it.

The themes of frustration and dissatisfaction with the work situation, the challenges of working during the holiday season, and the struggles to find time for personal and professional development. These contribute to the portrayal of the experiences in her current job, highlighting her discontentment with the change in the ward's patient population, the difficulties of working during a busy period, and the obstacles she faces in pursuing her own growth and development.

End of Enquiry Entries: excerpts of entries from month 6

I can't believe I have been on the ward for 6 months; it is getting more organised now, we have been doing lots more ortho now. Soon after New Year, the elective lists started again and that was a relief. There are still always a few stragglers on the ward, the difficulty is their docs are never around, so things take twice as long, I mean this week it me 3 days to get some antibiotics changed and reviewed. The lady was quite poorly and never got a morning review. The ortho team are on the ward at 8ish before theatre and we do a whole ward round and get a plan for pretty much everyone right at the start of the day, which makes a real difference for everyone….

Analysis

The passage identifies the improvement in organisation and the increased focus on orthopaedic cases on the ward. Vicky mentions that after the New Year, the elective lists for orthopaedic surgeries started again, which was a relief. This indicates that there has been a shift towards more orthopaedic cases on the ward, aligning to her expectations and preferences.

She highlights the importance of having the orthopaedic team present on the ward early in the morning. She mentions that the team conducts a whole ward round and establishes a plan for the patients at the start of the day. This organised approach is seen as making a real difference for everyone, as formulated by Benner (1984) this organised approach suggests that it improves efficiency and patient care.

She also states the challenges that arise when the patients' doctors are not readily available. This results in delays in getting antibiotics changed and reviewed, affecting patient care, and potentially prolonging their recovery, which confirms her feelings of dissatisfaction with her practice.

Overall, the increased organisation and the focus on orthopaedic cases, as well as the challenges posed by limited availability of doctors, are the key themes in this section. These themes contribute to the representation of Vicky's experiences on the ward and the impact of improved organisation and teamwork on patient care.

4.6.3 Sections from the Interview

Excerpts from the interview with Vicky- March 2020

Vicky was shown the conceptual framework developed from the literature and was asked to comment.

Looking at the flow on this illustration what do think, what is your impression of the development of the different themes-

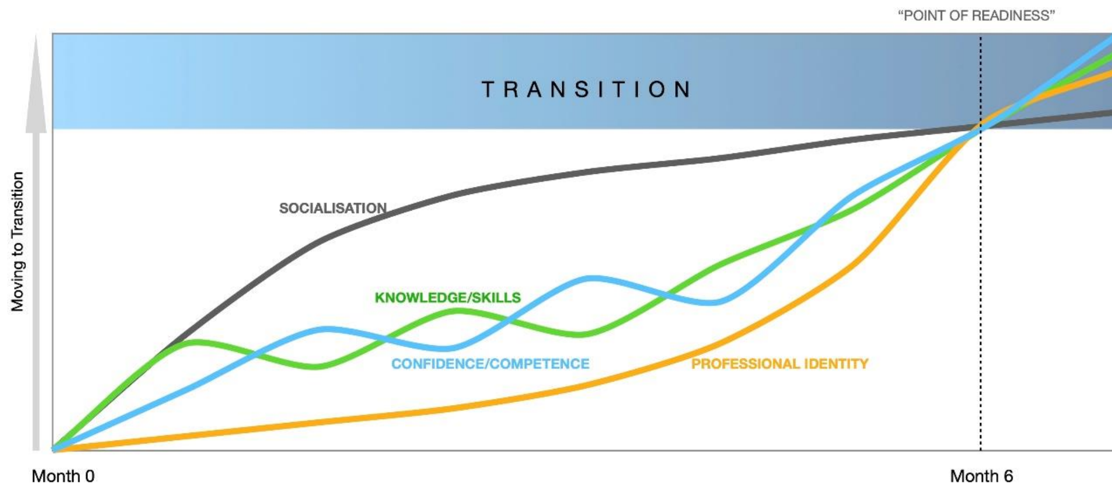

Figure 5: Conceptual Framework

Oh, wow, that's looks complicated!

I would say some of my lines went up much slower than that, and I am not really sure where the 'finish' line is. I would say I am starting to feel a little confident and competent in terms of the job. The knowledge and skills lines are probably a bit more complicated; I think I am getting better in relation to the ortho stuff. But the 2 things are not related… I mean I got better at stuff, was able to do things but I would not say I was confident... that took more time...

I think I socialised well; I mean I settled quickly, the induction stuff was quite quick, and I got used to the ward and everything quickly, was given in the Induction and the ward staff were all friendly. But then things changed… the ward changed, the patients mainly and some of the staff changed… some left, some were off sick, and I was just a bit lost after a while.

What do you mean?

I don't know, the job I took, elective ortho with the staff I met at the start all changed quite quickly. Some of the staff went and then with all the medical patients, so it just was not what I expected or what I wanted.

And Professional Identity?

I felt like a staff nurse from the start, sort of put on the uniform and got on with it. So, I felt like a staff nurse, I suppose that is what I think it means. I mean I was doing the job and stuff...

You talked about things not being what you expected, can you explain that?

When I took the job, which I have to say was ages before I started… when I think back did, I take this job for the right reasons. I wanted a nice job in an organised ward. I briefly did ortho as a student and it was so organised, calm, and predictable in a way. So, when this job came up, I applied and got it. But when I got there, it was not like I expected, I don't know whether that was the patients etc or the staff….

You keep saying organised and calm, what do you mean?

Like organised, so know what is going to happen and knowing what the people coming in have wrong with them and then knowing how to manage things. What I don't like is not knowing what is wrong with people and how to get them better. You can come into work and have no idea what you are going to face. Like with a planned surgical ward that should not be the case. I know all patients are different and go through things differently, so 2 arthroscopies are not the same but sort of similar. But after a couple of months on the ward…. Every day the place was full of loads of different things, anything from an MI to a COPD, and there is no rhythm nor reason to what is going to be there, and I really don't like it.

So, what now?

I am not going to stay here; I think I might look at a clinic job. I think I could get a band 6 in a clinic or GP setting, or something like that. I don't like the ward stuff and I hate doing nights, so a clinic job would be perfect, I think. But you never know….

So, do you think you have made a successful transition from student to staff nurse, qualified nurse?

Yes! I feel like a staff nurse now, I mean maybe not in the right place…. But that is not the point, I feel ready and prepared for whatever. What is quite nice is that now I can go wherever… I mean wherever I want…

Summary

The section of the interview reflects on Vicky's transition from being a student nurse to a qualified staff nurse. Several key points emerge from this reflection. She outlines a discussion of her confidence and competence in the job, noting that while she feels more competent in terms of her skills, they did not feel confident right away. She highlights the distinction between acquiring skills and feeling confident in applying them, indicating that confidence took more time to develop.

She also discuss her socialisation and settling into the ward. Initially, she felt well-inducted and quickly adapted to the ward environment. Nevertheless, she experienced changes in the ward, including shifts in staff and patient demographics, which left her feeling lost and disconnected.

Regarding professional identity, she states that she felt like a staff nurse from the start, as she was able to perform the job responsibilities. However, she expresses disappointment in the job not meeting her expectations, particularly in terms of organisation and predictability.

She emphasises her preference for an organised and calm working environment, where she knew what to expect and how to manage patient care. She expresses frustration with

the unpredictability and lack of rhythm in the ward, where patients with various conditions are admitted without a clear pattern.

Looking ahead, Vicky expresses a desire to explore other job opportunities, such as a clinic or GP setting, where she can avoid night shifts and work in a more structured environment. She highlights the flexibility of her qualification, allowing her to pursue different avenues. Despite her dissatisfaction with the current job, she believes she has successfully transitioned from being a student to a qualified nurse. She feels ready and prepared for any role, although she acknowledges that her current placement may not be the ideal fit for her.

Overall, this explores the themes of confidence and competence, socialisation and adaptation, professional identity, expectations versus reality, and future career aspirations. It highlights Vicky's journey of self-discovery and the importance of finding the right fit in terms of work environment and job satisfaction.

4.7 Development of Themes from the Case Studies

Themes in this research refer to overarching concepts or patterns that emerged from the data, reflecting the collective construction of meaning. Sub-themes are more specific categories that fall under a broader theme, offering a finer-grained understanding of the data. I then focus not just on describing these themes but also on analysing how they are created, sustained, or challenged within social contexts. Themes and sub-themes were identified through the interpretive and constructionist analysis, using the methods of coding in qualitative research to map the complexities of the social reality of transition in clinical practice.

Following the repeated and thorough review of both the diary entries and the interview transcript, using the Braun and Clarke (2006, 2022) principles, I used the colours attributed to each themes to identify and map the content. This allowed me to create the themes and sub-themes. This analysis illustrated that there were distinct phases of transition, initially phase one focussed on the ‘finding your feet’ and identified as building connections. The case studies highlighted the ideals of attempting to establish themselves as practitioners in the clinical setting, undertaking their induction process, with a clear development of the theme of ‘Building Relationships.’

Phase two concentrated on feeling 'Lost at Sea' and was described as challenges to confidence and competence / knowledge and skills. This was followed in the diaries with a discussion of feeling 'lost' at times while attempting to establish themselves within their respective teams, develop the confidence and competence in the clinical settings and to advance their knowledge and skills in practice.

Phase three explores when 'things' start coming together and was titled as becoming and knowing. Then the theme of the influencing factors, both positive and negative which will impact the transition was discussed. The case studies then proceeds to outline how things in clinical practice and the wards/ units started to make sense, the diaries discussed how the participants described how things were coming together, especially in terms of the development of additional skill and the ability to work in practice with confidence.

Significant events significantly influenced factors in a positive and negative. All of the case studies outlined the effect of external factors, environmental, organisational, personal which had an impact on each on their transitions.

From the Interviews

The interviews served as a mechanism to review the conceptual framework and functions as the interpretive lens through which the literature could be interpreted and understood by the participants. This iterative process leads to a revised version that better supports their transition from the initial phase of research induction to subsequent phases. Participant comments and visual aids were incorporated to enrich the framework and provide additional layers of context.

Discussing the distinct phases of transition highlights the evolution of understanding from the perspective of the participants. Initially, induction involves familiarisation with the existing body of knowledge and methodological approaches. This phase may include training in research methods or engaging with theoretical materials. As the researcher transitions into active inquiry, they further refine the conceptual framework based on their developing insights and experiences. Subsequent phases may involve data collection and analysis, where the influence of the framework becomes more pronounced in interpreting results.

Various factors play significant roles in the transition process. Unexpected events, mistakes, and management changes can disrupt research progress, necessitating adaptability and revision of the original framework. Conversely, positive events can reaffirm the chosen theoretical perspective and accelerate development. These experiences contribute to the growth of organisational intelligence within the research context – an enhanced capacity to draw lessons from a broad array of experiences, integrate them into the existing framework, and apply them constructively to future challenges.

Similarly, the development of personal emotional intelligence and resilience among research participants is crucial. Emotional intelligence allows for a more nuanced negotiation of interpersonal dynamics in the research process, while resilience provides the capacity to handle setbacks and persist in the face of challenges of clinical practice. Both are significant in managing transitions and ensuring continuity in research endeavours.

Ultimately, this research was participatory and reflexive, with my own perspectives, theoretical frameworks, and personal development intricately intertwined with the research process. The theoretical framework is not static but continually reshaped through engagement with the participants, evolving understandings, and the reflexivity – informing decisions and interpretations as the transition from induction to a mature research phase is achieved.

4.8 Case Study Summaries

The diary entries and the interview data confirm the transition from student to qualified practitioner is a complex and an individual journey. The socialisation process, the development of knowledge and skills, confidence and competence and professional identity occurs slowly over several months, but it is the external factors that have a substantial impact on an individual's progression. Some factors can be 'controlled' or managed, and some are outside either the individual's or the organisation purview of influence.

Three key factors emerged from the themes:

1. Feeling part of team and settling in had a significant impact of the ability of the practitioner to confidently perform their role and deliver safe care.
2. Multiple factors influenced the time it took for the practitioner to reach the 'point of readiness' and feel that transition had occurred.
3. External factors influence transition, especially knowledge of the organisation and development of organisational intelligence.

The themes or factors underpin our understanding of transition and demonstrate that the practitioner had many issues influence the speed and ease of transition from student to confident, competent practitioner.

5. Discussion

This chapter focuses on a discussion of all the data including the diary, annotated notes, and the interview transcripts as well as the development of the themes from the data. The emerging themes arisen from the themes of the previous chapter, these emerging themes form the discussion provided by crucial data exploring and illuminating the area of study. A critical stance, as a constructionist researcher was taken towards taken-for-granted knowledge, allowing me to question the assumption regarding transition and exploring the viewpoints of the NQNs and how they had had made sense of the process. The conceptual framework developed from the literature will be discussed and revised considering the emerging themes and the finding from the study.

5.1 Discussion of Themes from Diary and Interview Findings

Following analysis of the diary and interview transcripts, specific themes became evident and were prominent in both series of cases. The themes emerged from the first 3 cases and then were further confirmed by the second group of cases. These themes resonated with me personally, from my own experiences of qualifying and starting my professional journey from newly qualified to confident and capable practitioner. The analysis illustrated that there were distinct phases of transition, initially phase one focussed on the 'finding your feet' and identified as – **Building Relationships**, phase two concentrated on feeling 'lost at sea' and was described as – **Challenges to Confidence and Competence / Knowledge and Skills**, phase three explores when 'things' start coming together and was titled as – **Becoming and Knowing.** Then the theme of the influencing factors, both positive and negative which will impact the transition was discussed. These were identified as the themes and the sub-themes generated from the data.

5.1.1 Building Relationships

Building relationships and becoming part of the team in clinical practice was seen to be essential for providing effective and patient-centred care. It involves establishing trust, effective communication (Woodhams, 2014), and mutual respect between the team members and patients (Wray et al, 2021). All the participants, in both groups mentioned that it was important that trust and effective communication were vital in forming

relationships and practicing safely, in order to start feeling settled and to overcome the feeling of being 'lost at sea.'

> *I feel I have settled well. I am getting on with everyone and am enjoying it (Charlie-P1c)*

Initially, building relationships in clinical practice is crucial for establishing trust. Patients are more likely to feel comfortable and open up about their health concerns when they trust their healthcare provider. Trust is built through consistent and honest communication, being empathetic and understanding, and delivering on the clinical requirements of the setting.

> *It came from the patients too, I started to feel like they trusted me (Bob- P1a)*

Healthcare professionals should take the time to listen attentively to their patients, validate their concerns, and provide clear explanations about their conditions and treatment plans (Gerrish, 2000).

Effective communication is another key component of building relationships in clinical practice (NMC, 2015). As the participant settled into the clinical settings, they strived to communicate clearly with each other, during handover and in a way that patients can understand.

> *Things are starting to make sense, I am settling in, knowing what to do when and knowing who to ask what and stuff (Bob- P1a)*

Using jargon-free language and avoiding complex terminology can help the participants and their teams feel more engaged in the care of patients and the workplace. It is also important to actively involve patients in decision-making processes, ensuring that they have a say in their treatment options. Regularly checking in with patients and providing updates on their progress can further strengthen the patient-practitioner relationship, by establishing oneself as a competent practitioner.

I think when I started being able to manage a patient on my own. There are still things I am learning, like every day, but I think I can manage most things now and really feel part of a team (Zoe- P2b)

Mutual respect is a fundamental aspect of building relationships in clinical practice. Healthcare professionals should treat patients with dignity, respect their autonomy, and acknowledge their values and beliefs. Respecting patients' cultural backgrounds, religious beliefs, and personal preferences can help create a safe and inclusive environment (Clare and van Loon, 2003). It was important to remember that patients are individuals with unique experiences and perspectives, and their input should be valued and incorporated into their care (Duchscher, 2009).

To build strong relationships in clinical practice, noted a number of key strategies for relationship building and consolidation communications during transition. Spend quality time in practice and with senior colleagues, the meant allocating sufficient time for support both with patients and 'role models' to ensure that patients feel safe, and colleagues feel respected understood. When discussing relationship building, senior staff were described as by the participant in various ways, cited below.

…she is great, really chilled and so happy to chat and teach and stuff (Zoe- P2b)

*It was great to spend time, chatting (*with colleagues*) about the patients after handover…I mean just to check stuff (Charlie- P1c)*

Be responsive to requests from peers, and therefore promptly respond to inquiries and concerns, whether in the form of verbal and written communication formats allowing the participants to demonstrate the abilities. This demonstrates that the patients' needs are prioritised and reinforce trust and translate this into a verbal report. As well as continuing to show empathy and compassion, understanding, and acknowledging the emotional aspects of patients' experiences. Show empathy by providing emotional support and reassurance from senior staff member to the newly qualified practitioner during difficult times for both peers and patients allows for the participant to improve their communication skills (Halpin et al., 2017).

After a while I started to know what to do and what to say…I even started to feel able to talk things through with the docs, physios, and others. (Susie -P1b)

I feel like I am getting better at the reports…. (Helen- P2a)

I didn't think things with the patients would change so much, they treat me differently, it is nice, and I feel more connect with them and their families … (Charlie-P1c)

Participants described trying to provide consistent care by seeing patients regularly. This allowed them to develop a deeper understanding of patients' medical histories, preferences, and needs.

It's good to be allocated our own patients and stay with them…. Start to really understand what is going on and start to know what to do. (Zoe- P1b)

As part of the support and mentorship during transition, the participants regularly sought feedback from peers, colleagues, and patients to understand their experience and identify areas for improvement. This demonstrates a commitment to patient-centred care and fosters a culture of continuous improvement, senior colleagues supporting and guiding the participants allowed for that development and increase in confidence.

I was supported and helped, I mean really supported, I had someone there the whole time at the beginning, so I felt pretty confident, competence was something that followed especially when SSN told me how well I was doing… (Zoe -P2b)

Consequently, building relationships in clinical practice is vital for providing effective and patient-centred care. Trust, effective communication, and mutual respect are the foundations of strong patient-provider relationships supporting the transition process (Duchscher, 2012, Graf et al., 2020, Hampton et al., 2020, Halpin et al., 2017).

By implementing strategies aimed at fostering meaningful connections, participants can create a more supportive and empathetic environment for both patients and colleagues. Spending quality time with patients demonstrates a commitment to understanding their needs and concerns, while also enabling the development of rapport and trust. Being responsive to patient needs and feedback showcases a willingness to adapt and improve,

enhancing the overall experience. Demonstrating empathy towards patients can positively impact their emotional well-being and sense of being heard and understood. Ensuring continuity of care further strengthens the patient-practitioner relationship, instilling confidence, and comfort. Seeking feedback from both patients and colleagues creates a culture of open communication and continuous improvement. Overall, these strategies contribute to a more empathetic and cohesive workplace, ultimately enhancing the quality of care and interpersonal relationships.

5.1.2 Challenges to Confidence and Competence / Knowledge and Skills

Clinical practice can be a challenging and demanding field, requiring healthcare professionals to constantly update their knowledge and skills. However, there are several challenges that can impact confidence, competence, and the acquisition of knowledge and skills in clinical practice. These challenges will be discussed and their impact on transition will be presented. Confidence/competence are discussed and analysed together, suggesting that they are linked and 'ebb and flow'. This concept was discussed in the narrative review in conjunction (O'Driscoll et al, 2022), and is interwoven and interlinked through the research. I have throughout discussed and thought about confidence/competence together, and during the interviews, asked about them together, and my participants talked about them as interwoven.

One of the primary challenges faced by practitioners on qualifying in clinical practice is the rapid advancement of medical knowledge and language. New research findings, treatment guidelines, and technological advancements change and develop regularly, making it difficult to stay up to date (Alteren, 2019). This constant influx of information can lead to feelings of inadequacy and a lack of confidence in one's knowledge and skills.

> *.. but feel like I am back to square one all the time… (Susie- P1b)*

> *That bit...* (Clinical Information*) … is taking some time to get my head around (Bob- P1c)*

To facilitate and in turn overcome this challenge, newly qualified staff, the participants engaged in active learning through continuous professional development activities such

as attending induction sessions, workshops, and ward/unit teaching to ensure that the knowledge was consolidated. Collaborating with colleagues, participating in journal clubs, and subscribing to reputable medical journals can also help staying informed about the latest developments in the field, (Boud and Hager, 2012, Patterson et al., 2017) an essential aspect for all in clinical/ medical practice.

Another challenge that can impact confidence and competence in clinical practice is the complexity of patient cases. Healthcare professionals often encounter patients with complex medical conditions, multiple comorbidities, and unique healthcare needs. Managing such cases requires a deep understanding of the underlying pathophysiology, accurate diagnosis, and appropriate treatment planning. Lack of confidence in handling complex cases can lead to feelings of incompetence (Edwards et al., 2015, Parker et al., 2014). To address this challenge, the participants sought guidance from experienced colleagues or specialists. Structured mentorship would have been recommended (Whitehead et al., 2016, Whitehead et al., 2013) but was not offered or in place in the clinical settings. Collaborating with interdisciplinary teams and engaging in case discussions can also enhance knowledge and skills in managing complex cases.

> *Certain people took me seriously for the first time I think even some of the docs were really nice and did what I asked, which was weird. (Bob-P1a)*
>
> *I was expecting some supervision or support from the qualified... (Helen- P2A)*
>
> *That make such a difference… because you know that if you can't manage or don't know what to do…then there is someone there to help, or advise, sort of support, so you feel like a proper staff nurse. (Zoe-P2b)*

There was a distinct difference in the experiences of Helen and Zoe, Helen was left to her own devices and at time felt 'out of her depth' and not know how to learn or consolidate her knowledge (Jayne et al., 2005). Whereas Zoe had a different experience, her learning and development was supported and scaffolded by experienced clinicians (van Rooyen et al., 2018) which facilitated her transition. Time constraints and workload pressures are additional challenges that can impact confidence and competence in clinical practice. The clinical staff often face heavy workloads, long hours, and limited time for patient interactions and learning opportunities. This can result in a lack of time for self-reflection,

skill development, and staying updated with the latest evidence-based practices (Nyhan and Howlin, 2021). To overcome this challenge, the participants are advised by their colleagues to prioritise self-care and create a work-life balance. Allocating time for personal growth, reflection, and skill development is essential (Ortiz, 2016). Additionally, the organisations should support their staff by providing adequate resources, staffing levels, and opportunities for professional development (Zheng et al., 2023, Soerensen et al., 2023).

> *Sometimes I just needed some downtime…to think and get used to things, but there was never any time on the ward... (Charlie- P1c)*
>
> *There are still things I am learning, like every day, but I think I can manage most things now and really feel part of a team…. (Zoe- P2b)*

Another challenge that can impact confidence/competence in clinical practice is the fear of making mistakes or errors in patient care. All professionals are responsible for the health and well-being of their patients, and the fear of making a mistake can be overwhelming (Wieland et al., 2007). This fear can lead to a lack of confidence in one's abilities and hinder professional growth. To address this challenge, clinical settings need to embrace a culture of learning from mistakes and near misses. Openly discussing errors, conducting root cause analyses, and implementing strategies to prevent future errors can help foster a culture of continuous improvement (Whitehead et al., 2016). Seeking support from colleagues, supervisors, or professional organisations can also provide guidance and reassurance during challenging times. Some of the emotive language cited by the participants supports these feelings of being 'useless' and being at fault at times, whereas supportive, senior, experienced colleagues could overcome these feelings with encouragement and guidance.

> *I was completely useless; I had no idea what to do. All I did was call for help; I had no clue. (Susie- P1b)*
>
> *I knew something was off, but nobody would listen… (Susie- P1b)*
>
> *But it was my fault we took so long to find her - Everyone was great, but it was my fault she had to die in a loo. (Charlie- P1c)*

Therefore, there are several challenges that can impact confidence, competence, and the acquisition of knowledge and skills in clinical practice. The rapid advancement of clinical knowledge, complexity of patient cases, time constraints, workload pressures, and the fear of making mistakes are some of the challenges faced by healthcare professionals. However, by engaging in lifelong learning, seeking mentorship and guidance, prioritising self-care, embracing a culture of learning from mistakes, and seeking support from colleagues and professional organisations. Healthcare professionals can overcome these challenges and continue to provide high-quality care to their patients when they transition to a qualified practitioner (Whitehead et al., 2013, Rushforth and Ireland, 1997, Monaghan, 2015).

Although 'most' of the participants echoed the discussion of competence and confidence linked together, but two of the participants mentioned that they felt they were different and possibly not linked.

> *You look at the lines about confidence and competence and like they track together, but I am not sure they always do, (Bob- P1a)*
>
> *I mean I got better at stuff, was able to do things but I would not say I was confident... that took more time... (Vicky- P2c)*

Bob and Vicky suggested that the concept were not 'always' linked together. At times, being 'able to do things' was related to competence and being able to undertake tasks (Garside and Nhemachena, 2013: Aldosari at al, 2021). Being able to undertake key nursing skills such as blood pressure monitoring and drug delivery could be the key to competence. While competence could be a different notion, Bob felt confident in his practice, Vicky felt that her confidence in clinical practice needed further development and as suggested by Pfaff et al, (2014) needed to be facilitated by a supportive environment and a collaborative team.

5.1.3 Becoming and Knowing

Feeling settled and becoming an established practitioner in clinical practice is a process that takes time, experience, and a sense of personal and professional growth (Mellor et al., 2017). It involves developing and building a strong foundation of knowledge and skills, building confidence in one's abilities, and establishing a sense of belonging within the

healthcare team. Exploring the factors that contribute to feeling settled and becoming an established practitioner in clinical practice will be discussed.

One of the key factors in feeling settled and becoming an established practitioner is acquiring a solid foundation of your own knowledge of the clinical setting. Clinical practitioners must continuously update their knowledge base and refine their clinical skills to provide high-quality care. This involves staying up to date with the latest research, guidelines, and best practices in their respective fields. Seeking mentorship or guidance from experienced colleagues can also provide valuable insights and support in professional development and thinking (Kumaran and Carney, 2014).

> *when things started making sense, I started do things automatically…. (Bob-P1a)*
>
> *Looking after the patients stated to become clearer, I mean what to do and when… (Helen- P2a)*
>
> *Being part of things, learning on the ward, teaching session etc really helped putting things in place... (Charlie- P1c)*
>
> *Knowledge and skills were a vertical line…like straight up, I was learning all the time. (Zoe-P2b)*

Building confidence in one's abilities is another important aspect of feeling settled and becoming an established practitioner. Confidence comes with experience and successful patient outcomes (Tuckett et al., 2017). Over time, practitioners gain a deeper understanding of various medical conditions, become familiar with different treatment approaches, and develop effective communication and decision-making skills. Celebrating small victories and reflecting on positive patient outcomes can boost confidence and reinforce a sense of professional competence. Additionally, seeking feedback from patients and colleagues can provide valuable insights and help identify areas for improvement (Shipman, 2014), as this confirmation of performance, of skill can affirm to the practitioner they are making the transition to confident clinician.

> *She was great- I had to admit to felt really guilty, people keep telling me I have nothing to feel guilty about but that is easier said than done. (Charlie- P1c)*

Yeah- I think I have now but definitely only recently… it may have just all come together. (Helen-P2a)

Also articulated clearly by the practitioner when they able to recognise the transition in themselves.

I feel like a staff nurse now… (Vicky-P2c)

Establishing and solidifying a sense of belonging within the healthcare team is also crucial for feeling settled and becoming an established practitioner (Wakefield et al., 2022). Collaborating effectively with colleagues, nurses, and other healthcare professionals is essential for providing comprehensive and coordinated care. Building strong relationships with team members, communicating openly and respectfully, and actively participating in interdisciplinary discussions can foster a sense of belonging and create a supportive work environment (Halpin et al., 2017). Seeking opportunities to contribute to the team, such as participating in quality improvement initiatives or serving as a mentor to junior colleagues, can further enhance one's sense of professional identity and establish a reputation as a valued team member.

They are letting me do more now... I think because they trust me to get things done. (Bob-P1a)

I look back since I qualified, I can't believe how much I have changed and how much I can now do. (Zoe-P2b)

Embracing a growth mindset and maintaining a commitment to lifelong learning are essential for feeling settled and becoming an established practitioner. Clinical practice is constantly evolving, and healthcare professionals must adapt to new research findings, technologies, and treatment modalities. Embracing a mindset of continuous improvement and being open to new challenges and opportunities can help healthcare professionals stay engaged, motivated, and fulfilled in their professional careers (Roberts and Johnson, 2009).

I am definitely getting better all the time, and I think I am starting to really know what to do... (Helen- P2a)

> *But more than that, every single day, I was taught… like actually taught something, either a skill or we went through the gas or …. I mean not a single day went by without me learning something… (Zoe-P2b)*

In conclusion, feeling settled and becoming an established practitioner in clinical practice is a journey that requires a solid foundation of knowledge and skills, confidence in one's abilities, a sense of belonging within the healthcare team, and a commitment to lifelong learning (Pennbrant et al., 2013). By continuously expanding their knowledge base, building confidence through experience, establishing strong relationships with colleagues, and embracing a growth mindset, healthcare professionals can navigate the challenges of clinical practice and thrive in their professional roles (Laschinger et al., 2016).

5.2 Discussion of Influencing Factors

In clinical practice, external factors such as the environment, organisational issues, and personal challenges can significantly impact the performance of the participants as they negotiated transition. These factors can influence job satisfaction, work-life balance, and overall well-being, ultimately affecting the quality of patient care. The impact of these external factors on performance and transition in clinical practice, Aldosari et al (2021) discussed the influence of multiple internal and external factors on transition.

The environment in which healthcare professionals work plays a crucial role in their performance. Factors such as the physical layout of the workplace, setting, and availability of necessary resources can all impact efficiency and productivity (Missen et al., 2014). A cluttered or disorganised workspace can create distractions and hinder workflow. On the other hand, a well-designed and properly equipped environment can promote a sense of calm and facilitate effective patient care.

> The environment is *… Not helped of course by people being on holiday and bed closures. (Bob-P1a)*

Additionally, the availability of essential equipment, supplies, and technology is vital for healthcare professionals to deliver safe and efficient care, and although not directly

involved in the journey, it can impact on the ‘smooth’ transition to a competent practitioner.

> *The Ward is newly re-furbished, really clean and fancy- which is quite nice, (Vicky-P2c)*
>
> *Things are a real mess; it makes looking after people/patients I mean really difficult... (Susie-P1b)*

Organisational issues, such as staffing levels, workload, and administrative burdens, can also impact performance in clinical practice. Insufficient staffing levels can lead to increased workload and stress for healthcare professionals, potentially compromising patient care. Heavy workloads can result in work-related stress such as fatigue, burnout, and decreased job satisfaction (Guveli et al., 2015, Halpin et al., 2017). Furthermore, excessive administrative tasks and documentation requirements can take away valuable time from direct patient care, leading to frustration and a sense of being overwhelmed (Malouf and West, 2011). It is crucial for healthcare organisations to address these issues by ensuring adequate staffing, providing administrative support, and promoting a healthy work-life balance (Kumaran and Carney, 2014).

> *…still short staffed and had really poorly people. (Bob-P1a)*

As cited by Bob, the level of staffing and impact of the acuity of the patients has a significant impact on the transition journey for each participant. This facilitated the practitioner to either falter or fly, in Bob’s case he was able to cope with clinical practice, even when the staffing and patient acuity were extremely challenging. Others, such as Helen needed time to think and assimilate to clinical practice.

Personal challenges faced by healthcare professionals can also impact their performance in clinical practice. Personal issues such as health problems, family responsibilities, or financial concerns can create stress and distraction, making it difficult to focus on patient care. Additionally, the emotional toll of dealing with patients' suffering and challenging situations can impact mental well-being and overall job performance. It is important for healthcare professionals to prioritise self-care, seek support from colleagues and

supervisors, and access resources such as counselling or employee assistance programmes when needed.

Additional learning opportunities, courses, and supportive teaching events can assist the practitioners in navigating transition with confidence and competence.

> *I think things are good- I am hoping to do a leadership course next month and a think I will stay here for a little bit longer. (Charlie- P1c)*
>
> *you have* ***so much*** *to learn. It felt a little overwhelming to be fair… at the beginning but the team are always there… supporting teaching etc… they teach all the time, there isn't a day that goes by when you don't learn something new…(Zoe-P2b)*

To mitigate the impact of these external factors on performance in clinical practice, healthcare professionals and organisations can implement several strategies. Healthcare professionals should prioritise self-care, establish a work-life balance, and seek support when facing personal challenges (Guveli et al., 2015). Engaging in stress-reducing activities, such as exercise, mindfulness, and hobbies, can help maintain mental and physical well-being. Organisations should prioritise employee well-being by implementing policies that promote work-life balance, providing resources for stress management, and fostering a supportive and collaborative work culture. Additionally, open communication channels between healthcare practitioners and organisational leadership can help address concerns and find solutions to organisational issues that impact performance (Hampton et al., 2020, Duclos-Miller, 2011).

> *I felt really great- WM was on in the morning and we had a chat in the office before I went home, she was impressed and gave me a really great feedback….* (Bob- P1a)
>
> *Finding things really difficult with SSNa and SSNb gone and WM still on mat leave, things might get better when she is back!* (Helen- P2a)

5.3 Revision of Conceptual Framework

Following analysis and discussion the ideas of socialisation, competence and confidence, knowledge and skills and professional identity are presented moving towards a threshold or a 'point of readiness' which signifies the time when the practitioners 'transitioned' in practice, consolidating their clinical practice and move forward to embark on their future career. This **'revised'** conceptual framework represents the combination of themes from the analysis of the data into a visual interpretation of how they merge to take the individual over the threshold of 'transition' at the 'point of readiness' resulting in a capable confident practitioner. The new conceptual framework differs from the previous version presented from the literature as it presents a convergence or combination of themes and adds the impact of certain positive and negative influences and represents a new contribution of knowledge.

Figure 6 below more accurately represents the move to transition for practitioners.

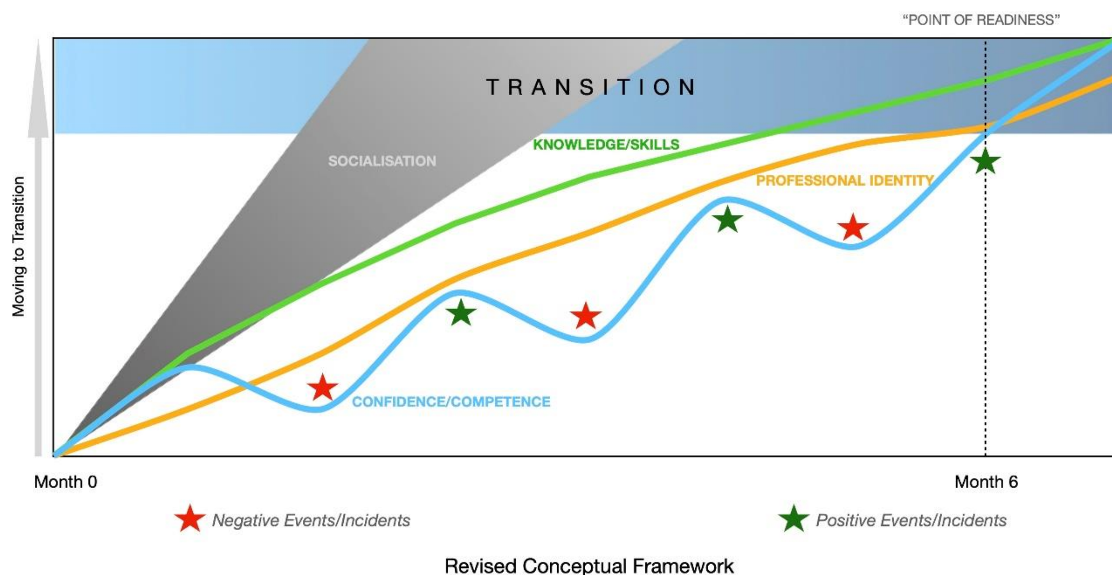

Figure 6: Revised Conceptual Framework

- Socialisation occurs more rapidly and is clearly influenced by personal factors such as your knowledge of the setting or environment. Practitioners who have worked in the setting previously are socialised more rapidly than those who are completely new to the setting.
- Knowledge and skills progresses rapidly on qualifying and continues with practice and is considered entirely independent of confidence and competence, and in all six participants did increase autonomously.
- Confidence and competence ‘ebbs and flows’, are interwoven and develops slowly over time, this is significantly influenced by factors external to the individual such as critical events, personal issues, organisation structures and clinical environment and varies between individuals.
- Professional identity builds constantly and rapidly initially and levels after 5/6 months in all participants once the practitioner have ‘settled’ into their role.
- It is the combination of all the themes, a combination that binds together to achieve a successful transition.

5.4 Summary of Discussions

To summarise the journey from qualifying as a nurse to a confident practitioner is influenced by multiple factors. Building and forming relationships is an influential factor in the socialisation process as part of the transition. The external factors such as the environment, organisational issues, and personal challenges can significantly impact the performance of healthcare professionals in clinical practice. It is essential for healthcare practitioners and organisations to recognise and address these factors to ensure optimal patient care, promote the well-being of healthcare professionals and facilitate the transition of practitioners. By creating supportive work environments, addressing staffing and workload issues, promoting work-life balance, and prioritising self-care, healthcare professionals can navigate these external factors and perform at their best. A structured process of transition should include a supported period of socialisation, including induction, personally tailored knowledge, and skills development, mentoring to facilitate confidence and competence and professional identity in combination.

6. Conclusions

This chapter outlines the key findings of the study, how they link to the study's aims, the development of a revised conceptual framework. This aids the understanding of the complexities of transition for nurses at the point of qualification to assist in facilitating this transition and make conclusions from the study.

6.1 Key Findings

The findings of the study reveal that a number of significant factors influence transition from student to confident practitioner. An effective structured and focussed socialisation process including induction, mentorship/ preceptorship and organisational interventions play a crucial role in the development of practitioner's confidence in their professional abilities, supported by Whitehead *et al,* (2016) and a recommendation of HEE (2022) that a formal preceptorship programme should be available to ALL practitioners at the point of registration. Participants reported that through interactions with more experienced colleagues, appropriate support, and exposure to clinical events, both positive and negative, they gained a sense of assurance in their skills and knowledge. This increased confidence and competence was attributed to the validation and support received from peers and mentors during the socialisation process, and led to transition to a confident practitioner occurring at approximately six months post qualifying as a nurse (Ortz, 2016; Duchscher, 2009; Duchscher, 2012).

In terms of competence, the study found that the socialisation process significantly contributed to the participants' acquisition of new knowledge and skills. Through observing and participating in various tasks and projects, individuals were able to learn from their colleagues and develop a better understanding of their professional roles and responsibilities. The study highlights the importance of supported hands-on experience and learning by doing, in fostering competence during the early phases of transition.

Furthermore, the research reveals that the socialisation process played a critical role in the development of a professional identity (Mackintosh, 2006; Mazyck, 2023). Participants reported that through interactions with colleagues and exposure to the values, norms, and expectations of the profession, they were able to internalise these

aspects and develop a strong sense of professional identity. This identity was characterised by a commitment to the profession, a sense of belonging, and a shared purpose with colleagues.

Overall, the study demonstrates the significance of a socialisation process in shaping practitioners' confidence, competence, knowledge, skills, and professional identity to facilitate and navigate transition. The findings emphasised the importance of creating opportunities for newly qualified nurses to engage in a socialisation process, including an induction, a mentorship/ preceptorship programme both pre and post registration, team projects, and networking events, to support their professional development. This thesis also highlights the need for organisations to provide a supportive and inclusive environment that encourages transition and fosters the growth of practitioners within their professional roles.

6.2 Contribution to Knowledge

Combining the themes of socialisation, professional identity, competence and confidence, knowledge, and skills to explain transition is what is new. This integration of themes, the combination or blend is what enables the successful transition to confident practitioner. The recognition that positive and negative events also have a significant impact on transition. The revised conceptual framework illustrates that it is not until all the themes reach a coming together does this successful transition occur. The combination of these themes contributes to the advancement of knowledge in relation to transition. Additionally, the integration of all themes further expands what is known and understood by the transition to confident practitioners.

In conclusion, combining the themes of socialisation, professional identity, competence and confidence, knowledge and skills in transition is essential for individuals to succeed in their professional roles. Developing a strong professional identity enhances their confidence and competence in their professional abilities, acquiring new knowledge and skills through transitions allows individuals to expand their expertise and contributes to their advancement through to transition, with a clear acknowledgment that positive and negative events have an impact on wellbeing during transition and can influence the length of time the transition process can take.

The significance of contribution to knowledge in this research is multifaceted and is crucial to the advancement of the understanding of transition. It is important because it can:

1. Expand our knowledge- this thesis has added to the body of knowledge and understanding surrounding the transition of newly qualified nurses from student to confident practitioners.

2. Develop healthcare practice- this research has had a direct impact on the development and progress of healthcare practitioners into their roles as competent clinicians and will make recommendation to the educational programmes.

3. Improvement to practice- by critically examining our practice, we can understand what we do. The participants were given the opportunity to explore and discuss their transition and personally reflect on the journey.

4. Identification of any gaps or unanswered questions- theses gaps serves as the opportunities for further investigation and exploration. The gaps are identified as it is the blend of the themes that enables transition, not just a singular theme.

5. Bridge any interprofessional gaps - Contributions to knowledge in this research can bridge gaps between disciplines, fostering interdisciplinary collaborations in the future.

This contribution to existing knowledge forms the guide to the recommendations in Chapter 7.

6.3 Conclusions

In conclusion, this thesis conducted using diaries and interviews provided valuable insights into the process of socialisation and its impact on various aspects of transition. The findings highlight the significant role of socialisation in shaping practitioners' capabilities, it is the combination of confidence, competence, knowledge and skills, and professional identity that has the critical influence.

The study reveals that socialisation plays a crucial role in building newly qualified nurses' confidence in their professional abilities in order to successfully transition from student to confident clinician. It was found to significantly contribute to the acquisition of new knowledge and skills. This research highlights the crucial role socialisation plays in the development of a professional identity, through interactions with colleagues and

exposure to the values, norms, and expectations of the profession, enabling them to internalise these aspects and develop a strong sense of professional identity.

Individuals can benefit from actively engaging in socialisation activities to enhance their confidence, competence, knowledge, skills, and professional identity. Seeking out mentorship programmes, participating in team projects, and attending networking events can provide valuable opportunities for socialisation and professional growth.

Organisations should also recognise the significance of socialisation in the development of their employees. Creating a supportive and inclusive environment that encourages professional development and facilitate transition, structured and supportive socialisation can foster the growth of individuals within their professional roles. Providing opportunities for mentorship, collaboration, and knowledge sharing can contribute to the overall success of the organisation by nurturing confident, competent, and skilled professionals with a strong professional identity.

In conclusion, this thesis highlights the importance of socialisation in the professional development process to facilitate the successful transition from qualifying as a nurse to becoming a confident and capable practitioner. Using a social constructionist approach the thesis allowed for the in-depth exploration of the experiences of NQNs as they made their transition from student to confident practitioners. Applying this perspective enhanced my understanding, constructed through the social process of dairies and interviews, of the transition process through the lens of NQNs in the Southwest in the present day. It emphasised the positive impact of socialisation on individuals' confidence, competence, knowledge and skills, and professional identity in combination. The development of a revised conceptual framework provided a perception of the literature and an appropriate understanding of the process of transition. The findings provide valuable insights for individuals, education programmes and organisations seeking to enhance professional growth and development to ensure newly qualified practitioners navigate the transition from student to capable practitioner.

7. Recommendations

This chapter will reflect on the critical recommendations to support students to assist prior to registration and after qualification and make a final statement for the undergraduate curriculum and future enquiry.

7.1 Key Recommendations

The recommendations result from the revised conceptual framework fall into two sections- in educational programmes and in the clinical settings. In the educational programmes a modules or explicit content regarding transition is vital to allow the practitioner to appropriately prepare. This should include discussion of professional identity, development of resilience strategy for clinical practice, consolidation of knowledge and skills in simulation setting to provide support and constructive feedback for continued development. As part of the final phase of an educational programme, students should be given the opportunity to network with the clinical setting that they intent to work in, if possible and visit the setting in advance of them starting. Higher Education Institutions (HEIs) have a fundamental role in the ensuring that students are adequately prepared for professional practice.

In the clinical setting all newly qualified nurses should be supported in a socialisation process including being given a named 'mentor' or 'preceptor' to support their transition. The clinical /practice area has an essential role to play in strengthening, supporting, and integrating newly qualified nurses into the workforce. The healthcare settings have a responsibility to facilitate transition, if successful in this then the new staff nurse will form a vital start of the future healthcare workforce.

7.2 Recommendations for Education and Future Enquiry

The previous section discusses the conceptual framework and its implications to transition of the newly qualified nurse to confident practitioner. The focus of the key recommendations will be on education, curriculum development, future research, and enquiry.

7.2.1 Education

The transition from qualification as a nurse to becoming a confident and capable practitioner is a complex process requiring adaptions to education programme. This research recommends that education programmes that prepare practitioners for clinical practice implement additional supportive learning opportunities. Based on this research the combined factors influencing this transition, including socialisation, confidence and competence, knowledge and skills and professional identity need to be explicitly embedded into a pre-registration curriculum.

Socialisation: The process of socialisation plays a vital role in the transition from a student nurse to a professional practitioner. Education programmes should facilitate the socialisation process by creating a supportive and collaborative learning environment. Encouraging teamwork, effective communication, and interprofessional collaboration will help nurses develop the necessary social skills to work effectively within a healthcare team. Additionally, providing opportunities for networking and mentorship programmes will enable nurses to connect with experienced professionals and learn from their experiences. A central recommendation would be to promote visits and interactions with the clinical settings and the practitioners prior to starting to facilitate socialisation.

Confidence and Competence: Building confidence and competence is crucial for nurses to become successful practitioners. Education programmes should incorporate strategies that promote self-confidence and self-efficacy. This can be achieved by providing opportunities for nurses to practice and refine their skills under the guidance of experienced mentors. Regular feedback and constructive criticism should be encouraged to help nurses identify areas for improvement and build their confidence in clinical practice highlighting areas around transition. A key recommendation would be to facilitate feedback mechanisms and formalise mentorship / preceptorship programmes prior to commencing in a clinical setting both within the professional preparation programmes and work-based initiatives at the point of registration.

Knowledge and Skills: To ensure a smooth transition, education programmes should focus on enhancing the knowledge and skills of newly qualified nurses. This can be achieved

through a combination of theoretical and practical training. Incorporating evidence-based practice and the latest research findings into the curriculum will help nurses develop a solid foundation of knowledge. Additionally, practical experiences, such as clinical placements and simulations, should be provided focussed on transition to allow nurses to apply their knowledge in real-life situations. An essential recommendation regarding simulation training and practical skills practice throughout professional preparation programmes would be advocated.

Professional Identity: Developing a strong professional identity is essential for nurses to navigate the challenges of their role confidently. Education programmes should emphasise the importance of professional values, ethics, and accountability. Incorporating reflective practice and encouraging nurses to critically analyse their experiences will help them develop a deeper understanding of their professional identity. Additionally, promoting lifelong learning and continuous professional development will ensure that nurses stay updated with the latest advancements in healthcare. A crucial recommendation would be the exposure of practitioners to appropriate role models and senior clinician throughout their programmes.

7.2.2 Future Enquiry

The recommendations for future enquiry regarding the transition from nurse qualification to a confident and competent practitioner range from longitudinal studies, comparative work, in-depth qualitative enquiry, research focussed on the impact on patient safety and from an international perspective.

Conducting additional longitudinal studies have provided valuable insights into the transition process over an extended period but could be repeated. This would allow researchers to track the development of knowledge, skills, confidence, competence, socialisation, and professional identity of nurses from the time of qualification to their early years of practice. Longitudinal studies can help identify the factors that contribute to successful transitions and those that may hinder the process.

A comparative study could be conducted to compare the transition experiences of nurses from different educational programmes, such as apprenticeship or healthcare settings, such as primary/community settings. This research could explore the differences in knowledge and skill acquisition, confidence and competence development, socialisation experiences, and professional identity formation. Comparative studies can help identify the most effective educational approaches and support systems for facilitating a successful transition.

Qualitative research methods, such as in-depth interviews and focus groups, can provide a deeper understanding of the subjective experiences of nurses during the transition process. Exploring nurses' perspectives, challenges, and coping mechanisms can shed light on the emotional and psychological aspects of the transition. Qualitative research can help identify specific areas of support that may be needed to enhance the transition experience.

Further research could evaluate the effectiveness of support/ preceptorship programmes designed to facilitate the transition from nurse qualification to confident and competent practitioner. These programmes may include mentorship programmes, transition-to-practice programmes, or additional training modules. Evaluating the impact of such programs on knowledge and skill development, confidence and competence levels, socialisation experiences, and professional identity formation can provide evidence-based recommendations for designing effective support interventions.

Research should also explore the impact of the transition process on patient outcomes. Investigating the relationship between nurse transition experiences and patient safety, satisfaction, and quality of care can help identify the importance of a successful transition in improving patient outcomes. This research can inform the development of strategies to better support nurses during this critical period, ultimately leading to improved patient care.

Research on the transition process should also consider international perspectives. Comparing the transition experiences of nurses from different countries and healthcare systems can provide valuable insights into the influence of cultural, educational, and

organisational factors on the transition process. This research can contribute to the development of global best practices for supporting nurses during their transition to practice.

7.3 Final Statements

Further research is needed to deepen our understanding of the complex transition from nurse qualification to confident and competent practitioner. Conducting additional longitudinal studies, comparative research, qualitative studies, and evaluating support programmes can provide valuable insights into the factors that influence knowledge and skill development, confidence and competence, socialisation, and professional identity formation. Additionally, exploring the impact of the transition process on patient outcomes and considering international perspectives can contribute to the development of evidence-based strategies to support nurses during this critical period of their careers.

The transition from nurse qualification to becoming a confident and competent practitioner is a multifaceted process that requires a comprehensive education programme. By focusing on enhancing knowledge and skills, building confidence and competence, facilitating socialisation, and fostering a strong professional identity together, pre-registration education programmes and work-place support mechanisms can effectively support nurses in this transition. It is crucial for educators, policymakers, and healthcare organisations to collaborate and implement these recommendations to ensure the successful transition of newly qualified nurses into the workforce.

Ultimately, a well-designed pre-registration education programme, strategic change in healthcare settings and clear organisational support, through a comprehensive preceptorship programme during the transition to ensure newly qualified nurses are well supported during this phase will contribute to improving the quality of patient care, promote resilience and stability within the nursing workforce and facilitate the overall success of the nursing profession.

8. Epilogue

All the data was collected in the period between September 2018 and March 2020. The final interview was recorded in mid-March 2020, just prior to the start of the first national lockdown due to the COVID-19 pandemic, the final interview was conducted just a week before the lockdown was commenced. The impact of the pandemic was felt profoundly across the United Kingdom and especially in the healthcare sector. This resulted in a significant delay in the analysis, writing up and presentation of the thesis.

In the autumn of 2022, all the participants were contacted, for several objectives, to ensure they were still happy to have their information to be included in the research as per the University's Ethical Guidance and also to receive a brief update to their careers and wellbeing. All six participants responded to the email enquiry and were asked if a brief update could be included in the thesis for personal interest. Although not part of the formal research or thesis it was important for me to check on the participants for my own resolution.

Bob remained in the healthcare setting, the pandemic and the resulting workforce pressure meant that he was promoted quite quickly within the Trust. He remained in the same Trust throughout the pandemic and when contacted in 2022 was working as a Ward Manager (Band 7) in the Medical Directorate.

Susie remained in the healthcare for most of the pandemic in various roles and settings but resigned from her post in late 2021, she took a job in an estate agent for a complete change.

Charlie stayed in her clinical role for a while after her interview, she got married and moved during the pandemic to the Midlands. She currently is on maternity leave and will probably not return to a clinical role after her leave.

Helen retired from her post in clinical practice in 2021, she contracted COVID, and unfortunate has been unable to return to work in healthcare due to ill health.

Zoe remains in a clinical facing role, still in ICU. She worked throughout the pandemic in the critical care settings and now works in a much larger ICU out of region as a band 7 Charge Nurse.

Vicky was my final interview; she left the post very shortly after the start of the pandemic. Due to an underlying health condition, it was not safe for her to work in clinical practice during the pandemic and got a job outside the healthcare setting. She was subsequently selected for a management training scheme within a large retail company and has been successful in that role.

It was essential to have contact with the participants after the CoVid 19 pandemic, although sad to see that only two participants remained in the healthcare settings they were 'trained' for. It is impossible to say whether the outcome would have been different if the pandemic had not occurred. When asked why, there were several causes cited although the pandemic itself was not mentioned as a primary reason at all, they focussed on general wellbeing being the key factors that influenced their decisions to leave. The two that had remained in clinical role- cited that their first six months of clinical practice was the most influential feature in keeping them in their roles.

Both Bob and Zoe cited aspects of the transition phase were key to them staying in clinical practice- the support given at induction and during the socialisation process to improve their knowledge and skills, the consistent encouragement regarding their competence in the role from key 'mentors' and role models, the affirmation from senior colleagues and other member of the multidisciplinary team that they were 'doing a good job', kept them and has continued to keep them in clinical practice.

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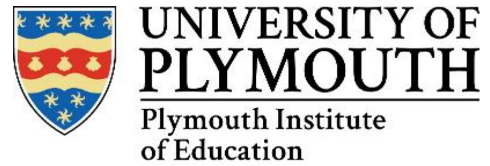
Appendix i- Ethical Permission



28 February 2019

CONFIDENTIAL

Rachel Pascoe

Plymouth Institute of Education

Faculty of Arts and Humanities

University of Plymouth

Dear Rachel

Application for Approval by Education Research Ethics and Integrity Sub-committee

Reference Number: 18/19-246

Application Title: Exploration of the complexities of transition to professional practice

I am pleased to inform you that the Education Research Ethics Sub-committee has granted approval to you to conduct this research.

Please note that this approval is for three years, after which you will be required to seek extension of existing approval.

Please note that should any MAJOR changes to your research design occur which effect the ethics of procedures involved you must inform the Committee. Please contact Claire Butcher on (01752) 585337 or by email claire.butcher@plymouth.ac.uk

Yours sincerely

Professor Jocey Quinn

Chair, Education Research Ethics Sub-committee -

Plymouth Institute of Education

Faculty of Arts and Humanities

Appendix ii- Participant Information Sheet

Participant Information Sheet

Title of Study: **Explore the complexities of transition to Professional Practice experienced by Newly Qualified Staff Nurses following a BSc (Hons) Nursing.**

Invitation to participate in the above study:

Part 1

We would like to invite you to take part in a research study. Before you decide to take part, we would like you to understand why the research is being done and what it will involve for you. Please take your time to read the following information carefully and discuss it with others if you wish. If you would like to hear more, we will go through the information sheet with you and answer any questions you have.

Please ask us if there is anything that is not clear. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

The purpose of this study is to explore the complexities of transition to professional practice of newly qualified nurses following an undergraduate professional preparation programme. More specifically this it will involve an examination of your experiences and reflective accounts following the first six months of your professional practice and to explore your transition from student nurse to qualified professional, focussing on your ability to move from competence to capability and development of your professional identity in the clinical practice area.

This study is being done as part of a doctoral research project.

Why have I been invited?

You have been invited to take part in the study as you are about to qualify and have a substantive post in a secondary care setting.

Do I have to take part?

It is up to you to decide whether or not to take part. We will describe the study and go through this information sheet. If you do take part, you will be given this information sheet to keep and asked to sign a consent form. You are still free to withdraw at any time and without giving a reason. A decision to withdraw or not to take part will not affect your nursing post in any way.

What will happen to me if I take part?

If you decide to take part in the research, you will ask to keep an online reflective diary to outline events in practice as they happen, to record key events, critical incident which demonstrate your abilities, your knowledge, and issues that you encounter in your first months. The expectation is that you make weekly online diary entries that will be analysed and from those entries an interview guide will be developed.

If during your diary entries any untoward or critical incident occurs or is reported, all safeguarding processes will be followed. This will include being contacted by the researcher to ensure all reporting and support mechanism protocols are adhered to. This will be followed up in the interview. After 6 months you will be invited for an interview, we will arrange a date for an interview at a time that is most convenient to you. The interview will be conducted by the researcher and will last approximately 60-90 minutes. You will be asked about your views and experiences of professional practice and as such there are no right or wrong answers for this.

This interview will be audio-taped and then transcribed for analysis by the researcher. With your permission, data collected during your interview will be anonymised (no identifiable data) and archived for up to ten years on a secure university computer. Audio-recordings will be locked in a filing cabinet and destroyed after the study is completed.

The researcher will also gather information on your academic pathway and achievements to this point to add context to the discussion and findings as appropriate. This will require access to your personal records. All information and data will be anonymised, and confidentiality is assured.

Expenses and payments

There is no payment for taking part.

What do I have to do?

If you are happy to participate, we will arrange a recruitment meeting to outline the reflective diary requirements and the subsequently a suitable date for the interview at which we will ask you to sign an Informed Consent Form prior to commencing the research process. A copy of the consent form will be given to you for your records and a second copy will be retained by the researcher.

What are the possible disadvantages and risks of taking part?

When discussing your experiences, it may cause sensitive subjects to arise. You will be free to stop the process at any point. You do not have to disclose anything you feel uncomfortable with.

What are the possible benefits of taking part?

This study is unlikely to benefit you personally. However, the information we receive from this research, we hope can guide us to improve transition support and processes for nurses as they transition into professional practice and might inform an improvement and development of Professional Preparation Programmes in the future.

What if there is a problem?

Any complaint about the way you have been dealt with or any possible harm you might suffer will be addressed. The detailed information on this is given in part 2 of this information sheet.

Will my taking part in the study be kept confidential?

Yes, we will follow ethical and legal practice and all information about you will be handled in confidence. The details are included in Part 2.

This completes Part 1. If the information in Part 1 has interested you and you are considering participation, please read the additional information in part 2 before making any decision.

Part 2

What will happen if I don't want to carry on with this study?

You can withdraw from the study at any time without explanation or any repercussions. If you choose to withdraw from the study all information provided by you will be destroyed

What if there is a problem?

Complaints: If you have a concern about any aspect of this study you should ask to speak with the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this by contacting the projects supervisor (Name: xxx Email: xxxx Phone: xxx)

Will my taking part in the study be kept confidential?

Yes. All information which is collected about you during the course of the research will be kept strictly confidential. Your name will be anonymised on the online diary and the audiotape and transcript. No identifiable data will be present in any written or verbal reports of this study. Access to the data will be limited and only available to the researcher and her academic supervisor who will independently check analysis of the data collected. All data will be kept in a locked filing cabinet in the researcher's office and will be destroyed ten years following the research project. Strict ethical and legal practice guidelines will be followed, and all information will be handled in confidence.

What will happen to the results of the research study?

The information gathered from this study will provide us with insight into the experiences of newly qualified nurses as they transition from student to staff nurse and will inform development in Professional Preparation Programmes and support for new staff in clinical practice. Anonymised extracts from the interviews may be used in publications however this will not be identifiable to you.

Who is organising and funding the research?

The sponsors of this study will be Plymouth University. This study is part of a doctoral project undertaken for the EdD Programme and no payment will be made to include you in this study.

Who has reviewed the study?

This study has been reviewed and given favourable opinion by University of Plymouth Research Ethics Committee (REC).

Further Information and Contact Details: Researchers contact details: Rachel Pascoe

Telephone: 01752 586565

Email: Rachel.pascoe@plymouth.ac.uk

Appendix iii- Consent Form

Participant Identification for this study:

Title of Study: **Explore the complexities of transition to Professional Practice experienced by Newly Qualified Staff Nurses**

Name of Researcher: Rachel Pascoe

Please initial box

1. I confirm that I have read the information sheet dated................... For the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐

2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason. ☐

3. I understand I may be invited for interview and the interview will be audio recorded and that the tapes will be erased at the end of the study. Only non-identifiable information will be used in the transcription. ☐

4. I understand that sections of my anonymised data collected during the study may be examined by individuals from University of Plymouth auditing the conduct of the research. The final research may also be submitted for publication in an academic journal. I give permission for use of my anonymised data for these purposes. ☐

5. I agree to my own words being used as anonymised quotations in this study. ☐

6. I agree to take part in the above study. ☐

____________________	____________________	____________________
Name of Participant	Date	Signature
____________________	____________________	____________________
Name of Researcher	Date	Signature

When completed 1 for participant; 1 for researcher.

Appendix iv- Interview Guide

Following review of your reflective diaries entries/ blog:

- Can you tell me more about the significant events that made you feel confident about practice?
    - Positive and negative

- When did you start feeling confident and competent about your role as a staff nurse?

- Tell me more about your confidence in your role in relation to others, such as senior colleague, other professionals, and your peers.

- Tell me about… the events mentioned in the diary that was significant and/or important.

- Do you think you have successfully ‘transitioned’ from student to staff nurse- and why/how?

Appendix v- Gantt Chart

Appendix vi- Prisma Diagram