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UNIVERSITY OF SOUTHAMPTON

FACULTY OF LAW, ARTS & SOCIAL SCIENCES

School of Education

**The invisibility of being a new nurse: the experience of transition from student to
registered children's nurse**

by

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Thesis for the degree of Doctor of Education

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ABSTRACT

FACULTY OF LAW, ARTS AND SOCIAL SCIENCES
SCHOOL OF EDUCATION

Doctor of Education

THE INVISIBILITY OF BEING A NEW NURSE: THE EXPERIENCE OF TRANSITION FROM STUDENT TO REGISTERED CHILDREN'S NURSE

by Helen Clare Farasat

This research examines the transition from student nurse to Registered Nurse (child). Earlier studies suggest the transition always involves a period of discomfort and uncertainty. However, there is a dearth of longitudinal studies of children's nurses, revealing a gap in the evidence that this study aims to fill. This longitudinal study commenced in one HEI in England where the six participants were completing their undergraduate programme in child nursing. A phenomenological interpretive design was used to answer the research question: 'What is the experience of making the transition from student to RN (child) like?'

Data was collected using focused qualitative interviews at three stages: mid final year, and at 3–4 months and 12–14 months post-employment as an RN. The data was analysed using descriptive and interpretive methods.

The thesis draws out the changes in the participants experience over time and suggests the transition extends beyond the first year of practice. It involves development within four overarching themes: Personal and Professional Identity, Primacy of Practice, Working with People, and Managing Newness. These key themes are present across the participants' experience but their importance changes over time. The transition is characterised by the visibility of being a nurse and the invisibility of being a 'new' nurse. This study supports the findings of some earlier studies and introduces some new evidence in relation to children's nursing, such as responding to crises, coping with grief and the difficulties and challenges of working with parents.

The main limitations are that this is a small-scale study within a specific branch of nursing, with participants drawn from one HEI and conducted by a single investigator. However, because the participants took up employment in different locations in England, the findings may have some resonance with other neophyte children's nurses beyond the original setting of the research.

Recommendations are made for undergraduate programme providers and employers to strengthen and develop the preparation of RN (child) pre- and post-qualification, particularly in the areas of preceptorship, prioritising care and managing time, working with parents, and coping with emergencies or the death of a child.

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DECLARATION OF AUTHORSHIP

I, Helen Clare Farasat, declare that the thesis entitled

THE INVISIBILITY OF BEING A NEW NURSE: THE EXPERIENCE OF TRANSITION FROM STUDENT TO REGISTERED CHILDREN'S NURSE

and the work presented in the thesis are both my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly while in candidature for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;
- parts of this work have been published as a conference poster.

Signed:

Date:

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ABBREVIATIONS

A&E	Accident and Emergency Department
DfES	Department for Education and Skills
DH	Department of Health
DHSS	Department of Health and Social Security
DipHE	Diploma in Higher Education
FCC	Family-centred care
HCA	Health Care Assistant
HCC	Healthcare Commission
HDU	High Dependency Care
HEI	Higher Education Institution
HESA	Higher Education Statistics Agency
HCHSC	House of Commons Select Committee
MoH	Ministry of Health
NHS	National Health Service
NHSEO	NHS Employers Organisation
NICU	Neonatal Intensive Care Unit
NMC	Nursing and Midwifery Council
NSF	National Service Framework for children, young people and maternity services
OPD	Out-patient Department
PCT	Primary Care Trust
PICU	Paediatric Intensive Care Unit
PIN	Professional Identification Number
P2000	Project 2000
RCN	Royal College of Nursing
RN	Registered Nurse
RN (child)	Registered Nurse (child)
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing Midwifery and Health Visiting
USA	United States of America

1 BACKGROUND TO THE STUDY

1.1 Introduction

This thesis examines the experiences of children's nurses as they make the transition from student nurse to RN (child). The limited literature on the early professional experiences of children's nurses suggests that they share some of the same difficulties as other newly qualified nurses, although there are also thought to be some issues that are more specific to children's nurses; for example, working with parents. This study contributes to the existing literature by demonstrating that the transition from student to RN (child) extends beyond the first year of practice and involves developments in Personal and Professional Identity, Primacy of Practice, Working with People and Managing Newness. For the participants, the experience was characterised by the public visibility of being a nurse and the invisibility of being a 'new' nurse.

The study uses a qualitative approach underpinned by the philosophical tradition of hermeneutic phenomenology. With its focus on the 'lived experience', the phenomenological approach is appropriate for an investigation of how the transition from student to RN (child) is experienced (chapter 3: 3.2). By examining the experience of six nurses from one university in the south of England, as they progressed from student to completion of their first year in practice, it has been possible to describe and interpret aspects of their experience of that transition.

1.2 Outline of chapter 1

This chapter locates the study within the policy context of the nursing workforce, in particular the children's nursing workforce. The recruitment and retention of nurses and the drive to reduce attrition from pre-registration nursing programmes are considered together with the provision of induction, supervision and preceptorship to newly qualified nurses. It then addresses developments in the delivery of health services to children, young people and families, and their significance for newly qualified nurses. The discussion then moves on to address current issues in the context of nurse education.

In hermeneutic phenomenology, a review of potential theoretical frameworks is deferred until completion of data collection and data analysis. However, theories of transition and the related concept of occupational socialisation may be relevant; therefore these

theoretical perspectives are briefly defined in preparation for a more detailed discussion in chapter 2. This is followed by a summary of the focus of the study, the research questions and reflexive positioning of me within the research process.

1.3 Policy context of children's nursing

Contemporary children's nursing has its roots in the Platt Report (MoH, 1959), which emphasised the importance of sick children receiving care from nurses trained in the care of children. They are RNs with a specific qualification in preventative and health promotion practices and the care of sick or injured children and young people from birth to 18 years (NMC, 2011). The key policy issues influencing the education and employment of children's nurses in the UK are considered below.

1.3.1 Children's nurses in the context of NHS workforce development

The NHS is the largest employer in Europe with 1.3 million employees, approximately 29.9% being nurses, midwives or health visitors (Hyde et al., 2006). Key policy drivers for developing this large workforce are: *Modernising Nursing Careers*, *Child Health Strategy*, *Maternity Matters*, *World Class Commissioning*, *Transforming Community Services* and the *European Working Time Directive* (cited NHSEO, 2009). Children's nurses in the UK currently account for approximately 5% of the total number of nurses but they have the potential to make a significant contribution within this policy agenda.

The NMC register for 2007-08 recorded only 19,164 children's nurses (NMC, 2008a), which appears consistent with an earlier estimate of 15,305 children's nurses in England (Elston and Thornes, 2002). This relatively small workforce is employed in a wide range of child health services, including paediatric medical care, school nursing, community nursing, respite care, rehabilitation, and health promotion services. A recent study of children's nurses in England found they are primarily employed in acute paediatric services, with 90% in NHS acute trusts, 4% in PCTs, 3.1% in independent hospitals and 2.9% in charities (Elson and Thornes, 2002).

The successful transition of new nurses into the workforce may have implications for the longevity of their careers in child health; this is therefore of interest to policymakers and employers who wish to retain and develop those nurses who enter the workforce (DH, 2006; DH, 2008).

1.3.2 Recruitment and retention of nurses

Recruitment and retention of nurses is a concern for employers and with limited training places for new recruits annually it is a particular concern for children's nursing services. The challenge of ensuring an adequate supply of children's nurses was expressed in 1976 (DHSS) and such concerns persist (HCHSC, 1997; Price, 2002; Melia, 2003; DH, 2006). Indeed, an estimated shortfall of 2,700 children's nurses in England was noted in 2002 (Elston and Thornes). More recent evidence suggests the number of training places is insufficient to meet the demands of the NHS (Robinson et al., 2006). This is thought to be a significant concern for NHS trusts seeking to fill vacancies.

1.3.3 Attrition from undergraduate nursing programmes

Buchan and Seccombe (2006) and Elston and Thornes (2002) highlight a delicate balance between supply and demand in the education of children's nurses. There are approximately 2,100 places for pre-registration children's nursing annually in the UK (Buchan and Seccombe, 2006). Whilst there are no problems recruiting to children's nursing (Buchan and Seccombe, 2006) attrition from undergraduate nursing programmes has long been a source of concern, with Hutt (1983) noting significant attrition. More recent studies in children's nursing suggest the level of attrition remains high (Elston and Thornes, 2002; Price, 2003). Overall attrition from pre-registration nursing diploma programmes was recently estimated at 24.2 % in the UK and possibly higher for degree programmes (Buchan and Seccombe, 2006). Child branch students traditionally have a lower age profile than those in other branches of nursing (Buchan and Seccombe, 2005), which is potentially a factor in attrition from child branch programmes (Shepherd, 2008), although there is currently limited evidence to support this view.

1.3.4 Recruitment and retention post-qualification

With an estimated nursing vacancy factor of 9% in paediatric units (HCC, 2005), newly qualified children's nurses need to make a successful transition into practice (DH, 2006). Although new entrants to the profession sometimes find it difficult to gain employment in a specific geographical or clinical area, there are usually a significant number of vacancies for nurses within the NHS if they are willing to move (Buchan and Seccombe, 2002). Graduate employment for children's nurses nationally is buoyant, and HESA reports that 88.6% of child nursing graduates were in nursing jobs six months after graduating (2009: cited Paediatric Nursing, 2010:4). Attrition from children's nursing post-qualification is uncertain but a recent study found few signs of early attrition of children's nurses (Robinson et al., 2006). This may counter some of the concerns about pre-registration attrition.

1.3.5 The role of the nurse in contemporary health services

The role of the nurse within the context of an interprofessional approach to care is well recognised within the recent review of the NHS workforce (DH, 2008). Entrants to the profession face their own personal journey into professional practice but they must meet the expectation that care provision will be efficient, effective and high quality (DH, 1999), and also evidence based (DH, 2000; Pearson et al., 2007). They must have the ability to practise safely and contribute to clinical governance as a strategy for continually improving the standard and effectiveness of the care delivered to patients (RCN, 2001).

1.3.6 Standards of care

Recent concerns about variations in the standard of essential nursing care resulted in the introduction of standards to improve nursing care (DH, 2001; NMC, 2006a; NMC, 2007). In response to concerns about the clinical skills of newly qualified nurses, the 'essential skills clusters' competencies for pre-registration nursing programmes were also introduced (NMC, 2007). The latter were integrated into nurse education programmes after this study began but the concerns were influential in informing the curriculum followed by the participants.

1.3.7 An all-graduate profession and changes in doctors' contracts

The move to nursing becoming a Bachelor's degree level profession and an increased Assistant Practitioner and HCA workforce could cause a future reduction in the RN workforce and increase RN responsibility for managing unqualified staff (NHSEO, 2009). Concomitantly, a reduction in junior doctors' hours and a shortage of doctors has resulted in nurses assuming elements of the doctor's role whilst delegating nursing tasks to the expanding HCA workforce (Melia, 2003). This will impact on the accountability of nurses and the expectations placed on them by employers and the public.

When the current study was planned, the developments in nurse education initiated by Project 2000 (P2000) (UKCC, 1986) resulted in a debate about whether the profession should move to all-graduate status. As this study reaches its conclusion, discussions within the DH, higher education and the NMC, and wider consultations, resulted in a policy which stipulates that, from 2013, the minimum entry level to the nursing profession will be a Bachelor's degree (NMC, 2008b). This will bring nursing in line with other health care professions, and should attract more capable applicants and produce a more knowledgeable workforce (NHSEO, 2009).

1.4 The transition from student to RN

The transition from student to RN involves many changes; some positive, such as enhanced social and financial status, and some that present challenges and risks – in particular, professional accountability and increased role expectations. Final-year students must not only gain an academic qualification but must also meet the 'Fitness for Practice' standard (UKCC, 1999; NMC, 2004a) in order to register with the NMC. The majority of nurses are thought to navigate the transition from student to staff nurse satisfactorily within six months (Gray, 1998; Maben and Macleod Clark, 1998; Dearmun, 2000; Delaney, 2003), but little is known about how the transition is experienced and what factors help or hinder this transition.

1.4.1 Support for newly qualified nurses

The nursing profession has been criticised for expecting its newly qualified nurses to be fully prepared (Clarke, 1999); when much evidence suggests that initially they still feel new and uncertain about their ability (chapter 2: 2.8–2.9). The NMC requires newly qualified nurses to meet the proficiency standard of RNs (NMC, 2004b; NMC, 2006b) and, from the point at which they register with the NMC and enter employment, they become accountable for their practice. However, it also recognises that newly qualified nurses may need a period of support and guidance in the form of preceptorship to allow them to acclimatise to their new role and status and develop confidence in their own ability (NMC, 2008b).

Currently preceptorship is recommended for approximately four months (NMC, 2006b), during which the new RN is supported by an experienced nurse who has responsibility for guiding, supporting and monitoring their practice. Further, the NMC recommends that during the first year the RN should receive protected learning time and on-going support through meetings with their preceptor. The NMC acknowledges that the availability of suitable preceptors and the willingness of employers to provide this support will influence implementation. This longitudinal study is not designed to specifically focus on preceptorship but, through an examination of the experiences of the participants, it does provide some evidence of their perception about the amount of support provided.

1.5 Developments in the delivery of health services to children and families

Patterns of disease and illness in childhood have changed significantly over recent decades – many infectious diseases that historically caused hospital admissions are now

prevented by immunisation programmes. Equally, life expectancy for premature infants and children with life-threatening or life-limiting conditions has increased, creating an expansion in specialist services to meet their needs (DH, 2004). Developments across the whole field of paediatrics, including paediatric surgery and intensive care, have had major implications for nursing workforce requirements; with in-patient hospital care increasingly focusing on acute health problems, high dependency and critical care.

Demand has also increased for community children's nursing services (HCHSC, 1997; Whiting, 1985 and 1998) and nurses engaged in health promotion strategies to reduce the prevalence of contemporary health problems; for example, poor nutrition and obesity; mental health and behavioural problems in childhood; and substance misuse (DfES and DH, 2004).

The government strategy for modernising health services (DH, 2000), the cross government strategy *Every Child Matters* (DfES and DH, 2004), and the implementation of the NSF (DH, 2004) highlighted the imperative for children's services to be delivered in community settings. These policies have influenced a reduction in acute paediatric beds and an expansion in community-based care. This creates new opportunities for children's nurses in the community whilst reducing the range and type of employment available in hospital settings. Therefore, the initial preparation of children's nurses must facilitate the skills and knowledge to work in diverse settings: home, school, clinic, respite care, hospice, NICU, A&E, acute wards and OPD.

Demographic changes affecting the UK population have also impacted on nursing services for children and families; for example, changes to family structures, immigration, housing, health care, benefits system, and education. These changes have created a need for those working with children to have a grasp of diversity, cultural, social, legal and ethical issues (DfES and DH, 2004).

1.5.1 Implications for the RN (child)

Care is increasingly delivered in ambulatory settings like Day Surgery or OPD, the child's home, school or community clinic. Wherever possible hospitalisation is minimised and a parent or carer will usually accompany the child during this period. These are welcome developments for the child and family but they have implications for the learning experience of students and neophyte RNs. The parent is now more likely to be the expert in their child's care; the concepts of FCC and working in partnership with families and children are now central within children's nursing, although not always well implemented

(Corlett and Twycross, 2006). The new RN (child) therefore requires knowledge, skills and confidence in their own ability but also knowledge and understanding of parental perspectives and the ability to negotiate professional and parental roles in care.

1.6 Developments in nurse education

Nurse education has undergone major changes since the introduction of P2000 courses (UKCC, 1986) and the subsequent transfer of nurse education into HEIs. The P2000 strategy raised the academic level of nurse education to a minimum of a DipHE and introduced supernumerary status for student nurses, thus removing the apprentice-style role of the student and allowing them to focus on learning rather than becoming socialised into the ward culture.

Further major changes to nursing curricula (UKCC, 1999) and a new vision for nursing, midwifery and health visiting (DH, 1999) followed). These reports resulted in a significant refocusing of the content of pre-registration nursing courses towards a curriculum that placed equal value on academic content and practice education. Subsequently (and to the present day), all undergraduate nursing programmes consist of a one-year Common Foundation Programme followed by a two-year programme in which they study their specific branch of nursing.

1.6.1 Child branch programme

A number of studies have addressed the issue of transition from student nurse to RN and a small number examined the transition from student to RN (child) (chapter 2: 2.2). Although children's nurses are thought to have similar experiences to other nurses in the early stages of their career, it is suggested that children's nurses also experience stress in relation to meeting the expectations of parents and other family members (chapter 2: 2.6.1).

The impetus for this study was the knowledge that, objectively, we know that student nurses change their status when they qualify; they acquire a new title and access to a world of work and income, but we have little knowledge of the subjective experience, particularly for children's nurses.

1.7 Theoretical concepts

Hermeneutic phenomenology does not have as its goal the construction of theory (Annells, 1996); nor does it purport to apply a theoretical framework in advance of data collection (Munhall and Chenail, 2008). Rather, the data should 'guide the way of enquiry' (Chenail, 1995, cited Munhall and Chenail, 2008:4). However, the concepts of role transition and professional socialisation have been discussed in earlier studies. Therefore, a brief introduction is presented below followed by a more detailed discussion in chapter 2, part B, and in the discussion of the findings (chapter 7, 7.4).

1.7.1 The concept of transition

There are many definitions of transition but, in a review of the health literature on transition, Kralik et al. (2006) highlight the discipline-specific nature of definitions of transition. They conclude that, fundamentally, transition involves a response to change over time and involves adaptations in self-concept and self-identity to accommodate the change. This is encapsulated in van Loon and Kralik's (2005) definition of transition:

A process of convoluted passage during which people redefine their sense of self and redevelop self-agency in response to disruptive life events. (cited Kralik et al., 2006:321)

For the purpose of this thesis the specific area of interest is the experience of occupational or work-role transition. Van Loon and Kralik's (2005) definition is adopted within a discussion of theories of transition (chapter 2: 2.14-16 and chapter 7: 7.5).

1.7.2 Occupational socialisation

Early studies of the occupational socialisation of nurses and health visitors define it in terms of the individual working to make sense of new surroundings whilst acquiring the knowledge to conduct themselves as competent members of the profession, such that other members of the profession would recognise them as competent (Dingwall, 1977). Cohen (1981) similarly described professional socialisation in terms of acquisition of knowledge, skills and a sense of identity. This means internalising the values and norms of the profession such that they become part of the individual's own sense of self; replacing society's stereotypical views in favour of those of the profession (Cohen, 1981). This is examined further in chapter 2, 2.17

1.8 Overview of the study

The relatively limited places for child branch nursing education, concerns about attrition, and a significant vacancy factor within the health service, suggest that more knowledge about the factors that influence nurses' transition from student to RN would be of value to educators and employers. It is argued that failure to meet the expectations of newly qualified nurses may result in loss of these individuals from the profession (Kramer, 1974; Dearmun, 2000; Buchan and Seccombe, 2006; NHSEO, 2009). The policy, service and educational issues discussed demonstrate the importance of achieving a positive outcome for neophyte children's nurses. Theories of transition and occupational socialisation may offer theoretical frameworks for considering the findings of the current study.

1.8.1 The focus of this study

The aim of this study was to explore how children's nurses experience the transition from student to RN (child).

1.8.2 The problem

The objective evidence of the transition to RN is the completion of a three-year period of study, the award of a higher education qualification, and changes in social and financial status. However, with these changes come new challenges and risks; in particular, professional accountability and increased role expectations. At the point of registration with the NMC, the neophyte nurse becomes legally accountable for their professional practice and must accomplish the transition from being a student nurse one day to a qualified nurse the next.

1.8.3 Research question

The research question was:

What is the experience of making the transition from student to RN (child) like?

Sub questions:

- 1) Is there evidence of a transition occurring?
- 2) How is the transition experienced?
- 3) What contextual factors appear to influence the transition?
- 4) Do the participants play an active role in the transition?
- 5) Do others have an influence on the transition?

1.9 Reflexive positioning of self within the study

The motivation to conduct this longitudinal study was a desire to contribute to knowledge of the phenomenon of becoming a children's nurse. In the human sciences it is argued that the researcher does not pursue a study for the sake of it but because they have a particular interest in the subject or object concerned (Holloway and Wheeler, 2000; Robson, 2002). My interest in this subject arose directly from my role as a nurse educator; I was curious to know whether the experience of becoming a children's nurse had changed since I qualified and whether we were preparing these nurses well for professional practice. However, this does not explain the object of my interest: 'well prepared' in what sense and by whose judgement? I did not simply want to know objectively what they could do, with an inventory of skills, evidence of knowledge, or how this was observed by others. Rather, I was curious to know what it was like to become a children's nurse in the early 21st century. Analysing a personal narrative of my own career caused me to think more critically about my role as a nurse educator and to question whether or not, as educators, we understand and engage sufficiently with the student's journey to becoming a nurse in the context of contemporary child health services.

My apprentice-style training meant that inevitably there was a process of socialisation occurring within my education. I was also cognisant of significant changes in child health services during the span of my own career; for example, the development of community children's nursing services (Whiting, 1985 and 1998). During my early career, nurses provided all care and indeed became the 'experts', thus disempowering the parents who would rely on the nurses to teach them about their child's needs. This contrasts sharply with contemporary child health services as discussed earlier.

As a member of the teaching faculty where the participants studied, I was aware of the possible impact this could have on the study; for example, sampling bias, risk of coercion, role conflict and the influence of power relationships. Steps taken to reduce this risk are articulated in chapter 3: 3.7.1 - 3.8.1.

1.10 Conclusion

Ensuring adequate numbers of RN (child) are recruited and retained remains a persistent source of concern for policymakers and HEIs. Children's nurses form a significant part of the children's workforce and on attaining the status of RN (child) they must be capable of

working in a diverse range of settings within a service that is constantly evolving. Knowledge of the factors that influence a smooth and successful transition from student to staff nurse could be used to enhance the final-year curriculum for child branch student nurses and the induction programmes provided by NHS Trusts for newly qualified nurses.

2 LITERATURE REVIEW

2.1 Introduction

This chapter locates the study within a review of the literature and related theoretical concepts and frameworks. The chapter is organised in two parts:

Part A addresses studies of transition from student to RN in terms of their epistemology, chronology, methodology and the themes arising. The findings from these studies are then discussed under themes arising.

Part B addresses the concepts of role transition and occupational socialisation. These theoretical perspectives have helped to illuminate the experience of the transition from student to RN in earlier studies and are considered in the analysis of the findings arising from this study (chapter 7: 7.4).

2.2 PART A: TRANSITION FROM STUDENT TO RN

2.3 How the literature review was conducted

The review focused on recent research rather than historical studies because nurse education in the UK has undergone significant changes since the early 1990s. The initial literature review included studies conducted between 1996 and 2007. A total of 26 peer-reviewed papers and one thesis were identified; a further five papers published between 2008 and 2010 were added during the writing of this thesis.

The majority of the studies (n=17) were carried out in the UK. Studies from countries with similar nurse education programmes were also included (n=14). The non-UK studies all focused on the RN as a generic professional nurse.

Studies were included if they focused on the transition from student to RN or on a relevant aspect of the transition period; for example, Chang and Hancock's (2003) study of role stress and role ambiguity in newly qualified nurses. Two relevant unpublished studies were also included (Dearmun, 1997; Gray, 1998).

2.4 Methodological approaches used in earlier studies

Most previous single stage or longitudinal studies used interpretive phenomenological or broad qualitative approaches. A smaller number combined naturalistic and positivist methods or took a positivist approach (appendix 1).

2.4.1 Single stage studies

Fifteen studies used retrospective data collection at a single stage during the post-qualifying year (appendix 2). One study presented a prospective view of students' anticipated concerns about becoming an RN (Heslop et al., 2001). The single stage studies have limitations, such as the difficulty of appraising the significance of how the experience might change over time; for example, 'sink or swim' and 'fear' (Whitehead, 2001). Nonetheless, these studies provide some evidence that is consistent with findings from longitudinal studies (see 2.7).

2.4.2 Longitudinal studies

The longitudinal studies fell into two groups: the student nurse perspective (n=7) and the post-qualification year (n=8) (appendix 3 summarises the timing of data collection). Two studies examined student perceptions up to the point of registration (Gray and Smith, 1999; Holland, 1999). Five studies included pre-qualification data collection as part of multiple stages of data collection (Bradley, 1998; Ross and Clifford, 2002; Maben et al., 2006; Standing, 2007; Kelly and Ahern, 2008). Eight studies focused on the post-qualifying period (Dearmun, 1998, 2000; Gray, 1998; Chang and Hancock, 2003; Etheridge, 2007; Newton and McKenna, 2007; Duchscher, 2008, 2009) (see 2.6).

2.4.3 Sampling in previous studies

Five studies focused on RN (child) branch (Dearmun, 1997, 1998; Bradley, 1998; Dearmun, 2000; Evans, 2001; Jackson, 2005). A further two studies focused on RN (generic) who were employed in child health or paediatrics post-qualifying (Ramritu and Barnard, 2001; Ellerton and Gregor, 2003). The remaining UK studies (n=12) focused on RN (adult), and the remaining non-UK studies focused on RN (generic) (n=12).

2.5 Historical context

The transition from student to RN is thought to be stressful (Kramer, 1974; Dearmun, 1998; Gerrish, 2000; Ross and Clifford, 2002; Chang and Hancock, 2003; Delaney, 2003; O'Shea and Kelly, 2007) such that the neophyte RN requires effective support (Maben

and Macleod Clark, 1998; Dearmun, 2000; Evans, 2001; Jackson, 2005; Duchscher, 2008). Much of this research draws on the recollections of RNs after settling into their first post or expectations of undergraduate nurses prior to qualifying. A smaller number of studies follow a sample of students through to the post-qualifying transitional period (e.g. Maben et al., 2006; Standing, 2007; Kelly and Ahern, 2008). Some studies deliberately avoided collecting data in the 'honeymoon period' or three-month stress peak identified by Kramer (1974). This period is characterised by the relief and pleasure of success and not yet tainted by the realities of being an accountable practitioner (Kramer, 1974; Maben and Macleod Clark, 1998).

The dearth of longitudinal studies leaves gaps in our understanding of the relationship between pre- and post-registration experience and its influence on the transition. In effect, the research tells us something about the student experience of transition and something about the newly qualified RN experience but relatively little about the relationship between these stages.

2.6 Review of longitudinal studies

The longitudinal studies informing the development of the current study will now be reviewed: Dearmun (1997, 1998 and 2000) and Bradley (1998) for their longitudinal focus on children's nurses; Gray and Smith (1999) and Holland (1999) for the rich analysis they provide of the expectations of students about qualifying. Several pre- to post-qualifying longitudinal studies of RN (adult) help widen our understanding of the transition (Ross and Clifford, 2002; Maben et al., 2006; Standing, 2007; Kelly and Ahern, 2008). Post-qualifying studies that will be addressed include Gray (1998); Ellerton and Gregor (2003); Duchscher (2008) and Chang and Hancock (2003). This will be followed by a synthesis of findings from all of the studies reviewed.

With few exceptions, sample sizes in the qualitative studies limit the generalisation of the findings to larger populations. However, they contribute inductive theoretical perspectives that can be used in future larger-scale studies. The cumulative findings of the studies reviewed present a compelling picture of key features of the transition from student to RN.

2.6.1 Children's nurses

Dearmun's (1997) longitudinal, naturalistic study of 10 newly qualified children's nurses investigated role stress. Using data from interviews conducted four times during the first year of practice, three groups of factors creating stress were identified. Firstly, caring for

children and families; dealing with anxious parents, terminal illness, child death, and working with medical staff. Secondly, the challenge of unfamiliar tasks such as increased and extended roles, managing the ward, and coping with a new job (or unemployment). Thirdly, contextual aspects such as insufficient resources, staff or equipment and working shifts. Dearmun identified a chronological dimension to stress: from initial survival when the need for support was greatest, to achieving equilibrium but still coping with stress when a lower level of support was needed. The provision of support and the ability and opportunity to reflect on stressful experiences were proposed as essential if new nurses were to be retained. The findings suggest the nurses consolidated their learning and increased their confidence within six months. As the first study to focus on children's nurses during transition, this study makes a significant contribution to the research in this field.

Building on Dearmun (1997), the support needs of the 10 newly qualified children's nurses and the role of the lecturer-practitioner are examined by Dearmun (2000). A disparity was identified between the support offered to newly qualified nurses in the early months and the decline in this over the first year, despite the nurses still feeling the need for support. Dearmun identifies a 'psychological shift' in the nurses' attitudes as they make the adjustment to being accountable for their practice, something they felt they could not rehearse as a student. Four stages of transition were proposed. These are discussed further under the topic 'stages of transition'. The strengths of this paper include the focus on children's nurses and the longitudinal data collection.

In a qualitative exploratory study of six children's nurses, Bradley (1998) used a focus group with final-year students, followed by in-depth interviews with the participants five months post-qualification. The participants felt supported and well prepared but that their clinical skills were limited. They recognised their limitations and, despite initial feelings of fear and awareness of their responsibilities, all had a positive experience, reporting friendly, supportive environments. They felt they would benefit from longer periods of rostered service during the third year to get used to taking on more of the RN role. They felt they had the knowledge, competence and ability to adapt quickly. The pre-qualifying focus group data provided additional points of reference for the post-qualification interviews. Although the small sample size is a limitation, the focus on child branch and longitudinal approach enhance the relevance of the findings.

2.6.2 Student perspectives

Gray and Smith (1999) conducted a longitudinal grounded theory study of the socialisation of 17 DipHE nursing students (adult). Ten participants were interviewed on five occasions and they also kept a diary as an aide-memoire to be used during interviews. Seven participants kept only a diary. The mentor was found to be the lynchpin of students' experiences, and the learning environment was also a key factor. The authors proposed a model for the gradual transition from supernumerary to rostered service. The diary-only participants gradually stopped keeping their diaries, which is a limitation of the study.

In the same year, a longitudinal ethnographic study of the student nurse (adult) in transition (Holland, 1999) identified that the stress of transition begins during the student stage. Analysis of interviews, participant and non-participant observation, and open-ended questionnaires revealed eight themes including the desire and motivation to nurse, learning skills, developing performance and manner, managing stress, and building knowledge and experience. The transition was characterised as a rite of passage and status passage of indeterminate length; getting their NMC PIN did not account for the complexity of the changes they were experiencing. The multiple modes of data collection and ethnographic approach are strengths of this study but the lack of clarity about the sample size is a limitation.

A later longitudinal phenomenological study over four years (Standing, 2007) examined nursing students' acquisition of clinical decision-making skills, including how well prepared they felt for their responsibilities as RNs. The sample of 20 reduced to 10 (1 child branch) by the final stage due to attrition. Multiple modes of data collection including interviews and critical incident analysis enriched the evidence. Standing's participants found having to 'think on your feet' without the 'comfort blanket' of being a student was both stressful and formative. Multiple modes of data collection are a strength of this study but the reliance on self-reporting of decision-making is a limitation.

2.6.3 Pre- to post-qualification studies

A mixed-method study by Ross and Clifford (2002) explored the preparation and transition of 30 students to RN. Data from pre- and post-qualifying questionnaires and pre-qualifying interviews with four participants suggested the transition was stressful and they felt inadequately prepared. The nurses wanted more preparation for clinical skills and more structured learning in practice. Post-qualifying support was considered positive but not consistent. Strengths of this study include the use of pre- and post-qualification

quantitative data but there was limited qualitative data to aid the comparative analysis of the questionnaire data.

A study using questionnaires in the final year of training and in-depth interviews with a sample of 26 at two stages post-registration, examined the extent to which ideals and values taught on pre-registration courses are adopted by newly qualified nurses (Maben et al., 2006). The findings suggest the nurses emerged with strong values but professional and organisational factors 'sabotage' implementation of values. Professional sabotage was linked to covert rules, low support and poor role models. Organisational sabotage included time pressures, role constraints, staff shortages and high workloads. This was based on data from 1997–2000, which may limit its relevance.

A recent longitudinal descriptive study in Australia explored the experience of 13 final-year students through the first six months of employment (Kelly and Ahern, 2008). As students, the participants had positive expectations. Shortly after qualifying they spoke of negative cultural cliques, 'bitchiness' and lack of support. Rotational programmes were seen as a hampering factor that fostered negative experiences. The main findings – that the language and culture of nursing fosters power-games and hierarchies – do not resonate with findings from the UK studies.

2.6.4 Post-qualification studies

Gray's (1998) longitudinal grounded theory study of 10 nurses identified four milestones: first day; first three months; being in charge; and beyond the transition. The first three months as an RN, was identified as the 'most nerve-wracking, painful and stressful part' (Gray, 1998:33). Confidence was thought to ebb and flow during the transition. However, participants' confidence increased after three months, and by six months post-qualification they were more secure about their abilities, whilst still recognising limitations, and felt able to seek guidance. Gray suggests that managing emotions and coping with the unknown are key issues for the neophyte nurse.

A Canadian study of the perceptions of 11 new nurse graduates employed in acute care settings (eight employed in a child health centre) examined the adequacy of their preparation for the role of RN (Ellerton and Gregor, 2003). Data from open-ended interviews at three months post-qualification suggested the new nurses defined their work as a set of skills and tended to focus on routines and procedural aspects of care. It is argued that the nurses had limited capacity for helpful communications with patients and families. This was to be a three-stage, longitudinal study, but only the first stage is

reported on, providing limited insight into the transition. The initial deficit of communication skills may be a reflection of the fact they held a generic qualification and had limited child health experience.

An interpretive study of the professional role transition of 14 nurses conducted in Canada (Duchscher, 2008) used face-to-face interviews at 1, 3, 6, 9, 12 and 18 months; focus groups; pre-interview questionnaires; and monthly journals. A theory is presented that new nurse graduates evolve through three stages of becoming; a journey that is both personal and professional. The stages of 'doing', 'being' and 'knowing' are discussed later in this chapter (see 2.11). The stages were not presented as a linear process but Duchscher does set broad time points for each stage based on her findings. The findings are supported by sample size, number of stages of data collection, timely interviews (reducing reliance on recall), and multiple sources and types of data. The fact it was conducted in Canada may limit the relevance of some findings for the UK.

Very few quantitative studies of student to RN have been conducted, although Chang and Hancock's (2003) Australian study of sources of, and changes in, role stress 2–3 months after entering employment and 11–12 months later makes a valuable contribution. Using a sample of 154 (110 at second stage), questionnaires were administered at each time point. The findings suggest that stress related to transition was linked to role overload and role ambiguity. At the first stage, role ambiguity was the most important factor but, at the second stage, role overload was the main factor. These findings gain credibility from the sample size (drawn from 13 institutions in New South Wales and four hospitals in total), the use of a validated questionnaire and by having two stages. The absence of qualitative data to provide depth of detail about the influence of factors such as rotation programmes is a limitation.

DISCUSSION OF THEMES ARISING FROM THE LITERATURE REVIEW

2.7 The experience of change

Without exception the studies reviewed identify the transition as an experience of change but where they differ is on the nature of that change.

2.7.1 'Reality shock' or 'transition shock'

Some studies refer to the concept of 'reality shock', which describes the dissonance between nursing as taught and the reality of workloads and time pressures that hamper the delivery of ideal standards of care (Kramer, 1974). This theory suggests that the newly

qualified nurse must engage in a complex process of adjustment to the organisational culture as they move from student status to RN. More recent evidence from the UK suggests that the transition from student to RN status is indeed stressful (Dearmun, 1997; Charnley, 1999; Holland, 1999). Some suggest stress is largely influenced by the RN being out in the 'real world' (Jasper, 1996; Gerrish, 2000). Others more specifically suggest stress is due to coping with role ambiguity and perceived role overload (Maben and McLeod Clarke, 1998; Chang and Hancock, 2003). It is also argued that rotational programmes involving frequent changes of clinical area in the first year lead to repeated 'reality shocks' (Kelly and Ahern, 2008).

Building on Kramer's (1974) theory, Duchscher (2009) has labelled the first stage 'transition shock' but argues that transition is not a linear event and individuals will vary in their responses. Her sample spoke of the feeling of 'jumping in the deep end' (Duchscher, 2009:1105). However, other studies do not attribute the early stress experienced by their participants solely to 'reality shock' (Bradley, 1998; Dearmun, 2000; Wangenstein, 2008). Rather, the individuals' subjective responses to the change in role and responsibilities are seen to create a sense of uncertainty and fear, which occurs regardless of the organisational context or workload demands, but may be magnified by increased workload demands, lack of support and perceived skills deficits (Jasper, 1996; Dearmun, 1997, 2000; Maben and McLeod Clark, 1998; O'Shea and Kelly, 2007; Wangenstein, 2008; Andersson and Edberg, 2010).

2.7.2 Stress, uncertainty and fear

There is a broad consensus that stress, uncertainty and fear are experienced during the early post-registration period, but there is evidence that new, post-P2000 RNs cope with this because they are able to question and seek support when necessary (Bradley, 1998; Gray, 1998; Gerrish, 2000; Amos, 2001). Stress has also been identified in some studies of final-year undergraduate students as an obstructing factor in clinical learning that has been linked to self-doubt in the student (Lofmark and Wikblad, 2001) and apprehension about self-perceived limited clinical experience (Heslop et al., 2001).

There is limited research into the impact of stress on newly qualified nurses but it has been argued that nurses who cannot deal with work-related stress will leave the profession (Kramer, 1974; Chang and Hancock, 2003) or move on to other clinical positions (Dearmun, 1998). The causes of stress have been linked to subjective responses and the psychological adjustment to a new role and responsibilities (Dearmun, 1997). In particular, the challenge for RNs is to become more independent whilst ensuring

safe practice (Ramritu and Barnard, 2001; Whitehead, 2001; Ross and Clifford, 2002; Standing, 2007). A more specific connection is also drawn between stress and affective responses to challenging life events, particularly the death of a patient (Dearmun, 1997; Delaney, 2003; O'Shea and Kelly, 2007) and meeting the needs of parents and families (Dearmun, 1998; Jackson, 2005).

Several studies of newly qualified RNs identified subjective feelings of inadequacy and uncertainty during the period of transition from student status to RN (Charnley, 1999; Gerrish, 2000; Jackson, 2005). Indeed, Duchscher's (2009) analysis of four earlier studies of transition identified intense experiences of fear during the first four months that were considered physically and psychologically debilitating. However, although the transition from student to RN is perceived as a stressful and difficult period for most nurses, a number of studies concluded that the majority of nurses make this transition successfully within 6–12 months of qualifying (Gray, 1998; Maben and Macleod Clark, 1998; Dearmun, 2000; Delaney, 2003).

2.7.3 From supernumerary status to rostered service

The transferral of nurse education into HEIs resulted in formalising the status of the student nurse as someone who is there for the purpose of learning to nurse and who is supernumerary to the clinical workforce (UKCC, 1986). This change was intended to ensure that students could be protected from the pressure felt by pre-P2000 apprentice-style students to 'pull their weight' as part of the team at the expense of their own learning (Melia, 1987). There is much evidence to suggest that supernumerary status is poorly understood, poorly implemented and does not always result in appropriate learning opportunities. Indeed, some suggest the pre-P2000 apprentice-style model persists (Elcock et al., 2007; Driscoll et al., 2009), resulting in students doing repetitive menial tasks rather than working closely with a skilled mentor to develop their nursing skills. Others have revealed advantages and disadvantages to both supernumerary and rostered service:

Supernumerary status facilitated learning in the clinical environment, but was felt to be poorly understood by practice staff. Rostered service facilitated a sense of belonging at the expense of student learning. (MacLeod Clark et al., 1996)

Hyde and Brady (2002) found that many RNs misinterpreted the supernumerary status of students as one of observer rather than active learner. Such misunderstandings have implications for the type of experience students will be offered (Mooney, 2007). Mooney's

grounded theory study of 12 Irish nurses, 6–10 months after qualifying, identified perceived problems with supernumerary status. In the pre-registration stage, themes of 'learning on the edge' and 'feeling like a shadow' suggest that supernumerary status was misunderstood by other staff, resulting in a lack of opportunities to gain nursing experience or to feel part of the team. Her description of a post-registration 'metamorphosis' in which RNs felt they were 'becoming visible' and experiencing a new awakening suggests there was no gradual transition for those nurses.

In preparation for the transition to RN, students are thought to be aided by a period of rostered service during the latter part of the final year, i.e. they are no longer supernumerary and are allocated their own patients under (less direct) supervision. There is no consistent evidence to suggest what the optimum period of rostered service should be in terms of its contribution to a smooth transition. Some studies suggest that students feel a period longer than the final six months would be beneficial (Bradley, 1998). Being rostered enables the student to take responsibility for a group of patients, but if this occurs too early in the branch programme it causes students 'significant upset and brings unexpected pressures' (Gray and Smith, 1999:642) and still does not permit them to adequately experience ward management. If the transition from supernumerary status to rostered participation is delayed until the third year, it is thought to facilitate a smoother transition (Gray and Smith, 1999). Although stress was experienced by the participants, the rostering became more manageable as they neared the end of the course. Others also support a more gradual bridging from student to RN (Gerrish, 2000; Wangenstein et al., 2008).

2.7.4 Accountability

Arguably the most pivotal change in the expectations of society and employers is the requirement for a nurse at the point of registration to take on accountability for their own practice and for the supervision of others (NMC, 2004b; NMC, 2008c). Highs and lows have been associated with taking on greater levels of accountability, responsibility and autonomy, with nurses welcoming the anticipated benefits of their new RN status whilst also recognising and fearing the increased expectations of self and others (Maben and Macleod Clark, 1998; Amos, 2001; Evans, 2001). Some studies directly or indirectly describe the success of qualifying as a 'double-edged sword' (Amos, 2001; Heslop et al., 2001; Whitehead, 2001) in which enjoyment of success is juxtaposed with anxiety about what will be expected of them.

Gerrish (2000) compared the transition of pre-P2000 RNs with post-P2000 RNs and conceptualised the transition in terms of 'fumbling along', in which the latter experienced more support than the former yet also expressed more anxiety about their professional accountability. The availability of appropriate levels of support and well-planned induction programmes are thought to ease some of the neophyte nurses' concerns (Wangenstein, 2008) but cannot mitigate the legal requirement for the RN to be accountable for their own practice.

2.8 Self-perception

2.8.1 Self-image and self-belief

It is argued that the neophyte RN needs two types of acceptance: social and professional (Andersson and Edberg, 2010). They want to be liked as a person and respected for their professional ability (Cope et al., 2000). Anderson and Edberg (2010) suggest new RNs have high expectations of self and feel others also expect a lot of them. These perceptions form a potent combination that can have a debilitating effect on the new RNs' self-belief. Subjective feelings of inadequacy are a common source of negative feelings about the transition (Gerrish, 2000; Heslop et al., 2001; Ross and Clifford, 2002; Jackson, 2005; Duchscher, 2008).

There is some evidence of optimism and confidence in the student stage in relation to future working relationships (Heslop et al., 2001; Kelly and Ahern, 2007). Indeed the students' inability to envisage future demands are characterised as 'gliding through' by Newton and McKenna (2007). However, this optimism dissipates in the early months after qualifying (Delaney, 2003; Duchscher, 2008; Kelly and Ahern, 2008; Duchscher, 2009). Fluctuations in the level of responsibility granted to new RNs creates uncertainties; when the ward is busy its 'in at the deep end' but when it's quiet they get less responsibility thus leaving the new RN uncertain what is expected of them (Dearmun, 2000; Whitehead, 2001; Kelly and Ahern, 2008).

Duchscher (2008:444) argues that new RNs tend to be more idealistic than realistic and that a positive professional identity gained by the end of the course is 'fractured under the weight of performance anxiety and self-doubt'. She suggests that the RNs focus on feelings of inadequacy and fail to recognise shortcomings in the support and supervision being offered to them, internalising responsibility for their performance instead. New RNs respond to feelings of inadequacy by engaging in a rapid expansion of their skills but this

can expose them to risks, particularly the risk of being exposed as incompetent (Duchscher, 2008).

Self-awareness and self-belief in competency and the ability to be accountable are recognised as supportive of confidence in nursing skills (Etheridge, 2007; Duchscher, 2008). Confidence enables RNs to trust themselves and think like a nurse, promoting effective decision-making (Etheridge, 2007).

2.8.2 Losing student status

The transition to RN has been described in terms of leaving behind the 'comfort blanket' of student status (Standing, 2007) or 'student pedestal' (Whitehead, 2001). Mooney's (2007) participants welcomed the 'metamorphosis' because it allowed them to come out of the 'shadows'. For others, the loss of student status created feelings such as being 'in at the deep end' (Dearmun, 2000; Kelly and Ahern, 2008) or 'flying without a parachute' (Whitehead, 2001) which had an impact on their self-esteem.

2.8.3 Self-esteem and the effects of changing status

Positive support in the student stage has been linked to good self-esteem (Maben et al., 2006) and a positive attitude towards the post-registration period. The initial challenge to new RNs' self-esteem is coming to terms with new environments, new systems, and professional and organisational culture, which Wangenstein et al. (2008) conceptualise as 'uncertainty and chaos'. A key task is learning to understand their role in the hierarchy (Newton and McKenna, 2007; Duchscher, 2008); for example, what you can ask, who you can ask and what is expected of you. Jasper's (1996) sample felt it was more than just a transition; it was a complete role change that they did not feel prepared for in the early stages.

2.8.4 Confidence, competence and the affective domain

The NMC proficiencies for RNs (NMC, 2004a) focus on the ability of the practitioner to deliver care that is safe and based on the best available evidence. Hence, much of the research in this field has tended to focus on the assessment of competence with a primary focus on knowledge and psychomotor skills. A small-scale study of how neophyte children's nurses grade their own competence (Ramritu and Barnard, 2001) found that competence tends to be viewed in relation to performance and is seen as evolving.

The affective component of nursing practice and how this may influence the delivery of care and nurses' job satisfaction has had little research. One small-scale study that

explored this issue (Pfeil, 2003) attempted to develop criteria for the assessment of practice, including the affective component of clinical skills. The findings suggest that assessors and students lack skills in the assessment of the affective domain or that knowledge of the affective component of learning is seen as less relevant. This may be a reasonable assumption in students who are performing well. It does, however, leave a potential gap in the evidence regarding students who may be performing less well – it does not enable practitioners to identify whether the affective element may be impacting upon manual dexterity or interpersonal skills (Cope et al., 2000).

2.9 Nursing skills

2.9.1 Lack of management skills

Research into the transition of nurses from the pre-P2000 programmes highlighted common themes of concern about management and communication skills (Lathlean, 1987; Gerrish, 1990). Despite the UKCC (1990) recommendation that new RNs should experience a period of 3–6 months' preceptorship, more recent studies found that nurses still feel they are 'dropped in at the deep end' (Amos, 2001) and that they lacked the clinical, management and organisational skills necessary for a smooth transition (Maben and Macleod Clark, 1998; Gerrish, 2000). However, Gerrish (2000) suggested that post-P2000 nurses were more assertive and willing to speak up regarding their learning needs.

2.9.2 Clinical skills

New RNs tend to be preoccupied with perceived deficits in their clinical skills and their own competence (Maben and Macleod Clark, 1998; Gerrish, 2000; Ramritu, 2001). However, any such deficit is thought to be short-term (Maben and Macleod Clark, 1998; Delaney, 2003). Gerrish (2000) compared pre- and post-P2000 graduates and found that although the post-P2000 graduates shared a sense of feeling inadequately prepared for their role there was evidence that they were better able to make the transition than the pre-P2000 graduates. Maben and Macleod Clark (1998) and Gerrish (2000) each found that although new RNs still felt inadequately prepared they were more likely to acknowledge when they lacked skills or knowledge than traditionally trained nurses (Gerrish, 1990).

Few studies have examined the relationship between confidence and competence but NMC (2004b) identified mentors' concerns about students who are confident despite exhibiting poor clinical skills. Others suggest that students usually have a good range of competence at the point of qualifying (Lauder et al., 2007) but lack confidence. Roberts

and Johnson (2009) argue that lack of confidence is sometimes misinterpreted as lack of competence. They argue that contemporary students' awareness of legal and ethical dimensions of practice may influence perceived deficits in confidence rather than deficits in competence.

2.10 Organisational culture

2.10.1 Preceptorship and support

The purpose of preceptorship is to facilitate nurses during the transition from student to RN (Morton-Cooper and Palmer, 1993; Ouellet, 1993; UKCC, 1994). In the USA, preceptorship is provided during the latter stages of the students' undergraduate programme (Ouellet, 1993; Barrett and Myrick, 1998) whereas in the UK it has been introduced as a post-registration support strategy. There is little evidence to suggest that either of these approaches offers advantages but there is consensus within the literature that senior student nurses and newly qualified nurses benefit from some form of support in this transitional period. However, mentor support varies and most studies suggest that more support is needed than is provided (Jasper, 1996; Gray and Smith, 1999; Dearmun, 2000; Duchscher, 2008 and 2009).

There is little evidence of a coherent approach to the provision of preceptorship across the UK. However, there is some evidence that where preceptorship is provided the new RN benefits from this (Bradley, 1999; Hancock, 2002). However, a shortage of qualified nurses to take on the preceptor role and workload pressures often result in some preceptorship programmes not being as effective as originally intended (Allen, 1999; Charnley, 1999; Bick 2000).

2.10.2 Organisational sabotage

Maben et al. (2006) use the term 'organisational sabotage' to describe the impact of time pressures, role constraints, shortage of staff and work overload. Other studies also identify lack of resources, staff or equipment as organisational deficits that create additional stress for the new RN (Dearmun, 1998; Whitehead, 2001; Chang and Hancock, 2003; Duchscher, 2009).

2.10.3 The influence of final-year placements

Clinical placement experience plays a key role in the undergraduate nursing curriculum, with students spending 50% of their time in practice settings. A number of studies highlight the impact of placement experience on the student and stress the importance of

supportive and positive placement experience (Ogier, 1981; Dunn and Hansford, 1997; Savage, 1998 and 1999; Andrews et al., 2005).

There is also some evidence to suggest that the final-year students' anticipation of the post-qualifying period influences their future employment preference. Heslop et al. (2001) surveyed the expectations of third-year student nurses from an Australian university and found that, although the participants felt well prepared in many aspects of nursing, significant numbers expressed concern about caring for caseloads of five or six patients and about communicating with doctors. This study identified that most graduates sought good graduate programmes and preferred their first RN appointments to be in large public hospitals where they could gain further guidance and support.

2.11 Stages of transition

Five of the longitudinal studies have identified 'stages' or 'milestones' of transition: Gray (1998) – four milestones; Evans (2001) – three stages; Dearmun (2000) – four stages; Duchscher (2008) – three stages; Andersson and Edberg (2010) – two stages. However, there is limited consensus about when the stages occur or the labelling of these stages (see appendix 4).

All five 'stages models' suggest transition is completed within 12–18 months, but this may be arbitrary as only one study has extended beyond the first year. Gray (1998) argues that the first three months were the most difficult but confidence was seen as ebbing and flowing throughout the first year. She suggests that within 4–6 months her participants settled into their roles. Evans (2001) describes a separation from student status and transition to RN status followed by integration into the profession within the first year; however, the limited data collection limits the value of these findings. A slow and steady transition culminating in the need for new challenges by the end of the first year in order to maintain motivation and interest is presented by Dearmun (2000):

- The initiation stage, involving psychological adjustment, mastering skills, becoming accepted, learning the ropes.
- A consolidation stage, with increasing confidence and integration of knowledge and skills.
- Out-growing the role stage, looking for new challenges.
- Promotion vs. stagnation stage, confusion and uncertainty, making difficult career decisions.

A simpler conceptual model of passage between two poles of 'rookie' (up to 12 months) and 'genuine nurse' (6–18 months) is proposed by Andersson and Edberg's (2010) retrospective study. They argue that there is an indeterminate period of overlapping progress that primarily occurs in the 6–12 month post-qualification period.

There is consensus in the stages models that the early months are the most stressful, in which nurses focus very specifically on building up their clinical skills as a basis for building their confidence and gaining the trust of others. With some individual variations, the core issues are thought to be predictable:

The initial professional role transition experience of the NG [Nurse Graduate] is felt with varying intensity, is founded upon relatively predictable fundamental issues, and exists within individually motivated and fluctuating states of emotional, intellectual and physical well-being. (Duchscher, 2009:1105)

Despite the lack of consensus about when stages of transition may occur, there is some congruence in the evidence from these studies about the actual experiences of the nurses across the stages in terms of awareness of leaving the student status behind; an emphasis in the early months on gaining clinical and management skills; feeling like an RN; and looking to the future.

2.12 Themes potentially more specific to children's nurses

Children's nurses share many of the same concerns as other nurses in relation to clinical skills, accountability and management. For children's nurses (and generic RNs working in child health), an additional focus of anxiety centres on communicating with parents and meeting their expectations (Dearmun, 1998; Ellerton and Gregor, 2003; Jackson, 2005) and coping with stressful events (Dearmun, 1998). However, other studies (Gray, 1998; Maben and McLeod Clarke, 1998) identified that adult nurses also have concerns about issues such as breaking bad news and communicating with relatives.

2.13 Empirical evidence and theorising

This review of studies of transition from student to RN has provided a basis for considering empirical evidence, related concepts, and theories that may be relevant to the current study. Implicit within the thematic groupings identified above (2.7–2.12) are the concepts of occupational (or work-role) transition and occupational socialisation. These

respectively refer to how individuals experience work-role change and how they internalise the values, norms, attitudes and behaviour of the professional role they have attained. The scale of this study limits the scope for empirical or theoretical generalisation; however, it is pertinent to examine the wider resonance of the findings from this naturalistic study with reference to both the empirical evidence of previous studies and theoretical models of role transition and occupational socialisation (Miles and Huberman, 1994; Dearmun, 1997) (chapter 3: 3.10; chapter 7: 7.4).

2.14 PART B: THEORETICAL FRAMEWORKS

2.15 Rationale

Theorising is characterised as moving from 'the empirical trenches to a more conceptual overview of the landscape' because empirical evidence without reference to concepts may be meaningless (Miles and Huberman, 1994:261). In the phenomenological tradition, a review of theoretical concepts was delayed until after data analysis. This prevented the imposition of a structure in advance of data collection and data analysis. However, van Loon and Kralik's conceptualisation of transition as convoluted and involving changes in self and self-agency in the face of challenging life events provided a broad conceptual basis for the study; it encapsulated a consensus derived from a major review of the literature on transition (2005, cited Kralik et al., 2006) (chapter 1: 1.7.1). The theoretical perspectives considered for subsequent discussion of the findings were: situated learning (Lave and Wenger, 1991), communities of practice (Wenger, 1998), role transition (Van Gennep, 1960; Nicholson, 1984; Meleis et al., 2000) and occupational socialisation (Dingwall, 1977; Ibarra, 1999).

Student nurses spend 50% of their time in a diverse range of practice placements learning under the supervision of mentors. This could be defined as 'situated learning' (Lave and Wenger, 1991) in 'a community of practice' (Wenger, 1998). Within these theories, the concepts of 'peripheral participation' and 'inbound trajectories' offer potential theoretical frameworks for the transition from student to RN. However, the focus of this study was the experience of the individual rather than the situation. There was therefore insufficient contextual data to apply these theories.

The theories of role transition and occupational socialisation were identified as potentially useful theoretical frameworks for the current study.

2.16 Theories of role transition

Role transition has been defined as a 'convoluted passage' (van Loon and Kralik, 2005) or an experience of 'discontinuity and flux' that requires individuals to work towards new 'synchronisation' (Ashforth and Saks, 1995:157). Such discontinuity may be caused by 'positive' as well as 'negative' life events. The unsettling nature of change and how individuals adjust to this is the focus of transition theory.

From Van Gennep's (1960) theory of Rites of Passage (ROP) which sought to explain socio-cultural transitions, and Glaser and Strauss's (1971) conception of work-role transitions as 'status passage', to Nicholson's (1984) theory of work-role transitions, theorists attempt to explain the processes involved in role transition. Meleis et al.'s (2000) midrange theory develops a specific focus on the experience of transition for the individual and how they engage in the process. These theories will now be considered in order to identify a theoretical framework that may help illuminate the findings of the current study.

Most theoretical models of transition follow a linear pattern of three or four stages and share similar features: the notion of leaving or losing some aspect of life, facing a new situation, managing feelings of uncertainty and challenges to confidence, and finally reaching a resolution involving an adjustment to the new situation (Van Gennep, 1960; Nicholson, 1984; Meleis et al., 2000; Bridges, 2004). The ROP model involves three stages: the pre-liminal (rites of separation); the liminal (rites of transition) and the post-liminal (rites of reincorporation), and has influenced all subsequent models. Nicholson's (1984) model also incorporates the influence of anticipation of change and the notion that transition involves an ending and a beginning; the leaving behind of something that may or may not have prepared the individual for their new role. However, the notion of linearity and unidirectional progression of transition is questioned by some (Kralik et al., 2006), who see transition as a back and forth movement in which stages overlap. Meleis et al. (2000) advises that transition should not be viewed as a single event but as a process occurring over time. The significance of time in transition justifies longitudinal studies (Kralik et al., 2006).

In the fields of psychology and health, role transition theory attempts to explain how individuals adapt to changes in their lives (Meleis et al., 2000; Kralik et al., 2006). Adaptation is seen to involve cognitive, behavioural and affective adaptation (Nicholson, 1984) but much research in the field is limited to quantitative studies of cognitive and behavioural adaptation. It is argued that individuals are subjected to both internal and

external influences during transition and face social and psychological risks during periods of change (Nicholson, 1984; Ibarra, 1999; Meleis et al., 2000). Given that transition is defined as placing demands on the individual to change, there is surprisingly little research examining the experience of role change from the subjective perspective (Ashforth and Saks, 1996).

Interest in the concept of transition within nursing has emerged primarily in response to the perceived need for nurses to understand the transitional experiences of their clients or patients (Meleis et al., 2000). However, these theories have also been considered in relation to the experiences of nurses and midwives making transitions in their employment or professional status (e.g. Hunter et al., 1996; Howkins and Ewens, 1999; Brennan and McSherry, 2007). Meleis et al. (2000) provide a broad-based model derived from five studies conducted from a feminist perspective, which takes into account the influence of a wide range of factors such as race, class, culture and gender.

Four broad types of transition have been identified: developmental, situational, health and illness, and organisational (Schumacher and Meleis, 1994). Developmental changes occur across the lifespan and are well recognised, such as child to adolescent or parenthood. Situational changes may include new jobs, new roles or more complex changes like migration. Health and illness may involve responses to awareness of threats to health, like diagnosis or treatment options. Organisational transitions include environmental, political, social and economic changes and their impact on individuals.

The transition of interest in this study is situational; specifically, changing roles, jobs and locations. There are no theories of role transition specific to neophyte nurses, or indeed nurses, and much of the theory in this field has emanated from research in the world of business (Nicholson, 1984; Ashforth and Saks, 1995) and finance (Ibarra, 1999). However, Glenn and Waddington (1998) applied Nicholson's (1984) theory in an analysis of the transition from RN to clinical nurse specialist. Nicholson focuses on two potential outcomes of transition – role development and personal development – as independent adjustment processes. Personal development involves adapting self to the role, whereas role development involves moulding the new role to fit the self. Nicholson explores the influence of four factors on role adjustment at times of change: role requirements, motivational orientation of the individual, prior occupational socialisation, and organisational socialisation (e.g. induction). These factors are thought to lead to four possible modes of adaptation: replication, absorption, determination and exploration. Nicholson hypothesises that high or low discretion in the new role are key influences on

occupational transition, i.e. low role discretion will lead to replication and absorption whereas high role discretion will lead to determination and exploration. West and Rushton (1989) found that nursing students experiencing low discretion and high novelty had high levels of personal change and low levels of role change (supporting Nicholson's theory).

A criticism of Nicholson's work-role transition theory is that it tends to focus on the amount of change observed rather than the valence of the change for the individual (Ashforth and Saks, 1995). Having applied Nicholson's model in a longitudinal quantitative study, Ashforth and Saks (1995) concluded that personal and role development are interactive in nature rather than discrete, i.e. changes in one can influence the other. They concluded that quantitative methods may not be conducive to revealing the personal experience in that changes that appear small on a standardised scale may be experienced as large by the individual. Hence they support the use of existential-phenomenological research design.

The purpose of transition processes is to enable the individual to adapt and accommodate the changes experienced rather than return to a previous state (Meleis et al., 2000; Kralik et al., 2006). The middle-range theory of transition developed by Meleis and colleagues focuses on how individuals may navigate transition and achieve a positive outcome, and emphasises mastery of the skills and behaviours needed in the new situation (Meleis et al., 2000).

Meleis et al. (2000) suggest that patterns of transition may be single, multiple, sequential, simultaneous, related or unrelated. The properties of transition identified in the theory include awareness, engagement, change and difference, transition time span, and critical points and events. The theory identifies three core influences on transition: personal, community and society, each of which may include facilitators or inhibitors. The key elements of personal influences are meanings, cultural beliefs and attitudes, socio-economic status, and preparation and knowledge (Meleis et al., 2000). Community influences may include the availability of information, support groups and role models, whilst societal influences may include stigmatisation and marginalisation. For example, the transition of migrants to a new culture may be experienced as stigmatising and marginalising (Meleis et al., 2000), whereas the experience of a student becoming a qualified professional may result in a higher social status. The model also proposes patterns of response in terms of process indicators and outcome indicators. Process indicators include feeling connected, interacting, location and being situated, and developing confidence and coping. Outcome indicators are defined in terms of 'mastery'

and 'fluid integrative identities' (Meleis et al., 2000). The findings of the current study are discussed with reference to Meleis et al.'s theory because it offers a comprehensive framework for considering the complexities of adjustment to change (chapter 7, 7.4).

2.17 Occupational socialisation

The concepts of role transition and occupational socialisation are frequently used either synonymously or as complementary to each other in the literature (e.g. Nicholson, 1984; Ibarra, 1999; Duchscher, 2009). Indeed, theories of role transition invariably include a focus on socialisation (Ashforth and Saks, 1995). As noted in chapter 1 (see 1.7.2), socialisation involves the internalisation by newcomers of the norms and values of the new group.

Socialisation is experienced at a personal level; Howkins and Ewens (1999) argue that the way in which individuals adapt has shifted from the notion of this being a passive or reactive response to an active, indeed proactive, process, requiring the engagement of the individual. It is seen as involving the individual's past, their capacity for reflective learning and ultimately the internalisation of the beliefs and values taught or experienced on an educational programme (Howkins and Ewens, 1999).

The socialisation of student nurses was first described by Melia (1987). She found that, when attempting to manage their role as both a learner and worker, students were willing to compromise their learning in order to fit in (Melia, 1987). More recent research suggests that the social context of practice still exerts these influences on student nurses (Greenwood, 1993; Philpin, 1999; Cope et al., 2000; Neary, 2000). Transition poses a threat to self-identity because it involves questioning and changing ways of seeing self, the social and environmental context and ways of presenting self (Meleis et al., 2000). It is argued that maintaining social relationships and/or making new connections plays a key role in how individuals respond to change because this facilitates access to information and support (Meleis et al., 2000).

The experience of transition is not unique to neophyte practitioners as revealed in studies of experienced nurses when they move to an unfamiliar workplace or change their professional role (Hunter et al., 1996; Brown and Olshansky, 1997; Kelly and Matthews, 2001; Rosser and King, 2003). However, discrepancies between the 'ideal' as taught and the reality of the clinical environment have been linked to role discrepancies and

potentially role conflict for neophyte RNs (Shead, 1991; Dearmun, 1998; Duchscher, 2009). This places a demand on the neophyte RN to adapt to the reality of their work-role.

Wanous (1992) focused on interpersonal interactions between the newcomer and the team as being central to the socialisation process; a process that culminates in mutual acceptance if socialisation is successful, thus facilitating movement from 'newcomer' to that of 'insider'. The influence of individual and situational factors on role adjustment was also examined by Ibarra (1999) who proposed a framework to demonstrate how individuals evolve a repertory of strategies to bridge the gap during periods of adjustment. Central to Ibarra's argument is the notion that socialisation involves changes in professional identity (which she distinguishes from persona or image), i.e. the impression an individual may hope to convey to others, as distinct from their self-perception.

This study is informed by Meleis et al. (2000) and Kralik et al. (2006) in that a process was developed that focused on the experiences of the participants over a period of time. However, decisions about the timing of interviews were based on evidence arising from previous studies in the specific field and are somewhat arbitrary in the sense that we cannot know with any accuracy when a process of transition begins or ends. Some transitions may be experienced as relatively small and some much bigger, but the theory proposed by Meleis et al. (2000) places in context the individuality of responses to changes.

2.18 Conclusion

Studies of the transition from student nurse to RN are limited in number and generally small scale, tending to involve single investigators, small samples and single locations. The main methodologies used are phenomenology or broad qualitative approaches, although a small group of quantitative studies were identified. The main methods of data collection are in-depth interviews and/or focus groups. Whilst the findings are of interest, they cannot be generalised to larger populations. However, the congruence in the broad findings of both the single time-point and longitudinal studies from the UK and other countries demonstrates some interesting trends in the experience of neophyte nurses. Where there is consensus across all the studies reviewed, it is that the transition from student to RN always involves a period of discomfort and uncertainty, and that neophyte nurses require appropriate levels of support and development in order to make a positive transition. The limited number of longitudinal studies and of studies of children's nurses highlights a gap in the evidence that this study aims to fill.

The theories of role transition and occupational socialisation, specifically Meleis et al. (2000), provide theoretical perspectives that will be considered in relation to the findings from this study.

3 METHODOLOGY

3.1 Introduction

This chapter examines the philosophical and methodological basis of the study and the rationale for a longitudinal approach. The research method and use of reflexivity is considered and ethical considerations are addressed. The research design is then described and justified followed by the research procedures adopted and the data analysis process. The trustworthiness of the research is then considered with reference to my decision trail.

My focus was on what becoming a children's nurse was like, or how as individuals they 'interpret and make sense of the world in which they live' (Holloway and Wheeler, 2002:3). Hence, I needed to access the personal, subjective experiences and stories of those making the transition from student to RN. The literature review has demonstrated the effectiveness of qualitative approaches for this type of study. Indeed, the rigorous application of qualitative methods can elicit qualities of an individual's experience that could not be accessed using a positivist approach (Miles and Huberman, 1994; Robson, 2002; Streubert Speziale and Carpenter, 2003).

Positivist methods do have a place in nursing research and have been used successfully within the field of interest. When much is known about the phenomenon, a deductive approach can be used, such as profiling the children's nursing workforce (Robinson et al., 2006); measuring stress and role ambiguity in new nurses (Chang and Hancock, 2003); measuring the socialisation of graduate and diplomate nurses using a validated scale (Taylor et al., 2001); a study of factors influencing theoretical knowledge and skill acquisition in student nurses (Corlett et al., 2003). However, for the purpose of the current study, the literature review did not demonstrate sufficient knowledge of the phenomenon of interest to justify a quantitative method, particularly in relation to children's nurses. Additionally, the focus of this study is on the 'lived' experience of being a student and becoming an RN; quantitative approaches are not amenable to accessing individuals' stories, therefore a qualitative method is considered appropriate.

The primary justification for choosing a particular research method is that it will enable you to answer your research questions; therefore, the method should not be the starting point

for the research (Kvale, 1996; Robson, 2002). Indeed, it is argued that the research design and method should emerge from the research problem or question (van Manen, 1983; Miles and Huberman, 1994; Robson, 2002). Within the qualitative paradigm, various methodological approaches are available to the researcher. Arguably the most significant decision to be made for this study was which approach to adopt.

As discussed in chapter 2 (see 2.3), a number of earlier studies in this field used a phenomenological approach (e.g. Delaney, 2002; Jackson, 2005; O'Shea and Kelly, 2007; Standing, 2007; Duchscher, 2008). Several used grounded theory (e.g. Gray, 1998; Mooney, 2007) and others used a broad qualitative enquiry approach (e.g. Maben and Macleod Clark, 1998; Whitehead, 2001; Wangenstein et al., 2008). Therefore, there is a range of qualitative methods that could have been used for this study. The methodological approach also needed to be congruent with the study's philosophical basis (Koch, 1993; Holloway and Todres, 2003; Munhall and Chenail, 2008) and a number of factors affecting the decision process are considered below (see 3.2–3.3).

3.2 Philosophical basis of the method

Phenomenology is both a philosophy and a method of studying human experience (Koch, 1993; Jones, 2000; Streubert Speziale and Carpenter, 2003). The essential goal of this philosophical approach is to describe the lived experience of individuals (Holloway and Wheeler, 2002) rather than being an abstract account of their experiences (Pollio et al., 1997). It was an appropriate philosophical basis for the study but I needed to decide which of the two broad schools of thought would guide the study: Husserlian descriptive or Heideggerian interpretive phenomenology.

Husserl's philosophy of transcendental phenomenology requires bracketing by the researcher of preconceived attitudes or experiences in order to access the essence of an experience (Jones, 2000). Van Manen (1990:25) describes this as the 'lived-through quality of lived experience', which he distinguishes from the later work of Heidegger who wanted to go beyond the pure description of a lived experience to develop an ontological understanding of 'being in the world' or 'Dasein' (Heidegger, 1962).

The main thrust of Heidegger's (1962) interpretive method was its focus on ontology or 'how we live in the world' (Taylor, 1995; Jones, 2000). His approach combined phenomenology and existentialism to develop a phenomenological hermeneutic approach

to the study of human experience (Jones, 2000). The significance of the way in which human beings assign meaning to experiences is articulated by van Manen (1990:3):

Through meditations, conversations, day dreams, inspirations and other interpretive acts we assign meaning to the phenomena of life.

Within the hermeneutic tradition, the analysis of language and text are central to the study of 'Being' (Gadamer, 1989; van Manen, 1990; Taylor, 1995; Pollio et al., 1997; Jones, 2000). The task of the researcher is to gather linguistic accounts of lived experience and through a hermeneutic process interpret the meaning of 'Being'. A fundamental principle of this philosophical approach is that the person and the world co-constitute each other. Koch (1995) describes this as the indissoluble unity of the 'person-world'. In the context of the research process it is the 'fusion of horizons' of the participant and the researcher that leads to understanding, i.e. there is no suggestion that an objective truth exists; rather, a shared understanding.

Philosophically, an interpretive phenomenological approach was considered appropriate for this study because my interest was on the experience of individuals and how they made sense of their experience of the transition to RN. A Husserlian descriptive approach was not appropriate because there was no evidence from earlier studies to suggest that a single phenomenon could explain the transition from student to staff nurse. The interpretive approach would also permit me as a children's nurse to draw on personal knowledge to gain a deeper understanding of the participants' experiences, which a descriptive approach would constrain. This is discussed further in 3.3.1.

3.3 Methodological approach

The method of data collection and data analysis had to be consistent with my philosophical stance and facilitate access to the participants' experiences. The former was influenced by Heidegger's (1962) hermeneutic phenomenology and Gadamer's (1989) emphasis on the structure of phenomena – the way people understand the world in which they live. The latter was influenced by van Manen's arguments about the significance of linguistic expressions as data.

My aim was to access descriptions of the experience of being a final-year student, leaving that situation to take on the role of RN and working in that role for a period of one year. The focus would be on gathering stories and reflections based on actual experiences of

the participants during that period. It was anticipated that each participants' experiences would be described in terms that were unique to them, i.e. the 'person-world', and that there would be multiple phenomena influencing their journeys. The emphasis was on accessing stories of those experiences – in particular, accessing the words and expressions of the participants.

3.3.1 Applying key concepts of hermeneutic phenomenology

The literature identifies two significant features of Heidegger's theory: the historicity of understanding and the hermeneutic circle (Koch, 1995; Taylor, 1995; Draucker, 1999).

3.3.1.1 Historicity

The historicity of understanding encompasses the argument that both participant and researcher bring their 'forestructure' to the research encounter, which combines past, present and future (Jones, 2000). This can be understood in relation to:

- **Background**

This is defined as the sum of the culture the person is born into and all the learning about the world that is carried with that; this influences what we see as 'real' (Koch, 1995). The notion of background relates not only to the presence of these influences but also to the limitations around the extent to which they can be made explicit (Annells, 1996).

In the context of this study, background may be understood on many levels: bodily awareness, personality traits, and social norms and practices such as dress, language, dietary practice and rites of birth and death. In addition to the individual, familial and societal learning that influences researcher and participant is the shared professional background learning of nursing. These add to, enhance or challenge (overtly or covertly) our personal background. I therefore needed to be open to recognising the potential influence of factors that may not be explicitly known.

- **Pre-understanding**

This is based on background, particularly language and cultural traditions. These are seen as being so implicit in our background that we cannot eliminate or 'bracket' them. The importance of this concept in interpretive hermeneutic research is that it causes us to acknowledge that these background influences will play a part in our interpretations, even within what might be claimed as descriptive findings. Van Manen (2002:2) points out that as humans we are always interpreting our experiences and the research encounter between participant and researcher is no exception to this; there can be no claim to

objectivity but rather a call to acknowledge our interpretations and the influences on us. This is considered in relation to my role in data collection (see 3.8.10).

Pre-understanding can also enable us to gain insights that another researcher may not gain. For example, as a children's nurse I share with the participants a professional language, ethical principles, professional regulation and understanding of the health care culture in England. Some personal memories of situations and feelings may resonate with stories from the participants. Conversely, I recognised that personal experiences and feelings from my past nursing career do not always resonate with my students because the world as they encounter it today differs from that of my own student days. Awareness of the influence of background helped me to develop the design and conduct of the study and is considered in reflexive positioning of self (chapter 1: 1.9).

- Co-constitution

This concept represents Heidegger's (1962) view that there is unity between the person and the world – person and world are mutually or co-constructed. 'From the beginning the person is amongst it all, being in it, coping with it' (Dreyfus, 1987: cited Koch, 1995:831).

- Interpretation

To understand our experiences we need awareness of our background, our historicity and our knowledge of the social context (Draucker, 1999). Heidegger (1962) argued that interpretation is always happening and is set against the background of historicity, i.e. it is not solely the act of a researcher but of all individuals. My goal in the research context is to use interpretation to bring into focus what Koch (1993) describes as shared cultural meanings

- Fusion of horizons and co-constitution

Gadamer's (1976) concept of fusion of horizons is based on co-constitution, which encompasses the context, the participant's perspective and the researcher's understanding as the basis for interpretation. This is achieved during the interviews and when discussing the results with the participants (3.10.1); It is about going beyond what is immediately obvious and seeing it in the wider context (Annells, 1996).

- Hermeneutic circle

The hermeneutic circle involves a movement between the parts and the whole in the search for understanding and is an essential part of co-constitution; it promotes a dialogue between understanding and interpretation (Annells, 1996). In the context of this study the

hermeneutic circle was used to examine the extent to which the descriptive and interpretive themes were a reflection of the original data (see 3.9 and chapter 4, 4.3).

Phenomenological research focuses on meaning, particularly on the meaning of an experience for the individual (van Manen, 1983; Benner, 1994; Cohen et al., 2000; Smith and Osbourne, 2003). The focus of the interpretive paradigm is on understanding the subjective experience of individuals (Cohen et al., 2000). I therefore approached the research process with the intention of being open and of questioning my assumptions in order to recognise when these may impact on the research process.

The significance of method to the integrity of a study is well established in the core methodology texts. The research design is seen as providing the researcher with a way of accessing the participant's world and gaining understanding of the shared experiences of researcher and participant (Janesick, 1998). The conceptualisation of qualitative research as an interpretive art form is well articulated within the literature (Miles and Huberman, 1994; Janesick, 1998; Robson, 2002). However, it is argued that, when done well, qualitative research is representative of art and science within the context of both its purpose and the processes applied (Holloway and Todres, 2007).

To achieve some consistency and coherence through each stage of the research, Holloway and Todres (2003) recommend the researcher is clear from the outset what kind of knowledge is anticipated. They argue that this should act as a guide to the choice of method and the processes of data collection, data analysis and presentation of results. If appropriate methods to answer the research question are selected, the whole thing should 'hang together'. For the purpose of this study, I selected hermeneutic interpretive phenomenology as the main research approach because this enabled me to focus on the way in which the informants articulated their experiences of being a student and becoming an RN and the way in which I analysed their experiences.

3.4 Reflexivity

At an early stage in the study I recognised that, because I had already experienced the type of transition the participants were experiencing, I would need to monitor and manage my own role and influence in the process. The research question stemmed from my curiosity about an experience that I had some knowledge of. However, my awareness of what the experience was like for more recent nurse graduates was limited to insights gained from my role as a tutor and evidence from the published literature (chapter 2, Part

A). The tendency for the researcher to be influenced by 'hunches' about a topic based on their own experience is well recognised and Holloway (2005) suggests that such 'sensitisation' is frequently an influence on health professionals when deciding on a research topic. Whilst this can help to guide the researcher to an issue worthy of investigation, the researcher is cautioned to 'become a stranger in a familiar setting in order not to predetermine the findings' (Holloway, 2005). By viewing the situation in this way, the researcher is more likely to see the unusual or unexpected (Holloway, 2005).

Within the qualitative paradigm, the influence of the researcher on the study must be addressed. The 'contingency, situatedness and intrusiveness – alternatively the creativeness – of the research process' (Rapport, 2004:101) must be recognised, particularly the influence of the researcher on the research process at every level. Rapport (2004:101) highlights what Heisenberg described as the 'uncertainty principle', which conceptualises the tendency for researchers to collect information using 'their own particular prism of perception'. As human beings researching other human beings we inevitable bring something of ourselves to the research process. We are always interacting with and become part of the research process (Rapport, 2004); it is therefore essential that such influence can be accounted for. This requires the researcher to make it clear what theoretical trail has been followed and what their role is in data generation, interpretation and analysis.

Within descriptive phenomenological research, the researcher is asked to 'bracket' previous knowledge in order to achieve a phenomenological reduction that permits the true essence of an experience to be seen (Jones, 2000). However, within the interpretive phenomenological method, Heidegger argued that it was not really possible to set aside or 'bracket' one's own experience in the hope that this would prevent it from influencing the findings. Therefore, interpretative phenomenology within the Heideggerian hermeneutic tradition does not require bracketing; rather, it requires enhanced awareness of the self and one's influence within the research. As Pollio et al. (1997:48) argue, bracketing is 'a way of seeing':

rather than suspending worldly knowledge the interpreter applies a world view such that a phenomenological understanding may emerge.

Indeed, Ahern (1999:410) argues that far from being opposites 'bracketing and reflexivity are fruit from the same tree' and that being able to put one's own feelings and perceptions aside is indicative of reflexivity rather than objectivity, on the grounds that 'it is not

possible for researchers to set aside things about which they are not aware' (Ahern 1999:408). It is the convergence of the researcher's understanding and the participants' perspective and the application of Heidegger's ideas that provide the criteria for judging the credibility of a phenomenological hermeneutic study (Draucker, 1999). Therefore, recognition and acknowledgement of the researcher's role in the process is essential.

I realised that in order to bracket, or become reflexively aware, of my own perceptions, reactions, responses and interpretations, I needed to take steps to ensure that I could recognise these influences. I found Ahern's (1999) 10 tips for reflexive bracketing a useful framework for monitoring and reflecting on my own role in the research (appendix 5). As part of this process I engaged in journaling, reflection and self-questioning. For example, what assumptions am I making? What values am I being influenced by? What conflicts are influencing me? At each stage I used a series of notebooks to record my thoughts and reflected on and analysed my decisions.

In hermeneutic phenomenology, Heidegger's concept of pre-understanding prompts the researcher to identify initial assumptions in order to facilitate an open and questioning approach to the data. This required me to identify my presuppositions so as not to impose these on the data. These were:

- My own past experience would resonate with at least part of my participants' experience;
- The participants will enjoy their work;
- Participants will feel positive as they near their qualification;
- Some uncertainty will be experienced in the early post-qualifying period;
- Participants will find some aspects of their work more challenging or enjoyable than others.

I acknowledged to myself that I was approaching the research from several perspectives, each of which could influence the study at any stage. As noted in chapter 1, I am a children's nurse, I am currently engaged in teaching children's nursing and I am also a novice researcher with an interest in the field of children's nursing. Each of these factors had the potential to bring advantages and disadvantages to the research process. My history of having undergone a similar transition several decades earlier had the potential to narrow my view; for example, by looking and listening for evidence that resonated with my experiences at the expense of ignoring that which did not. My role as a lecturer who was known to the participants had the potential to create a barrier between me and the

participants – would they be reluctant to share their experiences with someone who worked closely with their tutor and who knew many of their mentors in practice? Having identified this potential risk, I needed to gain the trust and confidence of the participants if I was to access their experiences.

One benefit of being from the same field of practice as the participants, knowing the contexts they were working in and understanding their programme of study, was that they could refer to things in shorthand – they knew I would understand their use of jargon and technical terms. Also, they didn't have to explain to me what they meant about the difficulty of juggling work and study because they knew I was fully aware of their timetables. There were potential disadvantages to this: they might assume that I had understood a comment in greater depth than perhaps they had articulated. Likewise, there was the potential for me to assume a greater understanding or perhaps read more into a comment than might have been intended. Therefore, at each stage it was essential for me to use Ahern's (1999) tips as a way of questioning my interpretations and assumptions (appendix 5).

3.5 The rationale for a longitudinal study

The decision to conduct a longitudinal study was premised on the theoretical justification for this (Kralik et al., 2006) and evidence from previous studies suggesting that the experience of transition from student to staff nurse occurs over a long period of time (chapter 2: 2.6 and 2.11). Only a small number of previous studies used a longitudinal approach. It was anticipated that by collecting data at three stages it would be possible to gain an understanding of how or whether the participants' experience of becoming an RN changed over time. To understand the experiences, I needed to gain access to them at a number of stages; to capture 'change' at discrete intervals rather than relying on participants' anticipatory awareness or their recalled experience.

3.6 Using interviews for data collection

A primary focus in phenomenology is the interpretation of linguistic expressions, and interviews are one of the most frequently used methods for gaining data in phenomenological studies. However, a number of methods for data collection could have been used. I considered interviews as the primary method because such face-to-face contact would aid in the co-constitution of the data. One-to-one, focused, in-depth

interviews were favoured because this approach fits with the philosophy of phenomenology – the focus on the individual.

Focus groups were also considered because this method has been used in some previous studies of transition. Focus groups allow exploration of general rather than personal issues (Parahoo, 2006) and a disadvantage is that they are more likely to produce a consensus than reveal individual accounts. Also, the views and experiences of more dominant characters might obscure or restrain the accounts of quieter individuals (Parahoo, 2006). Bloor et al. (2001) suggest focus groups may be a useful adjunct to other methods of data collection but cannot be a substitute for in-depth interviews. Therefore, focus groups were not considered suitable for answering the research question.

I also considered asking the nurses to keep a diary or write about particular incidents during the study period. However, I did not wish to burden the participants with something they would not normally have done. This decision was also influenced by Gray and Smith (1999) and Dearmun (1997) who used this method and found participants were reluctant or unable to write in the diaries. I was also conscious that diary entries might be more carefully planned, edited and less spontaneous than an interview as the participants might be more self-conscious about putting things down in writing. It is recognised that data collection is always a selective process and informants are selective about what they reveal (Miles and Huberman, 1994). In an interview it is possible to demonstrate interest and acceptance of the participants' accounts and also to encourage expansion on details or follow up particular lines of inquiry.

3.6.1 Style of interview

The purpose of qualitative data collection interviews is to access the life-world of the interviewee. The style is conversational with the goal of eliciting the participants' experiences of the phenomenon under study in their own words (Kvale, 1996; Jack, 2008). A focused qualitative interview enables the interviewer to introduce broad themes whilst still allowing openness and flexibility to change the sequence of questions or follow up the participants' stories (Kvale, 1996; Parahoo, 2006). The timing of the interviews was informed by previous studies and theories of transition (chapter 2: 2.4 and 2.14-2.15) which suggested three key points at which it was considered advantageous to gain access to the participants' experiences: mid final year, three months after qualifying and one year after qualifying.

In phenomenological research, what you ask participants to talk about can lead to unanticipated responses (Kvale, 1996; Cohen et al., 2000; Smith, 2008). The method needs to be able to deal with this. I therefore reflexively made decisions about when to prompt and use probes to encourage elaboration of data relevant to the research question, or when to guide the conversation back to focus on the participants' experiences in relation to the research question. Questions were not always asked in a linear pattern and if the participant had already spontaneously spoken in depth about a particular issue some topics were omitted.

The interview questions at stages 1 and 2 followed a pattern that encouraged the participants to focus on their experience as a nurse. For example, the question 'Could you tell me about what you have been doing during your placement?' was designed to initiate a focus on actual experiences. This enabled me to 'set the stage' (Kvale, 1996) without directing the participant to a specific topic. Follow-up questions encouraged elaboration on different aspects of their experience: 'What aspects did you enjoy?' and 'what did you find challenging?' were designed to facilitate and encourage depth of explanation about negative and positive experiences (appendix 6).

The times and locations for interviews were negotiated with the informants (appendix 7). It was anticipated that the final stage interviews may need to be conducted via telephone or webcam, although this was not the preferred mode of contact. The reason for this was that I felt the interviews would be less personal and that it might be more difficult to establish a rapport over the telephone. I was also concerned that lack of face-to-face contact would also hinder access to supplementary information such as body language and facial expressions, which I would normally record in field notes. I anticipated that it would also make it more difficult for me to show encouragement and interest through non-verbal cues such as nodding or smiling. However, at stages 2 and 3, due to travelling distance, some interviews were successfully conducted by phone because this was the least disruptive to the participants (see 3.8.7- 3.8.8).

3.7 Ethical considerations

Ethical approval for the study was gained from the University's research ethics committee and I ensured that my study complied with the ethical guidelines in the School's *Research Participant Handbook* and the British Educational Research Association guidelines (<http://www.bera.ac.uk/guidelines.html>). I also gained approval from the ethics committee at my employing HEI in order to access students as potential participants. The ethical

conduct of research requires the researcher to uphold four rights of research participants: not to be harmed, to be fully informed, autonomy, and the right to privacy, anonymity and confidentiality (ICN, 2003: cited Parahoo, 2006). These must be upheld at every stage in the research, from recruitment to the final report.

3.7.1 Recruitment of participants

Providing advance information is part of 'setting the stage' for the research (Kvale, 1996) and this was initially provided in writing (appendix 8) for the target population of third-year child branch students (n=20). This was followed by an informal information-giving session during early May 2007. I also explained why my 11 tutees in the group were not being asked to participate in the study; it was important to avoid any misinterpretation of the rationale for not including them (see 3.7.4). Potential participants were then invited to complete an 'expression of interest' form (appendix 9). Eight of the nine potential participants returned the expression of interest form and I subsequently met with each participant individually to discuss the consent form (appendix 10) and answer any questions. The participants were known to me but I had minimal teaching contact with them during the final year.

3.7.2 Consent

Written consent was gained prior to the commencement of interviews, and on-going consent was checked prior to each interview. The main query that arose during the early discussions was what would happen if they took a post in another part of the country; how would the stage 2 and 3 interviews be arranged? I explained that it may be necessary to conduct telephone interviews but that as far as possible I would aim for face-to-face follow-up interviews.

The right of participants to freely withdraw was made explicit in the invitation to participate in the project and in the advance information about the project. The right to withdraw was also stated clearly in the consent forms which participants were only asked to sign after they had received information about the project and had an opportunity to meet me to ask questions.

3.7.3 Confidentiality

It is essential when conducting research that all information about individuals is protected from misuse and that data storage complies with the Data Protection Act (1998). To prevent breeches of confidentiality, two key steps were taken to protect confidentiality of participants.

Firstly, all data was collected on a password-protected digital recorder before being transcribed into a Word document for analysis. The transcripts were then stored on a password-protected computer accessible only by me. All data was anonymised using the participants' pseudonyms and participants were informed of what data was being held about them.

Secondly, due to the small sample size and the participants being on the same course and at the same location, the anonymised data might still be identifiable. All third parties and locations referred to by the participants were therefore anonymised within the thesis: place names are recorded simply as hospital, ward, clinic, NICU or PICU. Third parties are referred to by their role; for example, mentor or senior nurse. Specific reference to a child's age, diagnosis or treatment has either been omitted from quotes or the details changed to avoid any potential breach of confidentiality.

3.7.4 Protection of vulnerable participants

As personal tutor to some of the target population I was in the position of providing both academic and pastoral support and was also responsible for completing references for job applications for my tutees. To avoid role conflict and the risk of my students feeling compelled to participate but perhaps not able to share some of their experiences with me, I decided not to ask my own tutees to participate.

The focus of the research was not specifically sensitive in nature but it was possible that some participants might be in the middle of a stressful transition and may have found discussing aspects of this upsetting. It was also possible that difficult clinical experiences might emerge during the interviews so I ensured that the participants had access to support from other sources within practice and at the University.

3.7.5 Data storage

As described in 3.7.3, all data was stored securely on a password-protected computer. All hard copy data was stored in a locked cabinet.

3.7.6 Risk assessment

The potential for risk to self or the participants arising from the research activity was relatively low because the participants and I were already acquainted and the locations used for data collection were all known to me and the participants. However, it was important to consider each situation objectively. All potential risks to my own safety and

that of the participants were assessed and appropriate steps taken to minimise risk. If I was travelling to conduct data collection, I ensured that my whereabouts were known to others and that I was able to communicate any concerns (e.g. via mobile phone).

3.8 Research design

The research design is summarised in appendix 11.

3.8.1 Sampling

Phenomenological research prioritises sampling from those who have had experience of the phenomenon (van Manen, 2002; Smith, 2008). Kuper et al. (2008) suggest sampling the most ordinary, usual cases of the phenomena rather than extreme cases. Final-year child branch students at one UK university were invited to participate in the study. A sample of 6–8 participants was considered desirable although there are no guidelines on how many participants are needed in this type of study. The potential participants initially received verbal information from me about the study.

One student was unable to participate due to illness and two participants left the study at stage 1 – one due to ill health and one due to repeating academic work. Their loss from the study did not result in any changes to the theme clusters at stage 1 but no quotes are presented from them.

The sample:

- 5 female
- 1 male

(In children's nursing the ratio of male to female student nurses is approximately 1:10)

- All single
- No children
- All white/British

Age range:

- 21-22yrs (Marie, Sam, Chris and Ann)
- 25-30yrs (May and Lee)

At the first interview all participants were asked how they would wish to be identified in the thesis and in any future published work. Each participant chose a pseudonym that had some significance for them but would not be recognisable to others.

There was only one male in the sample so any reference to 'him' or 'he' would breach confidentiality. Among the pseudonyms there were three names that could be either male or female: Chris, Lee and Sam. To further protect the anonymity of the male participant I decided to refer to all participants as 'her' or 'she' when using the personal pronoun within the text.

3.8.2 Data collection

Interviews were conducted in the middle of the final year, and at 3–4 months and 12–14 months after entering employment as an RN.

3.8.3 Pilot interview

I conducted a pilot interview with one of my final-year students to check the interview schedule. The results suggested that the interview questions were a useful guide for the participant but that the questions did not always have to be used.

3.8.4 Context of interviews

At stage 1, the interviews took place either at the University or at the hospital if the participant was on placement (but not during placement hours). Appointments were booked at the convenience of the participant. The University interviews were held in teaching rooms that had been booked for the purpose. In this situation, seating was arranged informally in a corner of the room with a table used for the digital recorder. In an ideal scenario, the same type of venue would have been used for each interview but this was not possible in the timescale available, and priority was given to not inconveniencing the participants.

The hospital interviews took place in whatever space was available, invariably an empty side ward. In this situation the only seating available was a visitor's bench, which the participant and I shared. In both situations the interviews took place against background noise levels – in the hospital this primarily consisted of voices, telephones and alarms; in the University rooms there was traffic noise from surrounding roads and voices from adjacent classrooms. In both situations the participants were accustomed to these noise levels and it did not appear to interfere with the interview.

At stages 2 and 3 it was more difficult to arrange face-to-face interviews due to the geographical distances involved. Therefore, several interviews took place via the telephone at each stage. For a summary of the timing and venues for all interviews, see appendix 7. My anticipatory concerns about telephone interviews were not borne out in reality: the participants were relaxed and spoke freely and I found that I was able to take less of a lead and allow the participants to talk.

3.8.5 Equipment used

A small digital recording device was used without lapel microphones. This was the size of a small mobile phone and it was placed in the immediate seating area but out of the direct line of sight of the participant. Interviews lasted, on average, 50 minutes.

3.8.6 Data collection stage 1

Using the interview guide (appendix 6) the participants were invited to talk about their experiences as a third-year student. The questions were broadly informed by the previous research in the field, which suggests that some experiences would be positive, enjoyable or challenging and some less so. The dearth of research about children's nurses precluded follow-up of specific issues and I did not wish to predetermine what their experiences were like. They were also asked to place themselves on a scale of 1–10 in terms of their readiness to make the transition from student to staff nurse. The purpose of this was to allow them an alternative way of expressing and rationalising their level of confidence.

There was no observable difference between the length of the interviews conducted at the University or the hospital. Neither was there any significant difference in the quantity or quality of the data produced in relation to the venues or modes of communication. However, in the interviews conducted at the hospital the participants appeared more relaxed and, despite the constraints of awkward seating, the participants seemed at ease as if they were just chatting about their experiences. Conversely, in the University setting the participants seemed a little more 'in interview mode' and possibly less relaxed. This may have been a function of the more formal situation in the classroom or that in the hospital the participants found it more natural to talk about becoming a nurse. The participants each consented to participate in two further interviews during their first year of registered practice.

3.8.7 Data collection stage 2

At the second stage, four interviews were conducted by telephone due to distances and two were face-to-face. The focus was on the change in status, and I began by asking them to recall the day they got their results and their first day as an RN. Similar follow-up questions and probes were used as stage 1 (appendix 6). The nurses were also asked what advice they would give to third-year students about preparing to become a registered nurse. The purpose of this question was to identify the relationship between what they had experienced since becoming an RN and their perception of what had aided their transition (chapter 5, 5.3.2) .

A time for telephone interviews was pre-booked with the participants to ensure they would be free and not interrupted. Arrangements for stage 2 and 3 interviews were often made to coincide with 'coming off-duty' or before 'going on duty' so in some sense the act of nursing still framed the context of these interviews.

3.8.8 Data collection stage 3

Four interviews were conducted face-to-face and two by telephone. The final interviews were less structured than stage 1 and began with an invitation to talk about their experiences as staff nurses. Similar probes and prompts were used to facilitate the interview but because both the participants and I were now more comfortable with the process these interviews were more fluent and focused than the earlier stages. The telephone interviews yielded very rich data; the fact that the participants belong to a generation that uses telephones constantly may have enabled them to feel relaxed about this.

3.8.9 Preparation for interviews

I prepared for the second and third interviews by reviewing the previously analysed transcripts for each participant, re-listening to the recorded interview and identifying key issues for each participant that could be used to ease them into the interview – for example, 'I recall you mentioned...' – and this often involved mirroring language or terminology they had used – 'I just totally panicked' (Chris).

The aim of this was not to follow up common themes arising from the previous interviews but to facilitate a relaxed environment in which the participants could feel that I was genuinely interested in their personal journey. So for each participant the issues I mentioned from previous interviews were personal to them.

As the stage 3 interviews took place after a longer period of time I preceded all the final interviews with a summary of the key issues the participants had talked about at the previous interviews. This seemed to have a positive effect as they would say things like 'oh yes I remember feeling like that but it's changed now', thus providing the opportunity to invite them to elaborate on what had changed and how. My intention was to re-orientate them to the last stage of data collection so that they could then think about the intervening period. The purpose of this was to create a connection for the participant between the stages and to convey my interest in what they had shared with me. For example, 'you talked about wanting to be self-motivated and being aware of your need to have a wide range of experiences' (to Chris); 'you told me about wanting to get "hands on" care experience and how much you felt you were learning from the carers' (to May).

3.8.10 Reflections on my role in data generation

The relationship I had as a lecturer with the students was a relatively formal yet friendly one. This was beneficial in establishing a rapport with the participants because this wasn't a new relationship. However, we each had to negotiate a different role: me as researcher and the student as participant. This role adaption evolved over the three stages, becoming more authentic in the second and third stages when I no longer had any role in their professional lives.

During data collection, the participants would occasionally appeal to me for advice or approval in a way that they probably would not have done with an interviewer they did not know. I recognised at stage 1 that there was a risk of me using a counselling approach directed at problem solving rather than focusing on the purpose of the interview. I had to actively resist this by remembering the purpose of the interview.

3.8.11 Data management

- 1) Digital recordings of the interviews were transferred to a password-protected computer.
- 2) A verbatim transcription was made of all the verbal information collected during interviews.
- 3) Field notes were kept during data collection. These included records of the location and timing of interviews and the demeanour of participants and my own responses.
- 4) During the transcribing process, decisions were made about the punctuation of speech, like defining pauses and paralanguage such as laugh, smile and frown. The punctuation of speech included recording of pauses, changes in tone, intake

of breath, etc. Pauses varied in length – no attempt was made to impose meaning on the pauses (e.g. thinking, worried, holding back) other than to record them as accurately as possible in the context of the narrative:

Short pause ...

Long pause

Laugh described as either humorous or rueful

Emphasis bold type

- 5) Transcripts were rechecked against the audio recording several times to ensure accuracy and to make initial notes in the margins of emerging units of meaning.

3.9 Data analysis

Qualitative data has been described as ‘an attractive nuisance’ (Miles 1979: cited Robson 2002: 455); the unwary/naïve researcher is liable to injury (Robson, 2002). Robson suggests such data is often claimed to be ‘full’, ‘rich’ and ‘real’ compared with quantitative data. However, when the data consists of individual accounts of lived experience, that very richness can become problematic. The tendency for physical data to pile up creates the need to reduce or condense the material into more manageable formats:

Words are fatter than numbers and usually have multiple meanings, which renders them more challenging to process. (Miles and Huberman, 1994:56)

The tendency for qualitative, text-based data to expand during data processing can add to this problem. Miles and Huberman (1994:56) suggest the researcher focuses on the purpose of the research i.e. ‘the conceptual lens you are training on it’.

The task of the researcher when analysing qualitative data is to develop a process that takes into account the art and science of the process (Robson, 2002). The goal of analysis in a phenomenological study of human experience is to develop a description of an experience that resonates with others who have experienced the same phenomenon (van Manen, 1990). However, the researcher also needs to demonstrate how they got from the data to their conclusions (Steeves, 2000). I developed a process of analysis that aims to demonstrate what I did and why I did it (3.9 and appendix 11). Initially Colaizzi’s (1978) structured approach to data analysis was used to develop descriptive themes.

Colaizzi's model involves:

- 1) Reading each transcript to gain a sense of the whole;
- 2) Extracting significant statements from the text;
- 3) Establishing a meaning for each significant statement;
- 4) Grouping the meanings into thematic clusters;
- 5) Developing an exhaustive description of the phenomenon;
- 6) Describing the fundamental structure (essence) of the phenomenon;
- 7) Validating findings by taking them to the participants.

This study did not address a discrete phenomenon, so stages 5–7 were not considered appropriate; however, the application of the first four stages of Colaizzi's generic guidelines were used within the philosophical framework of hermeneutic phenomenology. This decision was influenced by other hermeneutic interpretive studies that explicated the movement between the descriptive and interpretive elements of their study (e.g. Koch, 1993; Ajjawi and Higgs, 2007). Each transcript was read several times and examples of how steps 2–3 (table 1) and step 4 (table 2) were applied are illustrated below.

Stage 1 example of significant statements and the formulated meanings assigned to them	
Statement	Meaning
'When you have your own patients you kind of feel like, well, I'm more of a nurse now. It just shows them how much I've progressed over the years as well, as I'd never have done...Even in my second year I'd never have been comfortable having my own patients.' (Sam)	Having responsibility for her own patients made her feel like a nurse and enabled her to see how she had progressed since second year.

Table 1. Significant statements and their meaning

Stage 1 example of theme clusters and corresponding significant statements	
Theme cluster	Significant statements
Confidence in your ability to be a nurse is rooted in practice.	<p>'I had that fear inside me that I couldn't cope in those situations and actually doing it made me realise you know I can deal with things like that.' (Chris)</p> <p>'You build on that [confidence] the more you do things.' (Marie)</p> <p>'I find I have to do – practise it – before it really sinks in, you know, and I feel really confident to do something.' (May)</p> <p>'One of the biggest worries is the first time you are going to have to do CPR [resuscitation] on anybody ever; there is an absolute fear and yet when I was on A&E I got to do it four times and that hurdle's been bridged now.' (Lee)</p> <p>'Confidence is going to be the main thing at the minute, and I'm going to be able to just focus on practice and not have any other work to do.' (Sam)</p> <p>'I really need a lot of practise on that, I'm not very confident on that, 'cause I just haven't done it enough.' (Ann)</p>

Table 2. Examples of theme clusters and corresponding significant statements

When I had analysed all three stages using Colaizzi's stages 1–4, I began looking more closely at which findings helped to shed light on the transition. I returned to the original data using a more interpretive hermeneutic approach; to develop a dataset representative of the themes at each stage, and to examine the data arising from the theme clusters interpretively.

This process was informed by Edwards and Titchen (2003) who elaborate on Schutz's approach to data analysis in which Schutz (1970) identifies the significant difference between what he described as 'first order constructs' and 'second order constructs'. The

former represent the way in which the participant interprets and constructs their experience and the latter represents the researcher's interpretation of that experience.

The descriptive theme clusters identified at the first stage of data analysis were taken back to the original transcripts and further refined. Weak themes were subjected to additional analysis and if they were not felt to be a true reflection of the data they were discarded or occasionally relabelled based on a re-evaluation of meaning. The final theme clusters are recorded in appendices 12-15, to demonstrate their relationship to the themes of transition across the three stages. The theme clusters at each stage were not identical but I sought to apply a consistent approach to identifying the themes of transition. This was not a process of 'collapsing' the clusters into broader themes but rather further interpretive analysis of the findings from the descriptive stage of data analysis. The aim was to discover the meaning of the theme clusters in the context of the transition. This is discussed further in the presentation of the findings (chapter 4, 4.4).

Written descriptions are often expressed as conceptual substitutes; Miles and Huberman (1994:9), for example, refer to Counellis' (1991) description of a clenched fist and grimace as being 'anger' (influenced by the researcher's own feelings and perceptions). Miles and Huberman (1994) explain that, when such interpretations of concepts occur in descriptions of 'facts', such 'facts' then become part of the data and first order 'facts' undergo further interpretation at the second order stage, i.e. the interpretation of the interpretation. The influence of the researcher's own values will therefore influence the analysis and this should be given careful consideration. The apparent simplicity of qualitative data masks its true complexity (Miles and Huberman, 1994).

It is acknowledged that researchers have existing knowledge and that this will influence the way they focus on data; such knowledge can enhance the ability of the reader to 'see and decipher details, complexities and subtleties that would elude a less knowledgeable observer' (Miles and Huberman, 1994:17). This could therefore be viewed as a valuable asset to the researcher but it also raises the risk of them seeing what they want to see. I therefore actively sought to reflect on my actions and identify areas that I needed to address (chapter 1, 1.9; chapter 3, 3.8.10 and 3.10).

3.10 Trustworthiness

In qualitative research, trustworthiness is used to denote methodological soundness and adequacy (Holloway and Wheeler, 2002) and its aim is to show how conclusions were

reached from the data (Robson, 2002). Trustworthiness addresses dependability, credibility, transferability and confirmability (Holloway and Wheeler, 2002).

Dependability is the extent to which the context of the research is clearly explained and findings are consistent and accurate. After reading sections 3.9–3.10 the reader should be able to see how I drew my conclusions from the data.

Credibility is similar to the concept of internal validity in quantitative research and in the context of this study it refers to the extent to which the participants recognised my interpretation of their experience. This is discussed in 3.10.1.

Transferability in qualitative research refers to the extent to which the findings might be relevant in other situations. In a small-scale study of this nature there is limited scope for transferability, but the concepts evolved from this study may be applicable in another context (Holloway and Wheeler, 2002).

Confirmability relates to evidence that the findings are an outcome of the research rather than the researcher's prior assumptions. In phenomenological research, attention to the application of key concepts (see 3.3.1) and reflexivity (3.4) play a key role in demonstrating confirmability. I used a research journal, field notes and reflections to monitor and question my observations and actions at each stage of the process. I was also able to compare my analysis of scripts with that of my supervisor during stage 1 of the study.

3.10.1 Returning results to participants

The participants were invited to see their transcripts and to make comments on the accuracy and extent to which these were a true reflection of their experience. Only two participants took up this offer so, as an alternative, I arranged to present a summary of the analysis to the participants after completing the data collection. Five participants were able to attend the presentation and they confirmed that my findings resonated with their experience.

3.10.2 Presentation of the findings

The findings for each stage are presented in chapters 4, 5 and 6 using a 'thick description', which aims to make transparent the consistency between the method, the context, the processes and the findings. This provides a way of increasing the external validity of qualitative research (Lincoln and Guba, 1985).

3.11 Conclusion

This chapter has examined the philosophical and methodological basis of the research and the rationale for a longitudinal study. The research method and use of reflexivity has been considered and ethical considerations addressed. The research design has been described and justified with reference to empirical and theoretical perspectives. This has provided a basis for the research procedures adopted and the data analysis process. The trustworthiness of the research has then been considered with reference to the procedures followed.

4 FINDINGS STAGE 1: THE STUDENT EXPERIENCE

4.1 Introduction

This chapter begins with a summary of key demographic details about the sample and the context of the transition. This is followed by 'snapshot' summaries of the transition for each participant. The results of the thematic analysis of the first stage of the study are then presented. The findings from stages 2 and 3 of the study are presented in chapters 5 and 6 respectively.

Quotes are used to illustrate the themes, demonstrating the relationship between the data and the findings (Koch, 1993). Some additional quotes to illustrate themes are indicated in the text by a number and these are presented in appendix 16 for stage 1, appendix 17 for stage 2 and appendix 18 for stage 3. Quotes were selected using the concept of the hermeneutic circle which involves a backwards and forwards movement between the parts (the themes) and the whole (the transcripts). These are presented to demonstrate consistency between the descriptive and interpretive stages of the analysis.

4.2 Summary of the context of the transition journey for the participants

All six participants were studying for the professional qualification of RN (child), which would permit them to register with the NMC. Two participants (May and Marie) were studying for an Honours degree and four were studying for an Advanced Diploma which could be 'topped-up' to degree level after qualifying as a nurse.

The participants were undertaking third year clinical placements in 2007 and qualified in September 2007. They undertook placements in acute wards or departments within large hospitals (e.g. acute paediatric admissions unit, children's wards, NICU, HDU and A&E). Five were attending placements in the same hospital and one (Marie) was at a different hospital.

Four participants passed their programme at the first attempt (May, Chris, Ann and Marie) and two experienced several months' delay due to resubmitting academic work (Sam and Lee). The latter were successful at resubmission but both experienced effectively being in 'limbo' – neither a student nor a qualified nurse – for a number of months. During this

period their new employers enabled them to work as HCAs until they obtained their NMC PIN. Sam and Lee described advantages and disadvantages of being an HCA when they had really expected to be an RN. Lee was already in post as an RN when she got her results so Lee experienced the feeling of being 'demoted' to HCA. Sam was still going for interviews when she got her results, and the failure initially knocked Sam's confidence. However, this was boosted by a subsequent job offer.

All six participants were successful in finding their first posts either shortly before or after qualifying. When they got their results, four had firm employment offers and two were going for interviews. Only two (Chris and Ann) were able to start their first posts immediately. For Ann, this was a very hurried process as she was offered a post at very short notice and she recalled starting without a proper induction.

Marie and May experienced delays due to the time taken by their employers to process pre-employment checks. Both spoke of how that time was a breathing space that gave them time to reflect. With the exception of Marie, all the participants left the area in which they had undertaken their programme. They moved to other towns and cities in the UK to take up employment in NHS trusts or private (charitable) children's trusts in which they had no previous experience.

The process of gaining employment was therefore relatively smooth, with all students attending two or three interviews. Several received more than one job offer and, four months after qualifying, all were in employment. Their choice of job appeared to be influenced by several factors:

- 1) Geography (being near to family and friends);
- 2) Speciality (the search for more specialised experience such as PICU resulted in a geographical move for Lee);
- 3) The availability of jobs – perhaps the most influential factor.

4.2.1 Descriptions of the individual participants

Chris

Chris experienced a range of acute placements in year 3. She passed the programme at the first attempt and accepted a post in a children's trust (respite/rehabilitation centre). In that post, Chris rotated round three areas, i.e. worked three months in each area. At the first interview Chris had said that working in A&E as a third year had made her realise that this area of practice was her 'biggest interest'. Chris had developed a long-term plan to gain relevant experience on which she could build her confidence to become an A&E

nurse. One year after qualifying Chris had taken up her second post in an acute children's ward in a large metropolitan hospital. Her first two posts were selected as part of her long-term plan.

May

May had experience at a senior level in nursery nursing prior to beginning the course. As a third year, May had expressed the desire to work in a hospital ward on qualifying. However, when the opportunity to work in a children's hospice came up May realised 'it was really, really the thing that I wanted to do'. She took up her first post four months after qualifying and she used the intervening time to have a break and reflect on her course.

Lee

Lee had failed a piece of academic work but she passed at resubmission. In year 3 Lee found that acute placements (especially A&E) increased her confidence and she was subsequently offered employment in PICU before completion of the course. Lee had to inform the employer that she was not able to register with the NMC until the academic resubmission was successful. The employer was supportive and enabled Lee to continue working on the unit as an HCA until she was fully qualified.

Sam

Sam enjoyed the acute placements in year 3 and realised a desire to work in NICU after qualifying. Failing an academic assignment was a huge disappointment to Sam, especially as the results arrived when she was going for interviews. However, Sam was successful at resubmission and subsequently gained a position in the NICU, in a geographical location of her choice. Preceptorship support was provided for the first six months in the new post and Sam was sent on weekly study days that focused on the speciality she was working in.

Ann

Ann enjoyed her acute placements as a student and she thought she might like to look for a job in NICU when she qualified. She started her first post as an RN on an acute children's ward in a district general hospital. She had to start in post quickly and consequently did not receive a formal induction. However, she did receive 1:1 induction support from a senior manager. This was a rotational position that involved moving to a different ward every three months.

Marie

Marie had enjoyed her placement experience as a third-year student and, because she wanted to stay in that hospital, she decided to apply for a position on a ward where she had been a student. She competed with external applicants for the position she was offered. She experienced delay between completing her course and commencing her new position due to delays in the pre-employment checks.

One of the key features of this sample of participants is that, for five of them, not only did they enter employment in a range of different health organisations (NHS and charitable trusts) that they had not previously worked in, they also entered a range of clinical specialities: NICU, PICU, rehabilitation and respite, hospice care and general children's wards. Therefore, any similarities in their experiences of the transition could be seen as representative of the transition rather than specific to the clinical context in which they were working.

4.3 Overview of data analysis and presentation of findings

The analysis of interview transcripts at each stage identified clusters of themes that were shared by all participants (see appendices 12–15). The clusters of shared themes were considered to be of relevance to the 'experience of transition' and these were then subjected to a hermeneutic interpretive analysis of all three stages in order to identify how the parts (theme clusters) related to the 'whole'. In doing this, I was searching for the themes of transition, i.e. those that might help to tell the story of the transition. In determining the relevance of the shared themes to the research focus I returned to the research question; this process enabled me to refine the original lists of theme clusters identified at each stage to a final list of 14 shared themes of transition.

In identifying the themes of transition, I looked for the significance of these themes for the participants. In some instances the themes and sub-themes are representative of major changes between the three stages:

Theme 1.1: 'Self-image and professional identity' demonstrates key changes at each stage; for example, rehearsing (stage 1), holding back (stage 2), still feeling new inside (stage 3).

However, in other themes it was the persistent presence of the same issues across the three stages, albeit with some change in emphasis, which lent significance to the theme:

Theme 2.3: 'Skilling up' represents participants' persistent concerns about acquiring clinical skills; this theme remained significant at each stage despite the fact that the participants were becoming more skilled.

The themes of transition were then re-examined to identify links between them. This resulted in grouping them into four overarching themes: Personal and Professional Identity, Primacy of Practice, Working with People and Managing Newness. 'Personal and Professional identity' represents a group of five transition themes centred on self-image, professional identity, motivation and goal orientation, feedback from others, the evolution of roles and emerging career interests. The 'Primacy of Practice' draws together three transition themes that illustrate the participants' attitudes to nursing knowledge, their expectations (of self and others) and the pursuit of clinical skills. 'Working with People' draws together three key themes: the participants need to feel a sense of belonging and recognition in the workplace; their experience of closer working relationships with parents; and their focus on children. The overarching theme of 'Managing Newness' is derived from three themes that illustrate aspects of the nurses experiences that placed the greatest demands on them; to adapt and manage their new role as they progressed through the transition from student to staff nurse.

Thus, the transition is represented by these overarching themes, within which it is possible to identify the ways that the participants' experiences of becoming a nurse underwent a transition over the three stages. All of these themes are relevant at each of the three stages but their importance changes over time. 'Personal and Professional Identity' and 'Primacy of Practice' were relatively constant themes over the period of the study as illustrated above. However, the themes of 'Working with People' and 'Managing Newness' were weaker themes in the pre-qualifying stage; becoming more significant when the nurses entered employment as a staff nurse and continuing to evolve over the first year of practice. This is illustrated for example in a significant change in their focus on children. Table 3 illustrates the 14 themes of transition within the four overarching themes. The relationship between the overarching themes, the 14 themes of transition and the theme clusters (derived from the descriptive stage of data analysis) are illustrated in appendices 12–15. Highlighted versions of table 3 are provided in the key conclusions of chapters 4, 5 and 6 with bold formatting used to indicate the most significant themes at each stage.

1. Personal and Professional Identity 1.1 Self-image and professional identity 1.2 Maintaining motivation and vision of goals 1.3 Using constructive review and feedback 1.4 Evolving roles and role models 1.5 Career focus	2. Primacy of Practice 2.1 Knowing what you need to know 2.2 Measuring up: searching for authenticity and credibility 2.3 Skilling up: seeking opportunities to practise
3. Working with People 3.1 Need for belonging and recognition 3.2 Working with parents 3.3 Seeing the child	4. Managing Newness 4.1 Feeling exposed and over-exposed 4.2 Learning and working in the real world 4.3 Coping with crises

Table 3. The overarching themes of transition

To determine the relevance of the themes to the research question, I looked for typical and atypical cases. Examples of typical cases in the theme of 'Self-image and professional identity' are the themes of 'Rehearsing' (stage 1), 'Being the new girl/boy again' (stage 2), and 'Still feeling new' (stage 3). Examples of atypical cases in the theme of 'Feeling exposed and over-exposed' were: 'Managing people' (which was exclusive to May) and 'Distress due to failure' (stage 2) (which was exclusive to Sam and Lee). The theme of 'Holding back and traversing the route' was initially identified in relation to May and Marie regarding how they managed the delay before starting their first post. However, re-examining the experiences of Sam and Lee as they coped with delay due to failure showed that there were similar characteristics evident in their experiences. Therefore, rather than focusing on the actual event or cause of the delay, the experience of interest and relevance to the research question was the value that all four placed on having that period of time to prepare for taking on the role of RN. The absence of this pause for Ann and Chris was evident in their experience of the speed of transition; hence the theme of wanting or welcoming the opportunity to hold back or 'traverse the route' was retained as a sub-theme within transition theme 1.1 'Self-image and professional identity'.

In the process of analysing the transcripts there is a sense of having disintegrated the whole: the original narrative accounts were reduced to significant statements, to which meaning was assigned, before reassembling these into clusters of themes which were

then grouped into 14 themes of transition within four overarching themes. The themes of transition are not mutually exclusive because the experience of the transition is more connected and complex than any thematic explanation. This fragmentation of phenomena into themes requires the researcher to demonstrate the connections between themes (Sandelowski and Barroso, 2002). It is suggested that, in a hermeneutic approach, interview text presents:

a complex network of internal relations such that no single aspect may be understood independent of reference to the text taken in its entirety. (Pollio et al., 1997:37)

Therefore, it is acknowledged that each theme is connected to, and indeed influenced by, other themes. For example, the theme 'Coping with Crises' is closely connected to the themes 'Self-image and professional identity', 'Seeing the child', 'Empathising with the parent' and 'Feeling you have to sink to swim'.

There were two main options for presenting the findings: presenting each theme separately and tracking them across the three stages, or presenting the findings within each stage followed by a discussion about the connections between each stage. I initially used the former approach but found that it fragmented the findings. Ultimately I found the latter approach facilitated a more coherent way of answering the research question. Quotes are used to illustrate the findings at each stage and a paradigm case is included in chapter 5 that is representative of the experiences of the early transitional period.

4.4 Introduction to stage 1 findings

As third-year students, the participants spoke of their personal responsibility and professional identity. They described their desire to practice as a nurse and their experiences in clinical practice: their hopes and fears, good experiences and bad. They referred to those who inspired them and those who did not. They spoke of judging themselves and being judged by others. It was evident in the interviews that being recognised and valued by others in the clinical environment had a positive influence on confidence levels. The participants expressed a little apprehension about their perception that 'third years are expected to know everything' but also did not want to be patronised or treated like a first or second year. Crucially, the participants wanted to gain the trust of other nurses, particularly their mentors. They wanted to be less reliant on their mentors

and wanted the mentor to rely on them; they felt disappointment if the mentor didn't allow them responsibility.

Relationships appeared to be a challenge for the students as they spent limited periods of time in practice. There was a sense of them 'not belonging' and of wanting to fit in. They spoke of the parents and children, without whom there could be no learning but with whom they did not yet have an easy relationship (partly due to the brevity of their encounters). They also spoke about 'good' and 'poor' mentors and the type of mentor they aspired to be.

Working on full-time placements whilst completing academic assignments was referred to as a burden by all of the participants; an intrusion into their main interest of nursing. Practice was seen as essential and the relevance of knowledge was articulated solely in terms of its usefulness to practice.

Concerns were expressed about gaining sufficient clinical skills before qualifying. This was primarily a reference to the psychomotor skills needed to carry out aspects of clinical care, like passing a nasogastric tube or administering injections. Pride in their skills was balanced by their perceptions of how much more they still had to learn and the realisation that they could not know everything. Placements in acute or critical care areas seemed to have been experienced as supportive and had increased the students' confidence by propelling them into situations in which they could face their fears, gain new nursing skills and realise their own ability to cope.

The impending end of the course appeared to promote proactive planning for the final placement, by filling in any gaps or consolidating knowledge and skills in an area they hoped to work in once qualified, for example. The participants wanted to be prepared as best they could for when they qualified. A sense of achievement was certainly visualised if not felt and they frequently compared themselves with their first and second year, expressing surprise at how far they had come. They spoke of feeling both excitement and anxiety regarding what the future held. They also spoke of the stress of combining work, study and job hunting.

The findings from stage 1 are presented below using quotes to illustrate the themes. Additional quotes to illustrate themes are indicated in parenthesis by a number and these are presented in appendix 16.

4.5 Overarching theme 1: Personal and Professional Identity

Theme 1.1: Self-image and professional identity

As third-year students entering the final phase of their course, the participants appeared to focus their energy on preparing themselves for taking on the role of staff nurse.

'Orientating to the role' involved them becoming aware of their self-image as a third-year student and in particular about what it meant for them to be recognised not only as a nurse but also as a children's nurse. Their approach to professional identity was manifest in three smaller sub-themes: 'Rehearsing, Thinking and Acting like an RN'.

Most of the participants had had placements in A&E which provided opportunities to work with RN (adult) and adult patients. This exposed them to unfamiliar emergencies (see theme 4.3) but it also made them aware of their role as a children's nurse. For Lee this made her aware of what she had to offer and how others perceived her knowledge:

As soon as a kid comes in they're like **whoa** [anxious tone] and they're like 'here's one for you' and 'do you mind doing this one' and actually a couple of nurses came in with me while I was assessing and said 'well I don't really know much about kids and so can I...' so you do really get appreciated down there because you are able to give specific advice. (Lee)

Although the participants valued their A&E experience for the clinical skills it allowed them to achieve, their identity as children's nurses was also enhanced by this exposure to adult clients:

When adults are in resus it seemed to be chaotic and everyone shouting, I didn't like it, but as soon as a child came in I felt more comfortable.....I just felt more at home when it was a child than when it was an adult. (May)

Being assigned to a children's nurse was also seen as evidence of their professional identity (1).

The participants expressed increased expectations of self, characterised by feeling ready to take more responsibility and wanting to have their own patients. They wanted to be independent and just get on with the job but with some support:

I sometimes feel frustrated and that I want to do it all but still like having that bit of support...and I know as newly qualified you get mentors...but I think you almost need to do it and I don't know if I feel completely ready and I don't know if you ever would actually... (May)

Comparisons to earlier stages in their development were used to describe how differently they thought about their role and responsibilities, particularly their growing awareness of what would be expected of them in the future (2):

When you are actually on placement and practising as a nurse that's when it all comes home that you are becoming a nurse and you can be in situations, and cope in situations on your own...in the first year you are always standing in the background and observing and always having to ask 'what you are doing' whereas now we are independent and taking our own patients and just being a nurse.
(Chris)

Similarly, this example articulates awareness of rehearsing responsibility in preparation for the future:

Near the end of the second year, I was always asking and my mentors were always there with me, whereas now I kind of just go off by myself and do things, but always clarify with them if there's anything I can't do.....I just feel like I've got more responsibility and I've enjoyed that aspect, 'cause that's obviously what I'm gonna do next year. (Sam)

This was tempered by awareness of the tension between taking responsibility for patients, being accountable for your competence and knowing when to seek help:

I just literally took my own group of patients and only had to go to the nurse when I wanted to check things, and there are, you know, still situations where I have to go and ask but as long as you are aware that you are always going to be like that...when I qualify there are going to be things that I don't know. (Chris)

Being encouraged to take on more responsibility was sometimes a source of anxiety but taking these opportunities helped the students to experience aspects of their future role in a safe environment (3).

The type of experiences that created feelings of rejection or not being trusted were not related to direct criticism from others but more indirect actions; for example, not being asked to carry out tasks because staff appeared to forget that they were a third-year student:

Sometimes people forget that you are a third year and think that you can't do something when you can. (Marie)

Or feeling that mentors do not trust their ability:

Sometimes you have a mentor that...who doesn't allow you to do as many things as another mentor may allow you, I think I need a mentor who trusts me and allows me to get on with things, obviously supervising. (Sam)

Feeling trusted was manifest in Ann's experience of discrete supervision:

She obviously had a lot of confidence in me, she would just sit down and get on with doing something else, or would take a break and she knew that I was doing it. (Ann)

For Sam, being encouraged to test her management skills enhanced her sense of being trusted:

On one occasion I even ran the whole ward which was scary to begin with, but really good, and it's helped me to realise that I can do it, because I always feel like, I know there's so much more for me to learn, but I think when the mentors put that trust in you to allow you to run the ward.....makes you feel like...like they **do** trust you. (Sam)

4.5.1 Participants' self-rating of how prepared they felt for being an RN in a few months time

The participants were asked to rate themselves on a scale of 1–10 in terms of their perceived readiness to take on the role of staff nurse and the words they would use to describe their feelings. Their self-ratings ranged from 5–8. When asked to elaborate on what they based their rating on, they cited satisfaction with their progress in nursing practice, combined with an awareness of how much more they had to learn.

Participant	Self-rating on a scale of 1–10	Words used to describe how they were feeling
May	6	Butterflies, excitement, a bit apprehensive, really want to be there now
Sam	6	Worried (about getting a job), don't know what people will expect of me in another trust
Chris	7–8	Excited (very), anxious about getting a job
Ann	7–8	Excited, apprehensive
Marie	5–6	Stressed, nervous, apprehensive (said cheerfully)
Lee	6–7	Nervous, excited, tense

Table 4. Participants' self-rating of how prepared they felt for becoming an RN

This combination of modest scores and the consistent use of 'excited' and 'apprehensive' or 'anxious' suggests that the participants were realistic about their readiness for the transition. This question was used to elicit some of the emotions the students were feeling. The juxtaposition of excitement and apprehension in their responses illustrates the tension between what they would gain on qualifying and their awareness of future responsibilities and the prospect of change that lay ahead.

Theme 1.2: Maintaining motivation and vision of goals

This theme represents the way in which the participants appeared to actively promote positive feelings by using self-awareness and self-belief to counter negative feelings. Anticipation of gain and change were evident in their accounts. Self-awareness appeared to support a positive appraisal of their ability: Lee felt confident when she saw that her skills in practice were increasing but she recognised that she shouldn't expect to feel confident about everything at this stage:

I think it is quite difficult to be absolutely confident about something when you are not that sure of what you are doing. I mean how can you be? (Lee)

Similarly, May reassured herself that 'it's ok to be a beginner'.

There was evidence of all participants using self-knowledge to identify weaknesses and to proactively target learning at the beginning of each placement. The realisation that they could cope in other situations, not just child health, was a significant factor for most of the participants. A number of them found working part-time as HCAs during their training boosted their self-belief and confidence. Conversely, the few who hadn't had this experience felt at a disadvantage, as they were limited to their student practice hours (4).

The theme 'Anticipation of change' represents the participants' responses to actual change and the prospect of further change in the future. Chris, who had described a feeling of panic on entering the third year, found this feeling was replaced quite soon by an acceptance of the stage she had reached:

When I started the third year I don't know, something just clicked, and you just sort of get into the role and you know you are about to qualify. (Chris)

There was also a strong sense of how their level of responsibility would change in the near future:

I've still got a lot to learn but you learn as you go, and then, things will be different when you've qualified, so, I'd say there's still room for improvement, and still apprehension about moving on and, thinking, I've got to go from you know, student to being someone in charge. (Lee)

Engaging in change appeared to be hampered by the competing priorities and demands on their time (5).

Theme 1.3: Using constructive review and feedback

The participants placed value on using feedback to enhance confidence:

It's always nice at the end of the shift when they say, you've done really well today and I've been able to leave you, and I need that encouragement I think to build my confidence. (Sam)

Theme 1.4: Evolving roles and role models

This theme suggests a shift in how the participants saw themselves. Although they felt they still needed support, they appeared to be actively seeking to change their role in the student–mentor relationship:

I really want to...be at a level where I think I should be at this stage, and I want to have my own patients, and then towards the end of the year I want to almost run the ward with the support of a mentor. But I want to do that gradually.....and then I felt more confident when I did it. (May)

Being given the opportunity to demonstrate their ability was valued because it almost allowed them to test-run their own level of efficiency (6).

The ‘good mentors’ appeared to facilitate learning by not making the student feel they should know everything. Several participants perceived that mentors appeared more patient with them as third years than as first or second years, which made them feel better about what they were doing:

If you’ve got a really good mentor and have a really good placement, it makes you feel so much better about what you’re doing. (Sam)

‘Good mentors’ not only taught and facilitated the students but also became role models:

I always measure myself against good role models, when I see other nurses that I admire and I think, well I always think I can never be like them but I’ve got a long way to go. (May)

‘Poor mentors’ appeared to be perceived as not including the student, not asking them to assist or not delegating to them at the right level (this was perceived by the participants as lack of trust), or who kept checking up on them:

Sam described a poor mentor as ‘somebody that you can never work with.....and mentors that don’t allow you to take charge of things, and don’t give you the opportunities.’

Marie talked about the difficulties caused by poor mentor–student relationships:

I don't know if it was a lack of communication between us...we clashed, me and my mentor, we just didn't get on and I found it difficult getting my benchmarks done...and I've swapped mentors for my next placement. (Marie)

This reduced her confidence – she felt it was due to a combination of mentors and students having different expectations of each other but not being able to articulate these (7). However, all participants were buoyed by mentors who showed confidence in them and helped them to take more responsibility:

On [ward], they saw that I wanted to do things, so they allowed me that space to do it and have my own patients and they saw that I wanted to be quite hands on, so I think that's how I learned better. (Ann)

Theme 1.5: Career focus

There was an undercurrent of concern throughout the stage 1 interviews about the prospect of seeking a job and whether there would in fact be jobs available. Most of the participants referred to how the third year placements had helped them to develop their ideas about where they would like to work in the future and where their aptitudes might lead them:

I want to be an A&E nurse eventually...not straight away but in a few years...just brought it home that I did definitely want to do A&E because I didn't know for definite. (Chris)

4.6 Overarching theme 2: Primacy of Practice

Theme 2.1: Knowing what you need to know

This theme centred on the tension between academic work and practice. The participants wanted to be free of the distraction of completing academic work so that they could focus on their main interest: nursing. The central issues were the value the participants placed on theory that helped to inform their practice and a strong sense that they felt they ought to know everything:

I think all of a sudden as a third year you feel like you ought to know everything, but of course if you haven't been on the ward much you don't...know an awful lot. (May)

Knowledge acquired from academic work was perceived as transient and difficult to retain unless it was applied in practice:

I feel I have got the knowledge but until I'm putting it into practice all the time that knowledge could just go! (May)

Similarly, Ann valued being challenged by her mentor to really question her own level of understanding:

One of them was looking at the different levels of care, and like, they talk us through it and say, 'you know, there's one thing you **say** you understand it, but, do you **know** what it **means**?' (Ann)

Coping with the demands of working and studying simultaneously was a challenge for all the participants. The following quotes illustrate the way in which academic work was perceived as an obstacle to focusing energy on what they really wanted to learn:

We will have finished all our academic work and when we have I feel I can look at areas I really need to focus on, things like you know IV medication and just focus on things that I really need to keep practising that I feel less competent in...you know, practise, practise everyday nursing skills and procedures. (May)

When you are on placement, although it's really good, you've always got [academic] work at the back of your mind and you've always got benchmarks or an assignment to do and that's always at the back of your mind. (Chris)

Theme 2.2: Measuring up: searching for authenticity and credibility

This theme is closely related to the concept of orientating to the role (theme 1.1). It represents the participants' concerns with meeting the expectations of themselves and of others. It encompasses the themes 'Not blagging or waffling', which was expressed in one form or another by all participants. They wanted to see themselves, and be seen, as credible and authentic. This was not about knowing everything or having numerous skills (although they did want to achieve these too); it seemed to be more about knowing what you need to learn and knowing how to acquire knowledge and experience.

I feel as if I could probably start now as a staff nurse and waffle my way through but I don't want to be like that! (May)

Recognition from others played a key role in boosting confidence, as articulated by Lee. She found that demonstrating her knowledge and skills to others helped her to feel good about her place within the team and she felt recognised and appreciated:

It makes you feel worthwhile and important, and you feel like you are part of the team, rather than just a student. (Lee)

Discussions with peers appeared to act as a prompt for reappraising what they did or didn't know. This caused alarm in some instances:

Somebody will say, 'oh, I've done that skill three times' and you think, oh, I've never even done it, and you do compare yourself to what other people have done. (Sam)

But conversely it also prompted recognition of what they did know:

Someone will ask you a question and it will just come off the end of your tongue, and you're like, oh yeah, I do know that! (Ann)

Comparisons with recently qualified nurses were frequently mentioned by participants as a means of judging quite critically how well they were doing:

Looking at some of the nurses that have just qualified, I feel like they know so much more than I do, even if they say that they don't...looking at other people, and you compare yourself...I just feel that there's so much more that I need to learn before I'm qualified and it scares me slightly. (Sam)

Theme 2.3: Skilling up: seeking opportunities to practise

This theme demonstrates the importance the participants attached to clinical skills. Confidence in their own ability to be a nurse appeared to be largely based on what they could actually do in practice, so opportunities to practise enabled the students to build their confidence:

I find I have to do...practise it...before it really sinks in, you know, and I feel really confident to do something. (May)

Even when they had become skilled in caring for older children, transferring those skills to other contexts like neonatal care opened up a whole new challenge for them:

I knew what to do, like NG feeds and stuff, but because I'd never dealt with a child that small, you know...you know what you're doing, but it's like having extra encouragement and somebody to push you. (Ann)

Even when the students had had training and practised in a skills laboratory, they found they still didn't quite know what to expect the first time they carried out the skill in practice. On Ann's first experience of administering an intramuscular injection to a neonate:

I was well scared.....I went to do it and I stopped...I said, 'I'm really sorry, I just don't know what to expect', so I went to do it and I didn't have the confidence to do it.....but in the end I did do it...and I felt quite pleased with myself, but it's not something you can practise, 'cause you don't do it all the time. (Ann)

If they lacked opportunities in their placements, they wanted to gain vicarious or simulated experiences but recognised they were not a substitute:

I've never placed an NG tube, never had that opportunity because I've never come across it; I've done the theory, I've done the clinical skill on a doll...but I've never done it for real. (May)

They spoke about the gaps between clinical placements and how it made them question their ability:

You forget how to calculate certain drugs, and how to draw up drugs because you haven't done it for ages, which needle to use – and you think, 'oh no I should know this.' (Lee)

Using assertiveness skills appeared to be a key factor in gaining the support they needed to progress safely. For example, May felt she needed confirmation from others when tackling things that were either new to her or that she felt a little unsure about:

They didn't mind if I just said look I've got to practise that, and they'd go through it with me; they didn't make me feel like 'oh you ought to know that'. (May)

The ability to articulate their needs firmly appears to have been influential in achieving their objectives (8 and 9).

During the third year, students could choose from a menu of 'acute' placements; defined as areas in which the child's health problems require more intensive nursing care. The participants saw this as an opportunity to either test out their career aspirations or to ensure they had some insight into these areas of nursing. NICU and A&E departments featured in many interviews as having fulfilled one or other of these needs.

Pushing themselves to get the most out of clinical placement opportunities was evident, particularly regarding maximising learning; for example, Ann wanted to understand more about a child's medical condition and why she was being asked to do certain things. However, as she indicates, factors such as the number of patients, the time available for asking questions and the willingness of staff to respond placed responsibility on the student to seek answers:

I had the high dependency area at [hospital], and that's quite good because there wasn't that many patients on so that allowed me the opportunity to um...sort of look more into the care that patients would get, say, if a child came in with meningitis, what the process is involved with looking after a child with that sort of condition...that was quite good, because I was able to ask lots of questions, even though they were busy there was a lot of time where I could ask questions. (Ann)

Ann felt that staff valued her interest and motivation (10).

Experience in practice increased participants' awareness of how much knowledge and skill they had acquired, but this awareness also highlighted uncertainty about their ability (discussed in theme 4.1):

I am happy with things like drips and my assessing is much better now but I still would like more experience of that. (Lee)

Four participants gained HCA employment during their course and they felt this helped maintain their skills and confidence between placements:

Another thing I did from my training was join the [hospital] bank so when I am not around the ward I do the odd shift now and then to just keep me up to date with the environment and remembering everything. (May)

4.7 Overarching theme 3: Working with People

Theme 3.1: Need for belonging and recognition

This theme represents the temporary nature of the participants' role in the clinical teams. Their placements were short (five weeks) followed by long gaps of 6 to ten weeks. They didn't have time to form relationships with other staff and they expressed uncertainty about how to respond when they didn't agree with a trained nurse:

As nurses we are accountable and we are going to be responsible for our care but you know as a student you don't want to be.....confronting them really. (Chris)

When Sam had the opportunity to take charge of the ward, she welcomed the responsibility but there were some unexpected demands at different levels: appearing to be fair to all members of the team and working alongside medical staff. Although she enjoyed the experience, it opened her eyes to the complexities of 'being in charge' and what this might mean for her working relationships in the future:

I don't like to boss people around, so I found that aspect of it quite hard. It was just remembering everything that had to be done, the times, and talking to the doctors...I've been talking to the doctors about my own patients, but when you've got the whole ward of patients and you're trying to go in when the doctors are doing their rounds, that's quite difficult. But I really enjoyed it, I think I needed that to build my confidence. (Sam)

Theme 3.2: Working with parents

The students were focused on gaining as much practical skill as they could and sometimes found they were 'competing' with the parents for experience and that the parents weren't always well disposed to having a student care for their child:

I've had a couple of occasions where I've found the parents to be slightly rude because I'm a student, and there was one occasion where the parent wanted to give the child the analgesic herself and I asked if I could do it because I'm training

and I wanted to get as much experience as I can, and she was a bit reluctant to do that. (Sam)

Many of the participants had never given an injection prior to year 3 and they feared doing so under the critical eye of a parent. When Ann had the opportunity, she found it difficult and was relieved that no parents were present to observe her (11).

Becoming aware of the child's previous experience of hospitalisation enabled May to work closely with the family to improve the child's experience (see theme 3.3). This influenced May's rapport with the parent and she received positive feedback:

The mother rang up and said 'I just want to thank you again for all your care; it just really was lovely you know', and then she wrote a letter to the ward as well. (May)

However, she also highlighted her awareness of the constraints of high patient numbers and low staffing and worried that she may not be able to spend so much time supporting parents in the future (12).

Although the participants were preoccupied with gaining skills, there were some signs of emerging empathy for parents: having focused on her own role in assisting during an emergency, Lee became aware of what the impact of that situation might be on the parents:

After you've done that, the parents come up and they come and see their child...their little girl with just wires everywhere, a tube stuck down, tape all over their face...it must be quite upsetting for them. (Lee)

Having more prolonged or frequent contact with parents (e.g. in NICU) did result in greater involvement and a more positive relationship with the parent:

Obviously they're there for quite a long time depending on the gestation of the baby, you get so involved with the family...the parents are coming in every day, then you sort of build up that really good relationship with the family. (Ann)

Theme 3.3: Seeing the child

Although the participants were heavily focused on gaining practical experience and were conscious of the presence of parents, they also demonstrated sensitivity to the needs of

the child and concern that the child's needs were not always met. The students referred to spending time and playing with the child:

As soon as I met him I realised that he had had a lot of hospital care; he was about seven and he was very, very anxious about everything...every time a nurse came towards him, he had a look and his mum said he'd had quite a lot of nasty experiences and procedures...so I could spend that time with him and reassure him. (May)

We've had a child that's been in for weeks and is quite wary of being with nurses so we've been going with it more slowly with him, making it more fun to do obs on him... (Marie)

When caring for premature babies, the day-to-day challenges and fluctuations in condition enabled them to see the impact of their nursing care – seeing the child progress and go home was recognised as rewarding (13):

They're just so small and...so fragile and...you can kind of see the care that you are doing to a certain extent, more than what you can with other illnesses...every day is a battle for these children so you can see it. (Ann)

4.8 Overarching theme 4: Managing Newness

Theme 4.1: Feeling exposed and over-exposed

This theme identifies how the participants articulated feelings of vulnerability and self-doubt. These feelings were usually rooted in particular situations or contexts, although Chris' description of panic at the beginning of year 3 was expressed in less specific terms:

I totally panicked about going into the third year; I thought, I can't go, I'm not ready.....I'm not ready to be a nurse. (Chris)

For her, this appeared to be less about the situation and more about her perception of time – almost as if the third year had arrived unexpectedly.

Facing uncertainty about their ability involved seeing themselves differently and realising that others see you differently:

Once you have the actual uniform on [laughs] people will ask you questions and they want you to know, and it's like anything if you're not sure about something you feel a little bit downhearted about that. (Lee)

These feelings appeared to have a positive role in focusing the students' attention on areas of knowledge or practice that they needed to improve on.

In most cases, the negative effect appeared to be countered by the participants' enthusiasm for their work and their ability to promote positive feelings. Indeed, the ability to balance negative feelings with positive self-appraisal and feedback from others appeared to be a significant factor in maintaining confidence; being able to identify with the skills of more experienced nurses appeared to reassure them that they would reach their goal, for example. Ann refers to a recently qualified mentor validating her feelings of concern about her knowledge and skills:

She's quite young as well, and not been qualified that long, she said that, you know, she was in the same position as me, and she was in the same position when she qualified. (Ann)

May felt she had seen the challenge that lay ahead in the faces of newly qualified nurses and it resonated with her own fears about making mistakes:

Some of them have coped really well and they just cover it up and you can tell they've just covered it up but some of them just look all stressed all the time and I think oh no, it's so hard isn't it to suddenly have the whole responsibility for everything, I don't want to make a mistake. (May)

Although conscious that they were just at the beginning of their learning, a common theme in all the interviews was the anticipation of losing the 'security blanket' of student status:

Obviously at the moment we are at the tip of the iceberg and we are still just scratching at the surface and there is still a lot out there to learn. I think it's just the whole...it's the uncertainty of it all now...all of a sudden it's almost like that was a security blanket 'cos you knew what you would be doing. (Lee)

The impending end of their course was described as exciting and stressful (consistent with 4.5.1):

I think it's quite stressful as well, it's exciting to think well, on Wednesday it's like our last day, but then after that, it's kind of like going into the unknown, 'cause it's been like a routine for three years, it's like um a security blanket, then that's been taken away and it's woooo! (Ann)

'Scary' was used by most of the participants to describe feelings of uncertainty in practice. This was articulated by Sam in relation to taking on responsibility for the ward. Marie used this term to describe her perception of other people expecting her to 'know everything':

Scary, 'cause you perceive that people expect higher things from you because you're a third year and you're supposed to know everything, whereas I still think at times I don't know everything. (Marie)

May used the term in relation to the confusion felt in a busy and unfamiliar environment:

I really liked A&E; it was completely different and I think I found it scary at first. It was a lot of adults [ref to patients], a lot happening all at once, not knowing where you should be or what to do. It was a different situation to be in and I wasn't.....you know...it had taken me a while to get used to the children's ward and I was suddenly in a completely different environment. (May)

Ann's description (14) illustrates the mixture of fear and excitement the students often felt when faced with new learning situations. She couldn't sleep the night before due to excitement and anticipation, and felt like a first year going into the unknown. Her attitude towards new experiences as being something to be embraced enabled her to balance her mixed emotions about the placement.

Theme 4.2: Learning and working in the real world

Some of the major challenges evident in the students' accounts were the pressure of time, workload demands and the variations in learning opportunities. For some, adapting to long shifts was a particular challenge:

The only thing I find really hard about nursing is the long hours...I find that a bit challenging because you get to about six o'clock and you can feel you are starting to flag and you've still got to do your notes and your handover and still trying to

keep alert and you've still got medication to give and I can find myself getting a bit woooo...I've got to cope with these long hours. (May)

The pressure on mentors to meet the needs of children and parents before thinking about the students' needs was recognised by the participants:

They're so busy, it's really hard for the staff nurses to go, 'oh wait, student, come, you can do this', they just tend to get on with it. It's really hard to get in there and say, 'oh yeah, let me do that.' (Ann)

This also affected their feelings about asking questions:

Sometimes on the children's ward you can't always ask them questions 'cause they're busy, rotating work that they've got to do. (Marie)

However, there was evidence that they learned to be proactive and maximise opportunities:

Even though they were busy, there was a lot of time where I could ask questions, I would ask the doctors questions, sometimes I was asking, what do all the blood results mean? (Ann)

Whilst students welcomed increased responsibility and independence in practice, they articulated some of the frustrations that can arise when juggling working full time on the ward and completing academic work. This tension was expressed by Sam, who felt it affected her enjoyment of practice. She also highlighted how hard it can be for a student to find time to discuss their progress with their mentor:

I don't feel like I can fully enjoy my placements as much because I'm always aware that I've got lots of [academic] work to be getting on with, and it's finding the time to sit down with your mentor...to actually get my interviews done.....especially when I have been having my own workload as well, because I've been really busy and my mentor's had her half of the ward, so we just haven't had time to get things done. (Sam)

Having to juggle studying and working in clinical practice was cited as challenging by all participants; for some it helped that they already tended to be organised:

I have to be like one step ahead of myself, I have to like make timetables for my days off and my study days...if I didn't do that I'd panic I think and get a bit stressed thinking 'oh no I'll never fit this in' (May)

Ann described the excitement and anticipation of starting her first placement on NICU, only to find that the staff didn't even have time to orientate her to the unit:

I was kind of left on my own, and I didn't know what I was supposed to be doing...I really want to be doing something, see, I didn't know enough about the patients, I didn't know enough about the ward, and what to do and what not to do, and what students can and can't do. (Ann)

There was also an acceptance that learning in the real world would always place some limitations on precisely what skills they could gain:

It depends what patients you get, you can't say you're going to perform that skill today, 'cause you don't know if you've got that person. (Sam)

Coping with extreme fluctuations in workload also challenged their ability to adapt their responses:

I found on some of my placements it would be slow to start with...then suddenly hundreds of patients all at once and it's trying to get perked with adrenaline for all that after you've had a slow start. (May)

Theme 4.3: Coping with crises

Exposure to unexpected emergencies had a significant impact on the students – not least the opportunity to realise what they know:

All of a sudden he just started fitting...I was on my own, I knew there was a nurse just round the corner, so I just quickly grabbed him and said one of the staff nurse's names, and I needed help, and just ran into the assessment ward, and just, I don't know, some sort of instinct just took over...I've not really had that situation before, but, you sort of know what to do. (Ann)

Similarly, feeling that they had successfully coped with a situation they had feared allowed the participants to reappraise their fears about other issues:

I saw cardiac arrests and a lot of traumas and I had that fear inside me that I couldn't cope in those situations and actually doing it made me realise you know I can deal with things like that. (Chris)

4.9 Key conclusions

This chapter has examined the student nurses' experiences as they approached the end of their programme. The findings cover all four overarching themes but 'Personal and Professional Identity' and the 'Primacy of Practice' appeared more significant to the participants experience at this stage. This is illustrated in table 5, with the most significant themes in bold.

1. Personal and Professional Identity 1.1 Self-image and professional identity 1.2 Maintaining motivation and vision of goals 1.3 Using constructive review and feedback 1.4 Evolving roles and role models 1.5 Career focus	2. Primacy of Practice 2.1 Knowing what you need to know 2.2 Measuring up: searching for authenticity and credibility 2.3 Skilling up: seeking opportunities to practise
3. Working with People 3.1 Need for belonging and recognition 3.2 Working with parents 3.3 Seeing the child	4. Managing Newness 4.1 Feeling exposed and over-exposed 4.2 Learning and working in the real world 4.3 Coping with crises

Table 5. The overarching themes of transition: key themes at stage 1

Personal and Professional Identity

This theme was very dominant at the pre-qualification stage, demonstrating a strong focus on preparation, rehearsing, and taking on more responsibility. The students were focused on developing an understanding of their future role and acquiring a wider repertoire of nursing skills; which they perceived as providing a basis for increasing their confidence, demonstrating their credibility and gaining the trust of others. The juxtaposition of fears about future responsibilities and anticipatory excitement at the prospect of success

appeared to provide a stimulus to seek out good role models and to take opportunities to rehearse for future demands.

Primacy of Practice

This theme demonstrated a strong emphasis on the relationship between practical skills, knowledge that can be applied in practice and levels of confidence. Indeed confidence in their ability to be a nurse was rooted in practice and this promoted a determination to seek out opportunities to gain or improve their skills in readiness for future demands. They wanted others to recognise and value their contributions and place trust in their ability. The academic work was perceived as a distraction and an impediment to developing the nursing skills they needed and they were looking forward to entering the 12 week consolidation placement in practice. There was evidence of a strong desire to demonstrate their authenticity and a resistance to 'blagging'.

Working with People

The student nurses' experience at this stage suggested they had limited experience of building working relationships with colleagues, parents and children. This appeared to be a function of their supernumerary role and the brevity of their five week placement periods. Despite their fear of practising in the presence of parents and the sense that they were competing with parents to gain practical experience, the students were being proactive in gaining as much experience as they could. Therefore the focus of relationships with others was primarily on gaining practical nursing experience. However there was some evidence of emerging empathy with parents and children.

Managing Newness

Within the theme of 'Managing Newness', awareness of their fears and the impending loss of the 'security blanket' of student status, coupled with the demands of learning in a busy work environment, appeared to prompt proactive preparation for their future role. For example; exposure to emergency situations had enhanced their perceptions of their potential for 'Coping with Crises'.

The findings reflect the 'pre-liminal' stage (Van Gennep, 1960) and illustrate the student nurses' preoccupation with their future professional responsibilities and their motivation to proactively expand their knowledge and skills in preparation. It also illuminates the sense of vulnerability they felt, both as third-year students and future practitioners. The post-qualification period appeared to dominate their thoughts and actions and, in that sense they were anticipating the imminent changes in their role and situation.

5 FINDINGS STAGE 2: THE NEOPHYTE RN

5.1 Introduction

At the time of the second stage interviews, all participants had been employed as staff nurses for between three and four months. For those participants who experienced delays in commencing employment (Marie, May, Sam and Lee), the second interview was postponed to allow them to experience the first three months of being in practice as an RN.

Analysis of the second interviews revealed that much had changed since the participants became RNs. They spoke of the excitement of succeeding and of enjoyment in their new jobs; but this was balanced against a sense of loss, not least of student identity and familiarity with places and people. They spoke of both the pride and the fear that came with their success, particularly the reality of professional accountability. Their experience of induction varied greatly but all received some form of preceptorship and orientation to their role.

For five of the participants, the reality of wearing their staff nurse uniform (one was not required to wear uniform) and working in an unfamiliar environment with people who hadn't known them as a student appeared to have an impact on their sense of self. They spoke of being away from friends and family and still feeling 'new', of feeling scared and out of their comfort-zone. Long busy shifts, increased workloads and short staffing created the environment into which they were striving to fit and gain acceptance. They also wanted to gain support and guidance whilst not appearing to resist their responsibilities as an RN. For four of them, there had been an unexpected gap between completing their course and officially commencing their new role. This period appeared to bring the benefit of allowing time to step back and contemplate this major change in status.

Additional quotes numbered in parenthesis are recorded in appendix 17.

5.2 Overarching theme 1: Personal and Professional Identity

Theme 1.1: Self-image and professional identity

This theme represents a sense of loss and almost disorientation felt in the early months. The progress they had perceived in the latter part of their programme was replaced by a perceived feeling of regression; for example, most of the participants spoke of a feeling of stepping back into student mode and letting others tell them what to do. The following quotes from Chris and Sam highlight the difference between the early days post-qualifying and now, and how they can see a difference in four months:

I felt like, oh dear, I am a nurse and I don't know anything. Looking back I think I was not like I am now, I still felt like a student in a stepping back and letting everybody else tell me what to do and not taking a lead rather than taking a lead and saying shall we do this, shall we do that. (Chris)

Similarly, Sam recalled having less responsibility than she had as a student (1):

I felt like a student again really because I was like observing, so I didn't really feel like I was a proper staff nurse just yet [laughs] but I do now...a few months down the line. (Sam)

Sam and Lee experienced delay in gaining their NMC PIN as they awaited final academic results. This created some anxiety in case it affected employment prospects (2). Lee who had initially been treated as an RN and then transferred to HCA duties (whilst repeating academic work) saw the HCA experience as positive in some senses – he had a chance to get to know the unit, meet new people and learn new procedures:

I actually saw it as a positive experience, simply because the fact that, I felt because, you know when I started, first started in a new place, it means that you're completely, I didn't know anyone at all, then you've got the fact that you, you're going to a new place to work, there's new people to meet, new procedures, new, new...there's all sorts of things, you don't know where anything is, when you start a new job. (Lee)

For May, the three-month gap before commencing in post gave her time to prepare for her new role and in her words 'come to terms with' being a nurse. It also allowed her some respite after all the studying and a chance to reflect and prepare for her new role (3). May

continued doing bank shifts as an HCA, which she felt enabled her to continue learning whilst having less responsibility than in her RN post:

I think that that's helped me to make the transition, still being able to not have that responsibility for a bit longer while I had that break. (May)

Five of the six participants entered employment in other parts of the country where they had no history as a student. In some senses this seemed to almost be a negative because it effectively thrust them into a situation in which they would only ever be known as a qualified nurse:

I think I am treated differently, and not treated as a student, I was probably treated as the new person but they have only ever seen me as a nurse I suppose. (May)

It was evident that self-image and professional identity were influenced by both the way others saw the participants and the inner sense of uncertainty felt by them personally. The opportunity to step back and have a chance to reflect or to have less responsibility appeared to offer some brief respite at a time of significant change in status.

Theme 1.2: Maintaining motivation and vision of goals

At this stage, motivation seemed to be supported by a sense of excitement, pride and feeling positive about their jobs – feeling they were where they wanted to be. The academic qualification gained appeared to be of less significance than the RN qualification (4–5).

Most of the participants expressed a sense of fear towards the change in status; a sense that there was no going back (6). They identified some rapid changes in their ability to process information and a changing sense of self-belief:

I finally feel I am not a student anymore, I feel like I'm thinking on my feet now, I can take the lead a bit more and I feel I'm getting my confidence more about being in my nursing role, working really well with the team...but being more in the lead and not being a shy student anymore and being told what to do. (Chris)

Confidence was described as ebbing and flowing in the early months (7) but the overriding sense of reaching their goal was palpable in all interviews (8):

It's a case of, I did it, and I'm where I wanted to be, finally! (Lee)

Although the newness and unfamiliarity of their new work environments created stress, this appears to have been countered by enjoyment in their work: Lee found PICU a very challenging area to begin her first post but she was motivated by her interest:

I love it, I just feel that when you've got, you just have your one patient...particularly if they are quite poorly, it's just, you have a real sense of you know, achievement...it's almost like, this is my project for the day! (Lee)

Maintaining motivation appeared to be linked to 'Being where you want to be and 'Finding your feet':

I knew straight away it was the role for me.....I did feel anxious in the first couple of weeks, until I found my feet, it's finding your feet really and knowing what they want of you. (May)

The combination of excitement at achievement and being where they wanted to be appeared to promote motivation and self-belief in the early weeks until they became more confident.

5.2.1 Words used to describe feelings about being a staff nurse

The participants were asked what words they would use to describe feelings about being a staff nurse. Table 13 records the words they used; these words suggest very positive feelings, particularly pride, about actually being in the role.

Participant	Words used
Lee	Rewarding, interesting, fulfilling
May	Proud, very proud...sometimes a little bit nervous
Marie	Hard work but very rewarding
Sam	Happy, enjoy going into work, pleased to be a staff nurse
Chris	I am learning still, sense of achievement, feel proud of myself
Ann	I like my job, really glad that I chose this career, proud of my achievements

Table 6. Words used to describe feelings about becoming a staff nurse

Theme 1.3: Using constructive review and feedback

The RNs frequently referred to the way in which they sought out and used feedback and guidance from others to aid their development and build confidence. When Sam felt uncertain about her knowledge, she talked to senior colleagues and gained reassurance:

I have spoken to other staff on the unit about this and they said to me 'well there are still things that we don't know and we have to go and ask somebody so don't worry. (Sam)

Marie found that she sought support in and outside the workplace to help her to progress (9). Chris, however, reflecting on a difficult clinical experience (paradigm case presented in theme 2.2) realised that she could have asked for help sooner:

I should have realised sooner that I needed help. So I can now think to myself 'look if you need help ask for it, don't just try to get through it on your own'. (Chris)

May highlights the tension often felt between the participants' self-knowledge of their ability and the expressed views of other nurses. This required them to be discerning about the validity of some feedback:

You don't really learn until you're out there in the environment...they keep saying I have slotted in so well, part of the furniture and everything. (May)

She felt she knew her limits but had to keep reminding other nurses she was new and needed guidance (10).

Theme 1.4: Evolving roles and role models

This theme represents the evolution of the participants' role from 'observer' and almost feeling like a student again (theme 1.1) to taking on the role of RN. The theme clusters encompass the key influences on how the role transition was accommodated – from supervision and supernumerary, during which expert role models are identified, to the gradual realisation of what they were capable of. As indicated in theme 1.3, feedback from more experienced nurses was sought at this stage.

Some of the participants experienced quite structured and gradual inductions and this helped to ease them into the new role (11). However, even at this early stage the newly

qualified nurses were teaching and supporting others. At the time of the second interview, supporting students seemed to provide tangible evidence that they actually were RNs (12):

I know I'm not a student anymore, actually I think it takes a while to get that out of your head, the fact that I'm doing the teaching here now and passing on my knowledge to somebody else, rather than the other way round. (Lee)

Although the increased responsibility was perceived as scary (theme 4.1), it was welcomed (13).

All of the participants had some sort of mentorship or preceptorship provided, but this varied greatly in length and formality of the relationship. This is discussed more fully in theme 4.2 but is of relevance here in that it appeared to be a more distant role which focused on encouraging the nurses to develop their skills and confidence rather than supervising or monitoring their progress:

Although they call them mentors, it's not mentors like when we were students; it's more somebody you can go to if you have any problems and you want to speak to them about anything. (Sam)

One of the biggest challenges appeared to be the gap between knowing they have qualified, then wearing the uniform, and then beginning to feel that they are a nurse; that they are capable but are not alone and can ask for help. Lee illustrates the benefit of having a supportive mentor who could encourage her to extend her experience under supervision (14). Giving up the student identity and replacing it with the RN identity appeared to be a daunting process, and the participants recognised they would still need help:

I think it is not feeling like a student, you know feeling like you are a nurse. That accountability that you've got now, it is a big responsibility and just the whole aspect of having the confidence in yourself to do every aspect of care really. To learn that you can ask for help really, you're never going to know everything. (Chris)

More formal managerial supervision also seemed to help the participants because this established targets for their development (15). Some participants had less formal mentor arrangements so they used their initiative to seek out suitable mentorship:

I don't think I've really had a mentor as such, I think I've got one but nobody has actually told me who it is...it's access to people that I feel comfortable to talk to.
(Marie)

Expert nurses were recognised as role models in terms of their confidence, skills and knowledge:

I look at other staff nurses and they're quite confident to do things and they talk to parents and they know all the right answers, I just want to be like that. (Sam)

The ability to seek out and use role models and mentors during the early days required assertiveness and a willingness to acknowledge their own needs.

Theme 1.5: Career focus

Most of the participants referred to the influence of their third year placements on their subsequent choices of employment. They appeared to have a sense of where they wanted to work in the longer term but didn't always feel ready to go there immediately (16). The pursuit of long-term goals was associated with planning and gathering the right kind of experience. Ann referred to rotation as enabling her to sample career opportunities:

It gives you the opportunity to sort of, look through the window a bit, to see which direction you might go in. (Ann)

Chris aspired to work in A&E but did not want that as a newly qualified nurse; she saw this first job as part of a planned learning curve:

I do love A&E and I still like to think I would go back to A&E eventually but that's not the type of post I would want as a newly qualified nurse. (Chris)

It was evident that longer-term career planning had influenced the early job choices made and the participants' current development plans.

5.3 Overarching theme 2: Primacy of Practice

Theme 2.1: Knowing what you need to know

This theme represents the participants' consistent focus on having the right type of knowledge; knowledge they saw as being useful for practice. There was a sense that they felt frustrated about perceived deficits in knowledge:

You feel like you know lots of stuff, you know you know lots of stuff, but you feel you don't know enough. (Lee)

A common issue for all participants was that although they had knowledge and skills it wasn't always easy to simply transfer these to a new clinical setting:

The care and skills I learnt on the children's ward are completely different and I haven't had a chance to use a lot of those skills on neonates. So I'm having to learn loads of new skills and it has been quite challenging. (Sam)

This seemed to put pressure on the new nurses to be proactive in identifying their knowledge deficits and actively reading (17).

Theme 2.2: Measuring up: searching for authenticity and credibility

One of the key difficulties experienced by all participants was that after a brief settling-in period other staff ceased to recall their newly qualified status and placed expectations on them that weren't immediately achievable:

They see me in my staff nurse uniform...and they may think I had just come from another NICU somewhere else and can do these tests but actually a lot of these tests I have never done before or even seen; it's hard to then say, I haven't done that before. (Sam)

Similarly, being sent out of your normal work environment at an early stage can lead to feelings of not measuring up:

I kept having to go and help out on the main ward, and I hadn't really been there, so I felt that I was quite slow and I was given like a few patients to look after and I felt like I was doing it quite slow, and it wasn't very good me being slow, with how busy it was. (Ann)

They tended to compare themselves with more experienced nurses and had to remind themselves they were newly qualified (18).

5.3.1 Paradigm case

A description by Chris of an experience that is representative of all four overarching themes is presented in appendix 19. Her description conveys her effort to measure up to the responsibility she had been given whilst feeling very exposed. She doubted her professional ability following this experience but by reflecting and then working alongside a more experienced nurse she regained her confidence. Chris found she was judging herself against much more experienced nurses:

You look at the nurses who have been there for years, and you think 'you're really good', and I want to be like that. But you sometimes look at them and you think I'm not like that yet...you are always trying to be a bit better and feeling like you're thinking on your feet like they are. (Chris)

She wanted to show that she was 'working well within the team' and meeting that young person's needs. Her experience demonstrates some of the complex interpersonal challenges faced by children's nurses when caring for young people. It wasn't that she wasn't capable of providing the care needed but she was sufficiently unfamiliar with the young person, and he with her, that the situation became stressful for both of them. The main learning that came out of this for Chris was the need to ask for help earlier. She explained that it was about showing that you can do the job you trained for:

I mean you're newly qualified...you want to look like you're good at your job and that you can do it because that's what you train for. (Chris)

Although the new nurses were striving to show what they could do, they also conveyed their desire not to 'blag it' or have a 'know-it-all' attitude:

I would never say anything that I didn't know, I would go and find a senior nurse to let's find out, you know...nobody can know everything. (May)

It was evident that when the nurses hesitated or refused to act, this was not due to fear or uncertainty but rather an acute awareness of what they did and did not know. This was particularly evident in relation to drug administration (see theme 2.3).

Theme 2.3: Skilling up: seeking opportunities to practise

Becoming skilled in practice and feeling that they were making authentic contributions to care appeared to influence the RNs' confidence. They then sought out opportunities to fill any actual or perceived gaps in their ability. However, they were hesitant if they didn't have prior experience and wanted to know what they were doing:

I don't want to rush in feet first and do anything wrong, I want to sort of know what I'm doing before I'm doing it. (Ann)

Chris distinguishes between general/adequate confidence and that of an experienced nurse who can respond in each situation:

At the moment I am confident but I feel I'm still getting it, and still learning and getting the confidence to be that experienced nurse and know what you're doing, I mean know what you're doing in each situation. (Chris)

The delay of three months before commencing the first post created anxiety about possibly losing skills:

It made me more nervous, and I thought, I'm losing what I've just learnt and things, three months away from not doing anything practically. (Marie)

Some things they hadn't experienced before, such as supporting breast-feeding mothers, posed specific challenges (19).

Being responsible for drug administration appeared to prompt specific strategies for gaining experience and monitoring themselves:

I'm checking now, with the responsibility of doing drugs and IV drugs and things, going through it and making sure I know why, and making sure it's all set up right, so I'd check, make sure I'd doubly check it myself. (Marie)

Marie also illustrated how this awareness enhanced her approach to advising junior students (20).

5.3.2 Advice to third-year students

The participants were asked what advice they would offer to third-year students. Their responses are recorded in appendix 20. These focus clearly on encouraging students to gain as much experience as possible in practice, to take any opportunities available and to always ask questions. This advice appeared to be consistent with their own focus as newly qualified nurses in trying to gain as much knowledge and experience as possible.

5.4 Overarching theme 3: Working with People

Theme 3.1: Need for belonging and recognition

As four participants moved away from family and/or friends, and five moved to areas they were new to, they faced separation from familiar people and places. They had to get to know new people and establish themselves in new teams at a time when, although they felt excited and happy (theme 1), they were also anxious about their knowledge, skills and credibility (theme 2).

Peer support from other newly qualified nurses was a welcome resource and provided opportunities for reflection:

It's nice to know that there are seven other people that you can sit down with and you've always got that little team there. (Chris)

It's quite nice just to reflect with them how the shift's been...then that's it, then you can relax and go on to whatever you need to do. (Marie)

However, one of the difficulties faced by the three participants on rotation programmes was that after three months in post they moved to their next placement and felt like the new person again:

Because you're on rotation sometimes you feel like you are never going to settle within a team...and some of the team members don't fully accept you because they know you're going to leave eventually. (Chris)

At this early stage they were still tentatively building new relationships, and peer support appeared to be invaluable in this process.

Theme 3.2: Working with parents

As they settled into their new roles the nurses' interactions with parents increased in both quantity and complexity. One of the new RNs' key concerns was about appearing credible to parents (21). The need to support and communicate with parents was identified as a core responsibility (22). Lee managed her concerns about how parents might view her if she couldn't answer their questions by being honest about what she did and did not know:

I don't want them to think that they've got some incompetent fool looking after their child, so the stuff I do know about, I will happily tell them about it and then if they ask me something I'm not sure of, I can say, 'well I don't know about that.' (Lee)

Explaining that she was new helped Marie to gain the support of parents:

They were really nice and supportive, 'cause I'd not told them that I was just qualified, but made them aware that I was new and that I may go and ask questions, and they understand that. (Marie)

Working in close contact with parents also raised issues about the boundaries of professional relationships:

You have to be really careful about what you say and you have to keep the boundary there, you can't cross it...because there have been parents that said 'let's go out for a drink together' and you can't do that [laughs]. (Chris)

May perceived a hierarchy in the workplace and she wasn't comfortable with that. She prefers to work as a team and include the parents:

I do it all as a team...a lot of the parents do need a lot of strokes, they need to know that they are doing a good job. (May)

The need to understand the parents' perspective and to cope with and respond to their needs adds an additional dimension to the nursing role that children's nurses have to develop in order to deliver FCC.

Theme 3.3: Seeing the child

At the second stage interviews there was a significant change in the way the participants referred to the children; in some senses they no longer appeared to be competing with the

parents for experience and were instead working with them to meet the child's needs. Although Lee's clinical experiences in intensive care were not shared by other participants, the focus she places on the child, although specific to the setting, was not idiosyncratic and there were subtler examples from all participants:

You're the one with the eyes and ears for that, basically for that child for that day...
(Lee)

This extract from Lee provides an exemplar of what the new nurses hoped to achieve for the child. She refers to getting through the day without breaking the child:

When you have one child, and they're quite complicated...the challenges are really sort of like, trying to get through the day without breaking them I suppose!...It's probably the main thing if that makes any sense at all. Feeling like you've made some form of progress with the child at the end of the day is probably the main challenge. (Lee)

The participants also spoke about the importance of getting to know the child and being able to communicate with them:

You need to find a way of communicating with them and getting to know them and I think that's one of the good things about what I'm doing here. (Chris)

The subtle shift in the nurses' focus on the child seemed to be a consequence of the increased level of responsibility that came with their role as an RN; they were no longer caring for other nurses' patients but their own.

5.5 Overarching theme 4: Managing Newness

Theme 4.1: Feeling exposed and over-exposed

For all of the nurses, the first day in their new role was characterised by feelings of fear and uncertainty. Most of them described feeling nervous and not their usual selves, such as being quieter (23). For Ann, the first day left her feeling useless (24) – the new environment and different ways of doing things negated some of her earlier confidence:

I felt like a sheep, 'cause all these people kept coming in and rushing round, I felt a bit useless. (Ann)

May described a similar experience in which she felt confused about her role and why she was there because others seemed unprepared for her arrival.

So it was completely like I haven't got a clue what's going on – oh dear what on earth am I here for? What's my role as a new person as a newly qualified? (May)

However, Marie's first day was in a familiar environment and she was thrown 'in at the deep end' due to an emergency on the ward. She felt she benefitted from this exposure because she had support (25).

In the first few months, specific tasks such as collecting a patient from the operating theatre brought into focus a whole range of accountability issues for the nurses. Marie described the feeling of responsibility the first time this happened (26) and all the things she had to think about:

I'm thinking, what do I need to remember? What have they had done? Going through anything they need to have is done, make sure that any medicines are written up, making sure that the patient is awake and is able to come back and they're not in pain or anything for the transfer. (Marie)

Although the nurses recognised that they had previous experience they still found exposure to new environments and unfamiliar situations could almost take them back to feeling like a first-year student. Lee's experience of the initial exposure to intensive care is an exemplar of the discomfort and fear felt by the new nurses in the early days (27). The reality of being accountable for the care provided was brought into sharp focus very early:

You're kind of under the spotlight, 'cause you're the one person that's looking after the child for the whole day, the one who is.....you're the one who needs to liaise anything that needs to be said, **you're the one**, I mean, if anything goes wrong, no one else is going to spot it, you need to be there. (Lee)

Feeling out of their comfort zone was a common issue among the nurses but not always a negative one. Although Marie was on a children's ward, she found certain aspects, such as being alone on the acute admissions side, out of her comfort zone but she felt able to cope:

I've had the full responsibility of doing our day assessment unit, which is quite scary, where we have patients come in from A&E to be reviewed, or GPs have brought patients in so we've seen them first hand. I do that on my own, which was quite scary the first time. (Marie)

Another aspect of accountability that caused anxiety at this stage was delegating to others, because the nurses did not want to be perceived as pushy:

You come into a new setting and you're there as a newly qualified and there are people who have been there for years and sometimes you feel a bit uneasy to say, to delegate to people who have been there for a long time. (Chris)

The participants used assertiveness skills to cope with exposure and gain support in their new environments:

I was just honest and said, 'oh I can't get to grips with this' and someone would show me a few more times. (May)

There was also the positive side of realising that the reason for the increased responsibility and accountability was that they had a new status, which was inevitably a positive aspect of coping with exposure:

To introduce yourself to someone as the staff nurse it's like woaaa! [laughs].
(Chris)

Theme 4.2: Learning and working in the real world

Settling into their new role against a backdrop of busy wards and short staffing had an impact on the quality of the participants' experiences. Although all participants received some induction, the nature and length of this varied enormously; for example, initial induction was excellent for Sam, Lee and Chris (28 -29). However, it was very limited for Marie, Ann and May; in Marie's case this was less of a problem because she had stayed in her training hospital (30) but for Ann and May it was more of an issue:

My line manager gave us all a pack, called our induction pack, and she went through that with me and I had a one-to-one with her...so we kind of do it as we go along. (Ann)

Times when they felt negative about their work were usually related to circumstances beyond their control, such as short staffing (31):

When I'm tired and it's been a busy shift and I think, we haven't had a chance to sit down or even have a drink...you feel dehydrated and tired and things, but generally I do really enjoy it. (Marie)

This type of experience seemed to enhance their awareness of the politics of health care and the impact this can have on their working lives:

At the moment, things have been a bit hairy, because there's been a freeze on employment, and we're 20% down apparently on staff, which means that every day can be quite fraught. (Lee)

The impact of working in fast-moving environments in which staffing was not always adequate meant that the RNs' support needs increased, but this was not matched by the availability of support or time to access that support.

Theme 4.3: Coping with crises

Within the first few months of practice as an RN, all participants had experienced exposure to a range of unexpected or urgent clinical incidents. The following examples illustrate this:

Sam described a situation in which senior staff supported junior staff following the death of an infant:

It's a really hard environment to work in sometimes and recently a baby did die and on one of our study days the sister came and talked to us about it...I felt it was nice that they sat you down and asked if you had any questions you want to ask about it. (Sam)

The unexpected and shocking experience of a child being inexplicably injured propelled Marie into a formal investigation (32) that she felt ill-prepared for. The whole experience made her question her ability and she felt she needed support (33) rather than false reassurance that everything would be all right:

It made me nervous and think, ‘have I actually done something wrong?’ and from what I remember of that shift, I don’t think I did anything wrong. (Marie)

Marie acknowledged the academic programme had informed her of child protection procedures but she felt she could never really be prepared until she faced a situation herself.

May described feeling lost during a medical emergency (34) – she felt like an outsider still learning, and was conscious that others knew much more than her. This prompted her to think about how she would cope if she was the only trained nurse.

5.6 Key conclusions

This chapter has examined the participants experience as newly qualified nurses. The findings cover all four overarching themes but there was evidence of some themes in ‘Personal and Professional Identity’ and ‘Primacy of Practice’ being less significant than at the pre-qualifying stage; whilst the overarching themes of ‘Working with People’ and ‘Managing Newness’ came into sharper focus. Table 7 illustrates the findings with the most significant themes highlighted in bold.

1. Personal and Professional Identity 1.1 Self-image and professional identity 1.2 Maintaining motivation and vision of goals 1.3 Using constructive review and feedback 1.4 Evolving roles and role models 1.5 Career focus	2. Primacy of Practice 2.1 Knowing what you need to know 2.2 Measuring up: searching for authenticity and credibility 2.3 Skilling up: seeking opportunities to practise
3. Working with People 3.1 Need for belonging and recognition 3.2 Working with parents 3.3 Seeing the child	4. Managing Newness 4.1 Feeling exposed and over-exposed 4.2 Learning and working in the real world 4.3 Coping with crises

Table 7. The overarching themes of transition: key themes at stage 2

Personal and professional development

The findings at this stage were characterised by mixed feelings about the loss of student nurse status, excitement about succeeding and acceptance of the responsibility and accountability of being an RN. At the same time, awareness of their professional status, accountability and responsibilities appeared to promote greater awareness of responsibility for their own knowledge and skills. After some initial feelings of regression and feeling like a student again the nurses used self-motivation and self-belief, together with feedback from expert role models, to build their confidence, recognise their limits and decide when to seek guidance and support.

Thus, this was a very demanding period of time in their personal and professional development, during which they felt anxious and uncertain about what others expected of them. The support offered to the nurses was more distant than pre-qualification mentorship and had already receded 3-4 months after commencing their first post.

The Primacy of Practice

Practice remained a dominant source of confidence but the key challenges in the early months involved applying knowledge gained in one setting to another and gaining new skills specific to their clinical specialism. Gaining experience in practice and having good role models and support were key influences in helping the participants cope with the discomfort of their new role. They focused on gaining knowledge and skills that would boost their confidence and demonstrate their credibility to parents and colleagues.

Working with People

This theme demonstrated greater significance at this stage in terms of changes in the new nurses own needs and their awareness, motivation and ability to respond to the needs of others. The experience of moving away from familiar places, work environments and people, placed demands on the nurses' ability to forge new relationships and gain acceptance in the teams they joined. There was evidence of a sense of loss and of needing to develop new relationships in these new environments. This was coupled with increased expectations of self and uncertainty about how they were perceived by others, which impacted on early confidence and optimism.

The new RN's descriptions at this stage demonstrated increasing awareness of the needs of the children and parents in their care. Having responsibility for their own patients was welcomed as it allowed them to demonstrate their ability to meet the child's needs and a greater sense of their professional role and responsibility. This also facilitated greater

exposure to parental needs and expectations, an area that had been much less evident at the pre-qualifying stage. There was evidence of increased awareness and empathy with the needs of parents. However, there were still some lingering doubts about appearing to be a credible practitioner and a sense of feeling exposed and uncertain if they could not answer parents' questions.

Managing Newness

The experience of leaving the 'comfort zone' and awareness of the implications of being accountable for their practise contributed to 'feeling scared', particularly about the expectations of others. The nurses had all received a basic induction to their new roles; primarily experienced as a brief period of being supernumerary and introduction to the policies and procedures of the organisation. This was followed by immersion into the ward team as an RN.

The new RNs experience was articulated with reference to the fast pace of the clinical settings, long shifts, high workloads and in some instances inadequate staffing, which increased their need for support. At the same time, being treated as a new member of staff, rather than a newly qualified nurse, and the increased exposure to working directly with parents created a need for support and guidance from more experienced nurses. However, within a few months of qualifying, support was diminishing and the new nurses were already beginning to teach and support others.

These findings resonate with the 'liminal' stage (Van Gennep, 1960) in which the previous role has been lost and the new role not yet fully established. However, the nurses felt that to others, their status as an RN was visible, whilst their newness was invisible. This suggests that it is difficult for an observer to recognise a neophyte nurse or to accurately perceive how she is adapting to her new role. There was a sense that they wanted to say to others, 'I am a nurse, but I am new!' In their staff nurse uniforms, there was nothing to indicate to parents or other staff that they had only recently qualified. The support of other newly qualified nurses appeared beneficial in helping them cope with this.

6 FINDINGS STAGE 3: 12–14 MONTHS AS A STAFF NURSE

6.1 Introduction to stage 3 findings

By the third interview there was a sense of the participants losing the initial cushioning of support and in some cases feeling abandoned. The pace of change in the first year after qualifying appeared to be experienced as very rapid. The participants were no longer the new girl or boy and they were now taking responsibility for their own patients. Chris captures their sense of resignation about the speed of transition and the lack of any bridging or in-between stage:

We go from one day when you go on to a ward as a student, and the next thing you go on the ward as a staff nurse. There is no in-between, and I suppose there can't be that in-between, or you'd be there for ages trying to make the transition. It's just got to happen, and you've just got to get on with it and make that transition and find your way of working. (Chris)

Although the nurses still had a lingering sense of being 'new' and occasionally feeling like a student, they expressed their motivation to progress and were taking on more responsibility. Teaching others appeared to help them to see how far they had evolved in their role transition. However, they still expressed the need for guidance and support from more experienced nurses.

The acquisition of practical knowledge (or knowledge that they considered relevant to their practice) contributed to increased levels of perceived confidence, but the fear of not knowing enough remained and this appeared to work as a motivator. Now that the nurses were no longer studying as part of a curriculum, they referred to using clinical experiences as triggers to conduct reading or research into nursing issues.

The social aspects of being part of a team appeared to have increased in significance, and relationships with the children and their parents appeared to be more easily developed –more importantly to the nurses, these were sources of satisfaction in their work. However, communicating with parents was an area they still felt ill-prepared for.

As students, the participants were somewhat shielded from death and serious clinical incidents; this changed completely on qualifying and most had faced more than one crisis by the third interview. The themes of 'Feeling exposed' and 'Coping with crises' appeared more significant than at the earlier stages in terms of the types of incidents recounted and the feelings described. Although most felt they had some support, there was a sense of this receding too soon. Additional quotes numbered in parenthesis are recorded in appendix 18.

6.2 Overarching theme 1: Personal and Professional Identity

Theme 1.1: Self-image and professional identity

This theme represents the inner uncertainty of the nurses' self-image and their awareness of their professional identity. They still felt new inside and hadn't completely shaken off the student role (1).

The fact that they were still learning new things and sometimes felt like a student did not prevent them from seeing that they were functioning at a different level, as articulated by Lee:

I'm taking on the role of a staff nurse, and I'm making more decisions myself, you know, being more proactive, taking control of the patient care because that's what my job is to do. (Lee)

Feeling new inside but being compared to other staff nurses made them wish that others knew they were only recently qualified. Sam had started in post with other newly appointed nurses but she was the only one who was newly qualified:

I do constantly feel like I was maybe, slightly compared to the other girls, and people tend to have forgot that this is my first year of nursing. (Sam)

They didn't want to be seen as being stupid but did want others to remember that they still needed to ask questions. They were also beginning to feel that they couldn't keep saying that they were newly qualified, as expressed by May (2). However, they were not afraid to say when they did not feel ready to progress:

I was happy to do the special care but I'm not ready to go into the intensive care yet, 'cause that scares me. I did feel slightly pressurised into doing that. Um, but I

did stand my ground and say that I wasn't ready to do it, which I'm quite proud of myself for doing. (Sam)

Also, they still couldn't quite believe that they were now qualified nurses:

It's really strange, I still can't believe I'm a nurse sometimes...When someone says Nurse May, I'm thinking, who's that? (May)

Theme 1.2: Maintaining motivation and vision of goals

This theme represents the motivational factors that appeared to help them to stay focused on their goals. They all appeared to be happy in their work and felt they were making a difference but they also spoke of future aspirations. Being where they wanted to be was identified as a key motivational factor, and being happy in their first post appeared to slow down, if not inhibit, thoughts of future jobs, even when they had previously thought they would like to work in a different nursing speciality:

I've always been very interested in school nursing...but I do love working with these children. I don't know, if say, something came and hit me in the face locally, then I might go, apply for it but I would find it very difficult to move away from what I'm doing now. (May)

Similarly, Sam was missing general children's nursing but knew that she was where she wanted to be:

I do enjoy looking after neonates, and that's an area that I probably want to stay in for the next couple of years...I do kind of miss just general children's nursing though. (Sam)

Feeling they were making a difference to the lives of others was also a source of pride in their work (3). Although they were happy in their posts, they were also looking ahead to future career directions and this is presented in theme 1.5.

Theme 1.3: Using constructive review and feedback

The nurses spoke of how they used a combination of feedback and encouragement from others combined with their own motivation to move their practice forward. They valued having a little pressure from others to encourage them but also pushed themselves to gradually take on more difficult work:

I just try and move myself forward and take on more complicated patients. (Lee)

Feeling encouraged but not pressured was welcomed:

You also let the other staff know that you're not too sure but you want to go for it and they're all so willing to help and build your confidence. (Marie)

Being assertive in telling other staff how they were feeling also helped them to gain support:

If you talk to people about it...and then you get an outsiders' view about a thing, you're not bottling anything up in your head...I think it really has been, talking to other people, talking to more experienced nurses on the unit, talking to people that are closer to me at work...you get good feedback. (Lee)

However, they were discerning about whose support they would seek:

If I had a problem, there would be certain nurses I would say oh yeah I'll go and talk to her or him, or I don't feel as comfortable talking to that person. It's nothing that they've done wrong in their nursing; it's who you get on with and who you don't really. (Sam)

Lack of support could influence what they were willing to undertake; for example, May accepted the care of a child with very complex needs on the understanding that she would be supported by a more senior nurse. When the support did not materialise, she reappraised her views about what she was willing to take on (4).

Part of being a qualified nurse that evoked unease was coping with unhelpful colleagues, as articulated by Marie who felt that the attitude of colleagues could put you off seeking their support (5):

If someone comes in, in the wrong...not attitude, but in the wrong frame of mind, at work, it puts you off talking to them...and sometimes depending on what mood they're in, whether you can go to them. (Marie)

Theme 1.4: Evolving roles and role models

This theme represents the continued evolution of the participants' professional role. Teaching others appeared to provide tangible evidence to the nurses that they had moved on and were seen by others as being knowledgeable. Most of the participants were already scheduled to do mentorship training by the end of their first year in practice. They found teaching others both rewarding and challenging and it enabled them to see their own progress:

I have got a student now...which does help a lot, because she's asking questions a lot, and then you realise you can answer them. (Lee)

Ann described a situation in which she realised how fast she was now working. It reminded her of how recently she had felt completely out of her depth, when others were rushing around, and this helped her empathise with her student (6).

Feeling that they were influencing practice also provided a sense of their changing role – Chris felt able to influence practice when she took the opportunity to take the lead in educating colleagues about a child's needs:

It was the first time I'd dealt with somebody and had to take the lead...there were so many difficulties with people not knowing what to do with her, more for her [medical problem] ...I got involved in teaching a few people and trying to get more people to understand what to do, so it was a really good opportunity for me. (Chris)

Similarly, May found that she could learn from her colleagues and that she also influenced their practice (7).

Theme 1.5: Career focus

All of the participants spoke spontaneously about their future role development and career direction, and how they saw their current experience helping them to achieve their future goals. There was a sense that they felt the need to consolidate their skills at this early stage; for example, Lee could see how her current post would prepare her for a range of opportunities but she wanted to consolidate her skills before moving on:

Being in PICU is a great opportunity for me to learn an awful lot and in a way it will stand me in good stead for anything I do in the future, because um, if you can cope with a critical situation...it makes you be quite confident with any situation

that can happen in the future...I think I'll need to stay a few more years, I would have thought, before I will feel ready to move on. (Lee)

Further training was also a feature of their thinking about future directions; they didn't want to embark on a route that involved a lot of additional training until they were sure about it (8).

Even if they weren't planning to move on to a new job, they were thinking of how they could develop new roles in their current employment by developing new skills, like Marie who was interested in becoming a liaison nurse for blood transfusions (9).

The prospect of starting over as the 'new person' also featured in their thoughts about moving on to a new job:

It does scare me slightly the thought of going somewhere else to a new job; because you will be the new person again won't you. With all the new things to learn. (Sam)

6.3 Overarching theme 2: Primacy of Practice

Theme 2.1: Knowing what you need to know

The nurses had completed their formal educational programme and had indicated during the second stage interviews that they were relieved to finally be free from the demands of an academic course. At the third stage there was no sense of the learning process stopping; rather, it appeared to be channelled towards learning that was relevant to their work and their specific learning needs:

We are all students really aren't we?... 'cause every day's different, everything you do is different... hopefully we're all learning things every single day, new stuff, so when are you not actually ever a student? When you do a job where you don't learn anything I suppose. (Lee)

The nurses spoke frequently about their awareness of how much there is to learn and this appeared to promote motivation for acquiring new knowledge and skills that would help them develop their practice. Now that they no longer had the pressure from a mentor or the demands of being assessed, they appeared to be becoming more internally driven. The participants were making connections between previous learning, current

opportunities and future aspirations. These connections appeared to influence how the nurses viewed new learning opportunities. Ann illustrates the approach the nurses were taking to cope with moving away from their training hospital; they had to adapt to 'doing things differently' or simply remembering how to do something after a long gap:

Different places do different things, so it's like, 'oh, how do you do that again?' So it's like trying to jog my memory and it's the same with doing the IVs, although I'm a bit more confident at doing them now.' (Ann)

They also referred to using a patient's diagnosis as a stimulus to research a condition, particularly if it was a more rare condition (10).

Reflection on practice was also used as a tool for understanding situations encountered in practice:

I occasionally reflect on something and just write a little piece up, nothing major, but like that incident with the parents. Just for my own records. (Sam)

Anticipatory awareness of things that could happen, and the fear of not knowing how to respond, affected levels of confidence. Lee illustrated how disabling anticipatory awareness could be if it wasn't channelled or rationalised in terms of the stage they were at. By talking to a senior colleague she was able to rationalise some of these concerns:

I have actually had a couple of crises in confidence...I think I just had this thing where I was concerned that I don't know anything, and I think, everyone else here knows everything and they're so knowledgeable, and I've got myself in a little bit of a tiz, and what am I gonna do in this situation and that situation, and oh my god, what am I gonna do if a child arrests on me or near my patient. (Lee)

Theme 2.2: Measuring up: searching for authenticity and credibility

At stage 3, no longer being seen as the new person enhanced their sense of progress and helped the nurses to feel they were settling in:

I'm well embedded into the system now, as it were, and having a student also makes it hit home that you're not new anymore, and you have been there a while and you do know stuff. (Lee)

Reflection on what they could now do provided self-knowledge, enabling them to recognise their own progress:

When I look back and see my experience from back then, and all of the skills that I've learnt, in the year, um, things like I look after babies in CPAP [Continuous Positive Airway Pressure] now which scared the life out of me in February, so when I look back...I feel like I've learnt a great amount of nursing skills. (Sam)

Drug administration was a source of concern for the participants but being assessed as competent reassured them:

I am very careful, but I don't feel that it's something that I need to be overly worried about, 'cause I've been signed off for my IV and obviously central lines and peripherals and what not...and I'm really quite happy with that...I'm actually quite happy with my drug practice for definite. (Lee)

Not wanting to bluff was consistent with previous stages in the study and was articulated in terms of their accountability:

I'd rather do something right, than do it wrong and have to explain why I've done it wrong. (Ann)

They spoke of using knowledge of their own level of confidence in order to know when to 'get stuck in' (11):

My confidence has grown, but I think there's still more to improve on but definitely I'm more willing to go in there and do something that you're not sure about, and just go for it, 'cause otherwise you don't learn from it. (Marie)

Using self-knowledge and questioning their own uncertainty also appeared to provide the nurses with a basis for examining their credibility:

I've thought...am I just blagging my way through this job? Or am I actually really quite good at it? And is this something I should be doing, and I'm kind of thinking to myself, well everyone knows so much and I feel like I know not a lot at all...I just

had a bit of a confidence crisis, and I just had to overcome that little hurdle, and I have. (Lee)

A strong sense of progress was also evident in the comparisons the nurses made with earlier stages (12). However, it wasn't simply a case of reflecting and knowing cognitively that their knowledge and skills had progressed. Feeling uncertain still appeared to be a strong influence on their sense of authenticity. May described the tendency to mask uncertainty and appear confident:

You have to kind of show it, don't you, that you're confident, and probably inside, if there was an emergency, I know I'd be fine, but sometimes I think that you mask, that you perhaps, especially as a new nurse, that you're not very confident really and you haven't experienced a lot of things, and you might be a bit unsure about different equipment, but it's finding out and getting through. (May)

Ann's determination to 'shove myself in feet first' (theme 4.3) in two emergency situations appeared to be important to her on many levels: proving to herself she could cope, proving her credibility to others and that she could make authentic contributions. This was also resonant of 'knowing what you need to know' (theme 2.1) and 'skilling up' (theme 2.3). She wanted to be prepared for similar situations in the future.

Theme 2.3: Skilling up: seeking opportunities to practise

The relationship between practical experience and emerging confidence identified at stages 1 and 2 was still evident at stage 3. Opportunities to care for more seriously ill children were welcomed not only for the acute nursing experience but also for the opportunity to work closely with the child and family (13). The nurses also found that their confidence and willingness to be assertive was enhanced by increased exposure to situations in which they had to advocate for the child. For example, Sam felt confident to intervene when a child was vulnerable to pain during a medical intervention (14):

I can say, 'no, I think you've had enough goes now'...even though I know it's the right thing to do, it would have been quite difficult for me to actually stand up and say, whereas now I feel I have the confidence. (Sam)

As identified in theme 2.2, drug administration was one of the key markers of progress and change in status; this appeared to increase the nurses' confidence.

6.4 Overarching theme 3: Working with People

Theme 3.1: Need for belonging and recognition

Socialising with colleagues and being part of a team provided opportunities for the nurses to feel part of something bigger than just their job (15). Even if they weren't socialising with colleagues, feeling accepted and trusted by colleagues was important for their sense of belonging. The nurses on rotation programmes experienced more difficulty than those who stayed in one place. Chris illustrates trying to get established when the placement is only three months (16):

I moved to [clinical area] and the team didn't really welcome you in, they didn't like having rotation nurses. They very much had their own little team and kept you on the outside...I'd had 10 months of almost building up and then suddenly I feel I am almost back to square one because they have taken all the responsibility away from you. (Chris)

Her experience demonstrates how a team can make the newcomer feel unwelcome, held back, excluded and less knowledgeable.

Feeling that they were able to function at the level of RN in the team was identified in relation to having confidence when communicating with doctors:

Talking to doctors...um, I have found that a lot easier now, like with ward rounds, I find it easier to speak up. Whereas before, I kind of, if they were talking about my baby, kind of go in the background and let the sister talk quite a lot. Whereas now, I speak up about my baby, and obviously talking to doctors has been a lot easier now. Perhaps it all comes with experience, 'cause I'm all...more happy with the skills that I know. (Sam)

However, they were also sensitive about not wanting to seem pushy and this could make them hesitate before making suggestions:

I think, oh I don't know, it might just be me, I just get the impression that it might be 'oh, she's only been here a year but she's still suggesting things.' (Sam)

Recognition from others was very important particularly after difficult situations. To know that colleagues and particularly somebody more senior valued their actions was very

welcome. Ann and May valued the contact from their line managers following emergency situations that they had assisted in (17):

I had one of my line managers actually sent me an email and said, 'I've heard through the grapevine...what you did yesterday, you did really well, everyone's talking about you, everyone's praising how well you coped with it all and how good you were,' so that made me feel really good. (Ann)

This experience not only provided Ann with feedback from the manager (albeit by email) but also let her know that she was receiving approval from others. This experience is discussed further in theme 4.3.

Theme 3.2: Working with parents

In the earlier stages it had become apparent that working with parents was an area that the nurses felt ill-prepared for and an area they found challenging. One year after qualifying they described encounters with parents becoming more focused and more challenging. It was evident that they were becoming increasingly aware of their role in supporting and educating parents and that the concept of FCC really did mean that care extended beyond the child. They acknowledged that parents were often very grateful for the care provided; nonetheless, working under parental scrutiny and coping with the emotional and informational needs of parents was challenging for them as inexperienced nurses. Understanding and empathising with parents was evident in how the nurses articulated thoughts about how the parent might feel. Sometimes the nurses found they were caring as much for the parent as for the child:

It was more the parents that I was having to deal with just in the matter of I think keeping them updated and keeping them informed and explaining things to them because I had two babies so although I was dealing with them and their illness, it was more about having to be a support network for those families because they were so anxious. (Chris)

Chris had described one of the mothers as needing additional reassurance and information, which she attributed to the effects of what the mother had been through (18).

A number of the participants described coping with angry or upset parents and examples of these are given below. They also described incidents of parents expressing concern or complaints about care, and this was an area the nurses felt unprepared for. Sam

described the discomfort of fielding parental criticism about colleagues and her uncertainty about what she could say in such situations. The situation highlighted for Sam the need for support and guidance:

Recently we've had a set of parents that have been quite difficult to deal with, and have not been happy with certain people looking after their baby...I think I could have done with a bit more support actually dealing with the parents...it was like complaints, talking about certain staff members they don't like...I felt like I could have done with somebody else with me, to tell me how to deal with it. (Sam)

Knowing what you can and can't say to parents was a concern for the nurses as they wanted parents to have confidence in them and didn't want to appear not to know what they were doing. Being watched by parents had been a concern at the earlier stages and although the nurses were now more confident this remained a source of concern – the nurses felt their work was under scrutiny and that, in some cases, the parents may be more skilled than they were (19).

Family-centred care

As part of caring for children or young people, the nurses recognised that the families need support and information. Marie found that teaching the child and parents enabled her to meet their needs at different levels. This exemplar demonstrates the complexity of meeting the differing needs of three members of a family:

He came in with [complication of diabetes], and it was nice to, when he was well enough to teach him and the family about giving the medicine and injections, and getting him to practise on our dummy...look at what he understands about it and what his parents do, 'cause I think one of the parents was more intellectual, and understood it more...and it was nice to do it, sort of...not in layman terms, but I mean at their level, where they can understand it. (Marie)

May demonstrates sensitivity to the factors that influence how parents react in health care situations, but she acknowledges that she didn't always feel able to cope with the family because of her own fears about their expectations (20).

Responding to angry parents presented new challenges for the nurses. Although Marie had no direct experience of angry parents, she spoke of her awareness of other nurses'

experiences. She talked of using that knowledge about parental anxiety to spend more time talking to parents if she could (21).

Chris described a more extreme situation involving receiving verbal abuse from a parent and how she was able to view the situation from the parent's perspective and understand his anger:

He would just rant down the phone to me, swearing and being rude sometimes and then next time I see him he'd be like 'I'm really sorry about that'. And you'd have a good laugh with him, and it was totally up-and-down with him that he'd been through so much himself and you've got to still remember he's been through a lot. (Chris)

However, understanding the parents' perspective did not detract from the additional stress of coping with parents' emotional reactions when the nurses were still struggling to learn so much about the children's needs and their own role (22):

It's sometimes very challenging...if they're cross and just real impatient, and just, 'I want this done and I want it done now' kind of people. (Ann)

The fact that children's nurses work in close contact with parents creates a need to maintain professional boundaries. The following example demonstrates both this and the need for skill in coping with irate parents:

If it's long-term patients then you tend to know the family quite well, and um, sometimes you tend to know them a little bit too well...you just have to like, know where to draw the line, and then obviously sometimes, you get irate parents that think that they can just come straight in and it will get done and sorted out there, and it's just hard trying to get them to understand why their child is in for so long, and it can't be sorted out straight away. (Ann)

Theme 3.3: Seeing the child

The nurses specifically highlighted working with children as a source of satisfaction in their work. Those whose work was in critical care or neonatal care missed the interaction with children (23). Those who had more contact with the children enjoyed getting to know them and forming a more individual relationship with them. This was about not just caring for the child's health but seeing that child as an individual:

We have quite a lot of children come in that we know regularly now, and it's quite nice to know that you've got that sort of little bond with them, and you can joke with them and you know their personality and what they like and what they don't like...just being that...not a friend but just being, you know what I mean, there's another side to being a nurse and building that friendship up with the patients and the parents. (Marie)

The desire to be an advocate for the child, whether the child was unconscious in PICU or had communication difficulties, was a recurrent theme:

I always wanted to be one of those paediatric nurses who can sort of fight for the children with disabilities and provide better care. (Chris)

May found working with siblings of the child enhanced her ability to meet the child's and the family's needs:

I like to get to know the siblings and the whole family, 'cause I think you can care for that child better, 'cause you know the whole, what's going on. (May)

Becoming more closely involved with their child patients inevitably led to experiences of loss for some of the nurses (see theme 4.3 in 'Coping with crises') but Ann's experience is also included here in reference to her sense of responsibility for the child:

I dealt with my first patient death, so that was really, really hard. Obviously dealing with the parents and the child and I was with somebody else and she said I didn't have to stay there, but she was my one-to-one patient for that shift and I followed her through for the whole morning, and then obviously learning to grieve and talk to people after that, I think that's my biggest thing this year.....reflecting on it, it was hard at the time, and I struggled with it for a couple of days afterwards. (Ann)

May also described the impact of a child's death and how she tried to just carry on but in the end wasn't able to. However, she felt she benefitted from a supportive environment which helped her to cope with an emotionally draining experience (24):

We've lost two children that I've got quite close with, and one of those was a baby...I found that very difficult. We were very, I was very closely involved with

him, I saw the family a lot...that was my first real experience with death so closely...I'd never come across...never, a real critical or a death situation...and at the time I had to carry on [caring for other children], and I was the one doing the carrying on, carrying on, carrying on, come on everyone, trying...everyone crying, all the carers, come on everyone...and trying to motivate, and it wasn't 'til the end of the week that I just fell apart, 'cause I just realised that I hadn't coped. (May)

6.5 Overarching theme 4: Managing Newness

Theme 4.1: Feeling exposed and over-exposed

The participants had described varying levels of support in the early months after qualifying but as they progressed through the first year in practice they perceived a significant decline in this support. With increased awareness of their accountability and the fact that others ceased to be aware of their newly qualified status, this appeared to increase the sense of exposure and, in some instances, over-exposure. The quote from Chris at the beginning of this chapter sums up the sense of resignation that the nurses expressed about the lack of any bridging between being a student and being a staff nurse.

Sam illustrates the loss of support coupled with increased exposure and a sense of having been abandoned:

I was really supported in the preceptorship, but since then...I kind of feel like the preceptorship's finished and I've just kind of been left...to do my experience; which I found difficult, 'cause I think a lot of people forget that I've only just completed the preceptorship and that I was a newly qualified nurse, and like a year on now, I'm expected to know the same amount as somebody that's been nursing for a long time...I'm still enjoying it, but I just feel like I could do with a little bit more support now. (Sam)

She describes a situation in which she felt unprepared for the case she was allocated but equally felt reluctant to refuse because that wouldn't reflect well on her:

They didn't really know my experience, and they were just allocating me babies which I wasn't necessarily happy with...then I just felt, oh, if I keep saying I'm not happy to look after that baby it's not gonna look very good. (Sam)

Sam's experience of having to 'learn by doing', without the opportunity to observe others and practise under supervision (25), demonstrates one of the most challenging aspects of delivering care as a newly qualified nurse. Sam explained that being capable of accessing and understanding the available information about a child's condition or care didn't translate into feeling competent to deliver that care.

There was a strong sense of wanting to adapt to the changes in accountability and the reduction in support. Managing to prioritise and complete work within given time constraints was identified as a key difference between being a student and being a staff nurse. Marie articulates the role of stress in pushing her to complete her work and be thorough:

I think I'm adapting more to getting used to being busy and learning to cope with the work load...I suppose what's changed really, is the stress of knowing that you have to finish things to a degree, rather than as a student someone else can write the care plan, whereas now, you know you've got to do it and I've learnt more that you've got to be more thorough, you know, go over, make sure you do things in detail. (Marie)

As their awareness of accountability increased, there also appeared to be a sense of feeling that they had to 'feel the fear and do it anyway', not in a reckless sense but in embracing their role. For example, Marie was conscious of a need to take on more responsibility, such as running the ward, despite feeling a little daunted by this (26).

Lee described being encouraged to view fear as a positive trait for her job, something that would make her more aware of the value of what she was doing:

I still go into work every day, a little bit scared to be honest, but I think, I've talked to a lot of people about this and everyone says, that's probably a good thing, and they said, if you're not scared to a degree when you go to work, you probably shouldn't be in the job anymore. (Lee)

Ways of coping with exposure included seeking opportunities to talk about experiences (27).

Theme 4.2: Learning and working in the real world

As identified in the previous theme, the nurses were no longer cushioned by the support of a mentor or preceptor and they were adapting to their roles within an environment that did not always afford the staffing numbers or time that the new nurses felt they needed in order to work at a comfortable pace. They spoke of learning to deal with the stress of the increased demands and of being aware that they were not completing things like paperwork as quickly as other nurses:

It is stressful, but I think that's just something that is always gonna be there, and it's just learning to deal with the stress when it's busy and short staffed...especially when you're tired, and it's been busy all day and you've not had the chance to sit down, and everyone's going, are you done yet? And it's like, no I've still got four folders of notes to do; that's quite hard. (Ann)

Marie articulates the impact of short staffing on her perceived ability to meet patients' needs and how the stress of feeling she couldn't meet all their needs made her realise that prioritising care was a way of managing multiple demands on her time (28):

You don't always get time to spend with the parents and the children and discuss with them what's happening and why we're doing this and because you're busy sometimes I think you get frustrated if you're having problems giving someone the medicine and because, you feel you're busy you've got things to do, you don't always have time to reassure them, say it's alright, take your time and do that, kind of thing...but I sort of got used to it and then tried to build it in around, like, if you're doing IV medicines to talk to the patient and use that time wisely. (Marie)

Marie's experience was typical of the participants' struggle to provide holistic care when they were trying to adapt to increased workloads and time pressures.

Theme 4.3: Coping with crises

In children's nursing, the opportunity to gain skills in dealing with clinical emergencies varies enormously depending upon the clinical situation; some nurses can work for years without having to deal with an emergency. However, Lee and Sam had both chosen to work in intensive care settings and therefore experiencing such situations was to be expected. Indeed, Lee explained the ease with which she could summon help in an emergency and how this enhanced her confidence:

You're never really on your own at any point really; if you know something horrific is going on, you can guarantee that you'll have four or five people at your bed space within seconds. (Lee)

However, Ann and May also recounted significant experiences of emergencies and as their clinical areas were less likely to encounter such problems frequently they had a somewhat different experience to Lee. Even if the participants had not experienced an emergency, the possibility of an emergency was ever present in their thoughts.

All had benefitted from support, although Marie felt she needed more support during the long period of a child injury investigation that she described in her stage 2 interview. She waited almost a year before being told for certain that neither she nor any other member of staff had caused the child's injury. I asked how that had made her feel and she described feeling scared:

Very scared, well, scared, 'cause I had looked after him in the morning, and then someone had taken over...the next day I was thinking...did I do anything wrong? That's going over in your head...what happened and...trying to think what you did throughout that shift. (Marie)

Having finally been debriefed, she was feeling better but she'd had to wait a long time for resolution of her concerns.

Ann talked about two recent experiences that she had found traumatic but ultimately very rewarding and which provided an opportunity for her to grow professionally. The first quote is about a clinical emergency in which she offered to assist when a more senior nurse had to leave. It demonstrates how a potentially difficult experience resulted in a sense of greater readiness for future similar situations:

My hands were like shaking, and they said, 'oh can you work up the emergency drugs?' and I was like, oh my! Luckily I had a chart to work it out, so I did all that and just said, 'what do you want me to do?' and I just did whatever they wanted me to do. And then they said 'do you want to go for a break?' and I said 'no I'm fine'. The adrenalin keeps you going and as soon as she left to go to PICU, I was just like a zombie!....I went home about two and half hours later than I should've done. But I was glad I did it, because I thought, well next time there might not be

so many senior nurses around, there might be say just one and us, and although we're still juniors, we're not the junior juniors now. (Ann)

Ann appeared to be acutely aware that being 'new' was a relative term and whilst she still felt new as a staff nurse, other junior nurses had qualified after her, hence there seemed to be an unspoken pressure to take a difficult challenge whilst there was still time to do this under supervision and/or with the support of more senior nurses.

The second quote from Ann recounts her first experience of a child's death. Inevitably she found this experience very traumatic (also referred to in theme 3.3) and she described being encouraged by other staff to leave the situation but wanting to stay and support the mother:

I said, 'no, I want to be there for mum, you know, she...it's not down to me to grieve now it's mum's time, I'll sort myself out later.' I'm glad I did...I talked to one of the nurses there for quite a long time that night, um, and I was in on an early the next day, and I was quite run down, 'cause I was quite...that's when I was off sick. (Ann)

The praise and support of colleagues helped Ann on a personal and professional level but she was acutely aware of the parent's bereavement and that her increased confidence had been gained in very sad circumstances:

It made me cry at the same time, 'cause I was like, oh it's so sad. Yeah, I think it made me feel really good that I'd done it and that everybody knows that I've done these two things, that I've just shoved myself in feet first to make myself do it. (Ann)

Ann identified what she felt were the physical consequences of this experience for her in that she became unwell. However, she also appears to have discovered new self-knowledge as a result of this experience and despite her sadness she was proud of herself and felt supported by her colleagues and managers. Coping with crises provided the nurses with opportunities to not only learn about their role in such situations but also to be exposed to what are arguably some of the most emotionally challenging aspects of children's nursing.

6.6 Key conclusions

This chapter has examined the participants experience after one year in practice as RNs. The findings cover all four overarching themes but the themes of 'Primacy of Practice', 'Working with People' and 'Managing Newness' were more dominant than 'Personal and Professional Identity'. Table 8 illustrates the findings, with the most significant themes at this stage highlighted in bold. The nurses' experience was articulated with reference to the perceived pressure of high workloads; with time constraints continuing to exert demands on their ability to provide the care they aspired to deliver.

1. Personal and Professional Identity 1.1 Self-image and professional identity 1.2 Maintaining motivation and vision of goals 1.3 Using constructive review and feedback 1.4 Evolving roles and role models 1.5 Career focus	2. Primacy of Practice 2.1 Knowing what you need to know 2.2 Measuring up: searching for authenticity and credibility 2.3 Skilling up: seeking opportunities to practise
3. Working with People 3.1 Need for belonging and recognition 3.2 Working with parents 3.3 Seeing the child	4. Managing Newness 4.1 Feeling exposed and over-exposed 4.2 Learning and working in the real world 4.3 Coping with crises

Table 8. The overarching themes of transition: key themes at stage 3

Personal and Professional Identity

At the third stage the themes of 'Self-image and professional identity' and the desire for 'Constructive review and feedback', remained significant. The new nurses felt they were no longer seen by others as being 'new' and that they couldn't keep saying they were new. Feeling valued and trusted by others provided evidence of their progress, but they remained conscious of their limits and the need to continue developing their knowledge and skills. They felt recognition of their newly qualified status and provision of mentorship support had been withdrawn too soon; in most cases support was reportedly withdrawn at a much earlier stage in their first year of practice. They welcomed their increased levels of responsibility, but still expressed a need for guidance and support. Support was gained by being assertive and honest about what they felt their needs and limitations were. Teaching

and supervising others gave them a sense of their progress and they were looking ahead to future career directions.

Primacy of Practice

This theme remained significant, maintaining an emphasis on gaining hands-on experience; which continued to provide a major source of confidence. The desire to be credible and authentic practitioners was illustrated by the nurses' determination to increase their clinical skills, to seek out role-models and to resist 'bluffing'. No longer being seen as the new member of staff gave them a sense of their progress and teaching others provided a basis for judging how much they had progressed in both knowledge and skills. Although conscious of how far they had progressed they did not feel they knew enough. Indeed engaging in more complex care and being an advocate for the child, served to both confirm their progress and also maintain a stimulus for further development of skills. It was evident that after one year in practice the new nurses were still coping with inner feelings of uncertainty about their ability, fear of not knowing enough and awareness of how much more there was to learn. Self-knowledge enabled them to be proactive in managing their professional development, and a strong sense of determination and self-motivation to succeed was expressed.

Working with People

This theme demonstrated significant changes in the nurses' experience after one year in practice. For the nurses who remained in a single clinical setting, there was evidence that they were settling in and forming relationships and feeling accepted. However, rotation programmes appeared to hamper this process for others and they experienced a sense of recurring transitions. Socialising with colleagues and having a sense of their role in a team enhanced their sense of belonging and positive feedback from managers and others bolstered confidence.

Working under parental scrutiny remained a source of additional anxiety, but identifying and empathising with the needs of parents, appeared to take precedence over their own anxieties. Empathy with parents and recognition of their hopes and fears enabled the nurses to understand the behaviour of angry or upset parents. They were also more prepared and skilled in responding to parents' educational and informational needs. As identified in the early post-qualifying stage, the nurses' experience of responding to the needs of parents was limited at the point of qualification; therefore the changes in their ability were significant. These skills were a major part of their development during the first year of practice and remained an area they felt they still needed guidance on.

The theme of 'Seeing the child' also followed a significant trajectory of advancing skills and increasing confidence as their work became more child focused. It was evident that working directly with their own patients was their central focus. The responsibility of managing care was a source of satisfaction and confidence; contributing to significant changes in the nurses' ability to respond to the children's needs. In particular the nurses felt more confident in their ability to advocate for the child than at the earlier stages. A significant consequence of these closer working relationships with children was the experience of coping with grief; a new experience demanding new levels of personal and professional development.

Managing Newness

This overarching theme remained significant, demonstrating a steep trajectory with evidence of advances in the nurses' skills, knowledge and experience juxtaposed with persistent feelings of newness and uncertainty. Their articulation of still 'feeling new inside' illustrates the inner sense of uncertainty that they were experiencing one year after entering practice as an RN. They felt very visible as an RN but invisible as a neophyte nurse and felt that their anxieties about their ability and knowledge were not recognised by others. This appeared to be a consequence of the cumulative impact of increasing demands represented by the themes of 'Feeling exposed and over-exposed', 'Coping with crises' and 'Working in the real world'.

Although positive feelings were derived from demonstrating that they could adapt to the demands of their role, they felt the loss of support, particularly in the context of fast-paced clinical settings. Similarly, facing crises such as emergency situations or the death of a child had emotional consequences, both positive and negative that presented specific personal challenges. The nurses did not expect to be supported in the same way as a student but they regretted the loss of the support provided in the early post-qualifying period. They appeared to feel abandoned to cope with stress, staff shortages and high workloads, all of which impacted on their perceived ability to provide the standard of care they aspired to. There was a sense of resignation about this because they knew they were qualified and were accountable for their practice. Hence they accepted that being new was over, as accountability increased and support diminished. This illuminated significant limitations in the support provided to newly qualified children's nurses.

The findings at this stage were resonant of the 'post-liminal' stage of reincorporation (Van Gennep, 1960), in that their uniform and status signified the completion of the transition and others no longer saw them as new, let alone newly qualified. The nurses were aware that they had made significant progress professionally and personally, but rather than sensing that they had completed the transition, they appeared to take a longer-term view of the transition; possibly up to five years during which they expected to continue developing their knowledge and skills and finding their longer-term career direction.

7 DISCUSSION

7.1 Introduction

This chapter will review the purpose of the study and discuss the findings with reference to previous research in the field. This is followed by a discussion of the findings in relation to theories of transition and professional socialisation. The research methods will then be reviewed and some personal reflections on my role in the research process will be discussed. The limitations of the study and the implications of the findings for practice will be considered and areas for further research identified.

7.2 Review of the purpose of the study

The aim of this study was to contribute to the limited body of evidence about the experience of becoming a children's nurse. The goal was to answer the question:

What is the experience of making the transition from student to RN (child) like?

Sub-questions:

- 1) Is there evidence of a transition occurring?

There was evidence of a transition demonstrated across the time span of the study within the four overarching themes of transition. The patterns of change and modes of adaptation demonstrated are discussed with reference to the themes of transition (see 7.3) and with reference to Meleis et al.'s (2000) theory of transition (see 7.4).

- 2) How is the transition experienced?

The transition was experienced as a period of rapid and intensive change. The similarities in the way the participants approached the transition revealed patterns of intense personal preparation and motivation – to succeed and to be capable of demonstrating credibility and safe practice. The experience was characterised at stage 1 by a clear focus on looking forward and planning ahead for anticipated demands. This involved reflection and self-critique, which enabled them to identify areas of strength and for further development (see 7.3.1–7.3.2). The nature of some of the demands they faced changed at each stage, with some of the most significant

demands at stages 1 and 2 – such as acquiring practical skills – being replaced by concerns about coping with loss and supporting parents at stage 3 (see 7.3.3–7.3.4).

3) What contextual factors appear to influence the transition?

Having opportunities to increase their nursing skills played a key role in enhancing confidence. In particular, opportunities to gain experience in high dependency and acute care settings were valued during the third year and ultimately this experience appeared to aid their adaptation to some of the more demanding aspects of coping with crises in practice as an RN (chapter 4, 4.3). Induction and the availability of mentorship during the early months post-qualifying were valued but the amount and quality varied, the nurses would have appreciated an extended period of mentor support (chapter 6, 6.5).

4) Do the participants play an active role in the transition?

The findings at each stage within the overarching themes indicate that active engagement in the process of change was an inherent feature of how the nurses approached the demands placed on them (see 7.3.1–7.3.4).

5) Do others have an influence on the transition?

Support and guidance from mentors and preceptors were valued, particularly when these represented expert nurses or good role models (see 7.3.2). The availability of access to other newly qualified nurses also appeared to provide a specific type of support, i.e. not feeling alone and having opportunities to validate their feelings.

These issues are explored further in 7.3.

7.3 Discussion of main findings

The basis of my thesis is that the transition from student to RN (child) is experienced as the ‘invisibility of being new’; in which outsiders see a nurse in uniform undifferentiated from any other RN. The experience reflects van Gennep’s ROP theory in terms of the pre-liminal and liminal experience. However, the post-liminal stage was found to be poorly defined or incomplete by 12–14 months post-qualification. This can be identified in the 14 themes of transition grouped within four overarching themes of transition. These will now be discussed with reference to the research question and sub-questions, and to earlier research in the field.

7.3.1 Personal and Professional Identity

This overarching theme encompassed five themes of transition that together represented the nurses' evolving personal and professional identity. The pre-registration stage was characterised by a focused period of gearing up towards the transition within the theme of 'Self-image and professional identity'. This involved orientating to the role by rehearsing, increasing the expectations on self, gaining the trust of mentors and a gradual change in self-image and professional identity. In the pre-registration stage they exhibited modest but positive self-ratings of their readiness to be a staff nurse (chapter 4: 4.5.1) and appeared anxious but optimistic about their future role. This is consistent with earlier studies of student perceptions (Heslop et al., 2001; Kelly and Ahern, 2008) and supports Ashforth and Saks' (1995) view that personal development and role development are not independent.

To some extent, progress in developing their role stalled during the early months, or 'liminal stage', after qualifying; there was a sense that they became 'disorientated' by the changes they were experiencing. This was manifest in the experience of being the 'new boy or girl', feeling like a student again and of wanting others to know that you may be a nurse but you are new (chapter 5: 5.2). However, by the end of the first year, their professional identity was enhanced by feeling valued and trusted by colleagues and parents. There was still some evidence of inner uncertainty and 'feeling new inside' as expressed by May and Sam (chapter 6: 6.2), but they articulated this in terms of wanting others to be aware that they had not been qualified long. This was resonant of Duchscher's (2009) findings regarding the affective and socio-developmental needs of neophyte nurses. The participants felt they needed to know their limits and when to seek guidance, but they saw this as part of being an accountable practitioner and therefore normal for this stage of their career (chapter 6: 6.2).

'Maintaining motivation and vision of goals' appeared to influence the development of a professional identity. This was manifest at the student stage by a strong emphasis on promoting positive feelings through self-awareness and self-belief, cultivated through having realistic expectations of themselves and a strong sense of being on a learning continuum (chapter 4: 4.5.1). By the second interview, self-motivation appeared to be fuelled by success and positive feelings about being an RN coupled with a sense of being where they wanted to be (chapter 5: 5.2). They felt they were 'finding their feet', and the sense of 'being where you want to be' was enhanced towards the end of the first year by feeling that their work was valued and that they were making a difference (chapter 6: 6.2).

They were also confident enough to begin planning future moves after one year, which is consistent with earlier studies (Dearmun, 1997) (discussed further under 'Career focus').

'Using constructive review and feedback' from others and being proactive in gaining as much experience as possible was prominent behaviour across all three stages, but by the third stage they had to be more assertive in seeking the type of support that they felt they needed. This was a combination of wanting support, encouragement and gentle pressure combined with the ability to self-motivate (chapter 5: 5.2). This was strongly linked to theme 4.1 ('Exposed and over-exposed') in that support was diminishing rapidly after one year and they were beginning to feel abandoned (which resonates with the findings from earlier studies – Dearmun, 1997; Duchscher, 2009).

As third years they were very focused on their goal and exhibited motivation to become more independent in preparation for what lay ahead. A mixture of excitement and anxiety at the prospect of becoming an RN was expressed. They exhibited awareness of 'Evolving roles and role models' and the importance of identifying good role models at every stage – experienced nurses whose skills they wished to emulate. They were discerning in their choice of good role models as articulated by May (chapter 4: 4.5), which is recognised as an important contributor to role development (Ibarra, 1999).

In the first few months as an RN, the experience of being 'supernumerary' for a few weeks during induction contributed to the sense of being the 'new girl'. Their descriptions resonated with the uncertainty of the 'liminal' stage in which the previous self has been given up and the new self has not been fully established (van Gennep, 1960). All were assigned to a mentor (preceptor) for support but they found this a much more distant role than previously experienced (see Sam, chapter 5: 5.2). Their role evolved rapidly during the first year, culminating in all of them having experience of teaching and supervising others. At the final interview, most were already being directed towards becoming mentors.

As third years, the 'Career focus' was primarily about getting a job, and practice placements facilitated a sense of where their aptitudes may lie. During the early months as an RN, success in gaining employment in areas they wished to work in enabled them to focus on gaining skills to provide a foundation for their future career (chapter 5: 5.2). By the end of the year there was evidence of tentative anticipation of their future career (see Lee, chapter 6: 6.2). These findings are supportive of Dearmun (1997) and Duchscher

(2009) who identified that towards the end of the first year as RN future career directions become significant.

One of the most interesting aspects of the findings was the sense of vulnerability expressed at stage 3. One year after qualifying, despite the fact they felt valued and trusted by others and could see that their skills and knowledge had progressed, the nurses still felt 'new' and in need of support. This appeared in part to be reflective of uncertainty about their competence in clinical skills, which Ramritu and Barnard (2001) identified as influential on confidence. Teaching others reinforced that they were no longer seen as a new nurse, but they had a keen sense of their limits and how much they still had to learn.

7.3.2 Primacy of Practice

The underlying message from the participants was that confidence in nursing is derived from practice, which is a common finding in previous studies (Maben and Macleod Clark, 1998; Gerrish, 2000; Ramritu and Barnard, 2001). The relief of qualifying was replaced by the realisation that they had to keep learning; even at stage 3 there was no sense that they seemed to feel they knew enough. For the participants, knowledge was about 'Knowing what you need to know', i.e. knowledge that they perceived as directly relevant to practice. At stage 1, academic work was perceived as an obstacle to gaining the practical nursing skills they felt they needed (chapter 4: 4.6). This was also evident at the second stage in the challenge of transferring knowledge to new situations. This was a particular issue for these nurses because most moved to unfamiliar work environments where policies and procedures varied (chapter 5: 5.3). After one year in practice, this remained a source of anxiety (e.g. Lee's anticipatory concerns about having the practical knowledge to deal with future clinical incidents) (chapter 6: 6.3). This was reflected in the advice they offered to third-year students (chapter 5: 5.3.2): to gain as much experience as possible in practice, to take any opportunities available and to always ask questions (appendix 20).

A key finding in the theme 'Measuring up: searching for authenticity and credibility' is the desire to be authentic and to not 'bluff your way through'. At the same time, they wanted to cope with their uncertainty and take opportunities to learn by 'getting stuck in'. At stage 1, there was evidence of the nurses comparing themselves with peers and newly qualified nurses in an effort to gauge their own ability (chapter 4: 4.6). Shortly after qualifying they found that they were trying to measure up to the expectations others had of the uniform – which made them visible as an RN but invisible as a neophyte nurse (chapter 5: 5.3). The

tendency for newly qualified nurses to hold high expectations of themselves (Andersson and Edberg, 2010; Duchscher, 2009) caused the participants to question their readiness for some aspects of nursing. Indeed the paradigm case of Chris demonstrates how easily the confidence of a nurse can become undermined by failing to meet their own expectations of their role (chapter 5: 5.3 and appendix 19). The ability of neophyte RNs to acknowledge their limitations (Gerrish, 2000) was evident at stage 3 when there was evidence of a strong sense of progress, but the nurses were acutely aware of their limitations and expressed resistance to 'bluffing' (chapter 6: 6.3).

The focus in stage 1 of wanting to gain as much practise as possible, or 'Skilling up: seeking opportunities to practise', was followed through in the subsequent stages. This finding conflicts with earlier research (Maben and Macleod Clark, 1998; Delaney, 2003) which concludes that anxiety about clinical competence is a short-term concern. Most of the nurses reported practising some skills for the first time shortly before qualifying and expressed the need to practise repeatedly for learning to be consolidated (chapter 4: 4.6). By the second stage, the nurses were still focused on gaining specific skills and were hesitant about rushing in if they felt unprepared, like Chris distinguishing between adequate confidence and the ability to respond to different situations (chapter 5: 5.3). After one year in practice, the nurses identified practise as increasing confidence; not only in practical skills but also in areas like advocacy (see Sam, chapter 6: 6.3).

7.3.3 Working with People

The 'Need for belonging and recognition' was manifest in the disruption they faced at each stage. Stage 1 was characterised by a desire to fit in and to not be seen as awkward (chapter 4: 4.7). This was replaced at stage 2 by a sense of loss and of having to forge new working relationships in new environments (chapter 5: 5.4). By stage 3, there was evidence that they were settling in and receiving recognition from others (e.g. feedback received by Ann and May) (chapter 6: 6.4). However, this was hampered by rotation programmes and concerns about not wanting to be seen as 'pushy' (chapter 6: 6.4). This is consistent with earlier studies which suggest that the first six months as an RN are the most stressful period of the transition (Dearmun, 1998; Charnley, 1999; Holland, 1999) but possibly made worse for these participants due to geographical and employment changes.

Subjective responses to change are strongly influenced by the desire to be liked and respected on both a social and professional level (Cope et al., 2000; Andersson and Edberg, 2010). The combination of increased expectations of self, coupled with

uncertainty about how others viewed them, created a sense of not belonging and a reduction in earlier levels of optimism by stage 2, consistent with earlier studies (Delaney, 2003; Kelly and Ahern, 2007; Duchscher, 2008).

The second source of anxiety about working with people was 'Working with parents', which emerged as a significant challenge for the participants. The nurses progressed from 'competing' with parents for experience, and fearing their critical eye in year 3 (chapter 4: 4.7), to the emergence of empathy and skills in responding to parents; for example, angry or distressed parents (chapter 5: 5.4). By stage 3, the nurses exhibited a strong appreciation of the needs of parents and were becoming more confident in their ability to respond (chapter 6: 6.4). The confidence to respond to the very different needs of parents at this stage in their career was evolving but was certainly different from the tentative early steps at stages 1 and 2 of the study. In terms of transition, this theme demonstrated a steep trajectory. As identified in earlier studies, the nurses wanted parents to have confidence in them and to feel they were meeting their needs (Dearmun, 1998; Jackson, 2005). Perceived deficits in their knowledge and their ability to support anxious parents and answer their questions hampered this. They didn't feel well-prepared for meeting parents' needs at the point of registration and needed support in this area throughout the first year (e.g. Sam, chapter 6: 6.4).

The theme of 'Seeing the child' underwent a clear transition from empathy with the child (chapter 4: 4.7 see May, Ann and Marie) and a desire to gain experience at stage 1, to a strong focus on their responsibility for their child patients at stage 2 (chapter 5: 5.4). At stage 3, the child became a major focus of the interviews; the central focus of being an RN. This part of the transition produced descriptions of difficult experiences of coping with loss (chapter 6: 6.4, Marie Chris and May). The way in which they coped with loss was talking to colleagues and friends, but there was also evidence that in the immediate aftermath they just tried to struggle through, as articulated by Ann and May (chapter 6: 6.4). This finding is consistent with earlier studies (Dearmun, 1998; Jackson, 2005) and has implications for both the undergraduate curriculum and the support offered to newly qualified nurses. For example, this issue could be integrated into a module of learning in the undergraduate programme and extended into the first year of supervision as suggested by Duchscher (2009).

7.3.4 Managing Newness

Regarding 'Feeling exposed and over-exposed', as students, the nurses described feeling scared and vulnerable as they faced the 'loss of the security blanket', a common finding in

previous studies (chapter 2: 2.8.2). Grappling with insecurities about their abilities was contrasted with a sense of excitement about becoming an RN as described by Ann (chapter 4: 4.8). Shortly after qualifying they were still experiencing fear and were coping with their own uncertainty – feeling out of their comfort zone and worried that others may place too high expectations on them (chapter 5: 5.5). However, the sense of exposure can also be attributed in part to their own high expectations of themselves (Maben et al., 2006; Duchscher, 2009). By the third stage, these feelings were replaced by a sense of resignation that being new was over and that they had to ‘feel the fear and do it anyway’. Being seen as a new member of staff, rather than as a new nurse, meant having no allowances for their inexperience, which created a greater sense of exposure (e.g. Sam, chapter 6: 6.5). In some senses this theme resonates with the concept of ‘reality shock’ (Kramer, 1974) and ‘transition shock’ (Duchscher, 2009) but there are differences in that it was not the clinical environment that was the problem but the participants subjective awareness of their ability, limitations and professional accountability, as identified in previous studies (chapter 2: 2.7.1.1).

Diminishing support after the first few months contributed to feeling let down just as accountability was increasing. This appeared to be partly a function of the fact that they had been ‘Learning and working in the ‘real world’ where, inevitably, patient needs take priority over staff needs (chapter 4: 4.8). Coping with increased patient numbers and short staffing was a significant influence at the second and third stages (chapter 5: 5.5). The reality of not always being able to provide the care they aspired to provide was one of the negative aspects of their experience at the third stage (chapter 6: 6.5). This finding resonates with Maben et al.’s (2006) concept of ‘organisational sabotage’. Whilst coping with these challenges they also wanted ongoing guidance, but this was diminishing rapidly (chapter 6: 6.2) as identified in earlier studies (Dearmun, 1997; Duchscher, 2009).

‘Coping with crises’ demonstrated a trajectory from increased confidence arising from realising that they could cope as a student in clinical emergencies (e.g. Ann and Chris, chapter 4: 4.8) to a realisation that they still needed support as a newly qualified nurse (e.g. Sam and Marie, chapter 5: 5.5). For trained staff in child health services it can be easy for them to forget what it is like to face the first emergency or child abuse investigation as an RN, but these types of experiences have been identified as significant sources of stress for neophyte RNs (Dearmun, 1997; Delaney, 2003; O’Shea and Kelly, 2007).

By one year post-qualifying, there was evidence of the participants having faced a range of challenging situations: from child protection issues to clinical emergencies and the death of a child (chapter 6: 6.5). This had placed a burden on their coping strategies and, although these experiences primarily resulted in greater confidence, the participants identified the need for support and a determination to prepare themselves for future challenges, as did Dearmun's (1997) participants. As identified above, coping with the death of a child posed specific personal challenges for the nurses (see Ann, chapter 6: 6.5). The stress of such experiences placed physical, emotional and intellectual demands on the RNs which supports Duchscher's (2009) findings.

7.3.5 Summary

The transition was experienced as rapid and involved intense personal motivation, vision and willingness to learn by practising. Support from mentors or preceptors was highly valued but was arguably not sufficiently available after the first few months. On entering the workplace the RNs received support but this dissipated too early and the ongoing performance management was not a substitute for support from a respected and trusted colleague. Clinical skills provided a barometer of progress for the nurses, whilst coping with exposure to emergencies and deaths presented major challenges at an emotional, intellectual and practical level. The findings resonate with empirical evidence from some of the earlier studies, particularly in relation to meeting the needs of parents (Dearmun, 1997; Jackson, 2005).

7.4 Discussion of findings with reference to theories

Transition has been described as 'not only a passage or movement but a time of inner reorientation' (Kralik et al., 2006:324) that may be viewed as 'patterns of multiplicity and complexity' (Meleis et al., 2000:18). The participants were experiencing a transition from student status to that of a practitioner who is accountable for their own practice. They were also making the transition to new geographical locations, new work environments and new relationships both within and outside the work environment. The participants were experiencing situational and organisational transitions (Schumacher and Meleis, 1994) and also work-role transition (Nicholson, 1984). This creates a pattern of multiple transitions: they all changed role, five moved to new towns or cities and took up employment in previously unknown hospitals/health trusts, and they moved into new accommodation with previously unknown flatmates. The purpose of this study was specifically to examine the transition from student to RN, but some of their experiences in

the professional employment context may have been influenced by the other multiple transitions they were experiencing.

The findings resonate with the properties of transition defined by Meleis et al. (2000) (chapter 2: 2.14); at each stage the participants expressed awareness of their situation and how it was changing, their engagement in the experience (preparation), their perceptions of change and the difference between their experience prior to qualifying, shortly after qualifying and one year post-registration (e.g. chapter 4: 4.5, chapter 5: 5.2, chapter 6: 6.2). Time span is a key feature of transition theories but Meleis et al. (2000) note the difficulty of identifying the end point of transitions – individuals may seem to have made a transition and reintegrated, but changes in conditions can cause the sense of 'discontinuity and flux' (Ashforth and Saks, 1995:157) to resurface. The literature review supports this (chapter 2: 2.7.1.1) as do the findings; for example, rotation programmes caused feelings of regression (e.g. Chris, chapter 5: 5.4).

Critical time points and events in the transition to RN include the visible evidence and experience of success; for example, the results letter, the graduation and the first day in the new uniform. Less visible to the outsider but very significant to the RN were the 'first experiences'; for example, angry parents, an emergency or a child death. Similar to Dearnun's (1997) participants (who perceived that they couldn't rehearse accountability), the participants in the current study expressed a sense of resignation about such experiences; they felt they hadn't been prepared for them, but also that they couldn't prepare for such situations – they just had to learn from them (chapter 6: 6.5).

The time span of the transition and the critical points and events, such as coping with emergencies and death (chapter 5: 5.5) or angry or anxious parents (chapter 6: 6.4) suggest that the experience was perceived as both rapid and intense by the participants but was not necessarily complete by the end of the first year. This finding conflicts with that of previous studies, which suggest the transition is usually completed in 6–12 months (chapter 2: 2.11). Meleis et al. (2000) argue that mastery of the skills and behaviours needed in the new situation marks completion of transition. The fact that the participants were still feeling some uncertainty after a year in practice (chapter 6: 6.2) suggests that the transition may in fact take longer than some previous studies suggest. It has been argued that transition does not follow a linear unidirectional pattern (Kralik et al., 2006) and the participants may simply be exhibiting some 'back and forth' movement in which previously well-established transition becomes threatened by new challenges (Meleis et al., 2000).

7.4.1 Facilitators and inhibitors of transition

The influence of personal, community and societal factors on transition (Meleis et al., 2000) will now be considered in relation to facilitators or inhibitors. However, community and societal factors are only considered briefly because the focus of data collection was on personal experience.

Meleis et al.'s (2000) personal facilitating factors, derived from studies of specific patient/client groups, include meanings, cultural beliefs and attitudes, socio-economic status, and preparation and knowledge. The results of the current study reflect similar facilitating factors; for example, the students' preparedness, their ability to reflect on experiences, their communication skills, motivation and opportunities to gain skills and knowledge. Unlike some transitions, this was a transition about which a lot was already known, so to an extent the nurses were prepared. The transition was facilitated by some of the shared understanding of meanings and cultural beliefs and attitudes that they had been exposed to as students; for example, that their work would be physically and emotionally challenging but that it would be valued by others (see 7.3.1).

The ability to reflect on practice and empathise with parents was facilitative of the resolution of difficult situations and 'managing newness'. Nicholson's (1984) notion of social and psychological risks is manifest in the experience of coping with a death and attuning to the needs of parents. The ability to communicate and to be receptive to the subtleties of what was happening in a range of clinical situations assisted them on a professional level to manage the transition, but it did not protect them from the emotional learning that followed (see 7.3.4).

The personal motivation and determination to succeed, along with realistic expectations of the post-registration period, were underpinned by enjoyment in their work. The impact of having confidence in their clinical skills was immense; arguably the most important factor for the nurses (see 7.3.2). Nothing left them feeling more dejected than being unable to provide care they felt they should be able to carry out (e.g. Chris, chapter 5: 5.3.1). Knowledge was a facilitator, while a lack of it could be a hindering factor; recognising this, the nurses took steps to enhance their knowledge (see 7.3.2).

Personal inhibitors included limited exposure to crises, lack of experience in meeting the needs of parents, lack of knowledge, lack of opportunities to practise and being the new boy/girl. As students, the nurses had limited exposure to crises, having always been on

the periphery and protected by their mentors. They had developed a strong sense that they would be able to cope in emergencies but at the second stage interview the findings suggested that the reality of their role came into sharp focus (e.g. May, chapter 5: 5.5).

Community facilitators included the availability of information, induction, support groups and role models. The findings demonstrate that, as students, the nurses had developed a keen sense of the type of role models they aspired to emulate (themes 1.4 and 2.2, appendices 12 and 13). For those who had good induction programmes and access to support from other newly qualified staff there was evidence that they benefitted from this. Community inhibitors included high workloads, inadequate staff numbers and lack of resources. There was evidence that high workloads and insufficient staff were perceived to have an impact on the nurses. These deficits have been identified in the literature as 'organisational sabotage' (chapter 2: 2.10.2).

Societal facilitators included the positive change in status with visibly recognisable signs, such as uniforms and badges. The transition from a student bursary to a salary may have been an influence but this was not referred to during the interviews. Societal inhibitors included the uniform; rendering invisible the 'newness' of the nurse and exposing them to expectations that they may be unable to meet.

Meleis et al. (2000) identified patterns of response in terms of process indicators and outcome indicators. Their process indicators include: feeling connected, interacting, location and being situated, and developing confidence and coping. These indicators were grounded in health studies conducted by the authors in the USA and do not readily translate to the results of this study, but similar patterns of response can be identified within the four overarching themes. For example, the participants experienced some loss of day-to-day connections with friends and family but were able to maintain contact and all demonstrated the ability to form new connections in the new situation (see 7.3.1, 7.3.3). 'Interacting' refers to interpersonal support mechanisms (specifically, dyads in cancer care within Meleis et al.'s theory). In the context of this study, the pursuit of feedback from good role models and support from other newly qualified nurses may reflect this process.

'Location and being situated' refers to the way in which people make sense of where they are by making comparisons with where they were. This allows new meanings and perceptions to be accommodated. The nurses made comparisons with earlier stages throughout the study, demonstrating some resonance with this process. However, the nurses were always moving through similar situations, i.e. they did not transition to a

completely unknown situation in the sense that Meleis et al.'s participants did. The fourth process indicator is 'developing confidence and coping' in which a pattern of increased confidence is manifest in increased levels of understanding. Similar to this process is the nurses' pursuit of knowledge and skills that would directly lead to increased levels of confidence, identified as Primacy of Practice (overarching theme 2).

The successful completion of transition is identified in two outcome indicators: 'mastery' and 'fluid integrative identities' (Meleis et al., 2000). Mastery is defined in terms of developing the skills and behaviours necessary to manage their new situation. The findings suggest that during the first year as an RN the nurses achieved mastery in many, but not all, aspects of their role. Overarching theme 2 is strongly associated with the search for mastery. The areas in which mastery appeared less well developed after one year were working with parents (theme 3.2) and coping with crisis (theme 4.3). Given the complexity of these themes and the uniqueness of each situation, this is not an unusual or unexpected finding but it indicates an area that neophyte children's nurses need more support in.

Fluid integrative identities are defined as a dynamic ability to incorporate changes into one's life by making connections between the former self and the new identity. The nurses demonstrated this in their ability at stage 1 to project forward from their student status and imagine what the change in role would bring, and at stage 3 to reflect back on their previous role and recognise the changes they had experienced. For example, Ann was able to empathise with her student and it helped her to see how much she had changed in her new role (chapter 6: 6.2).

Empirical evidence suggests that student nurses may be willing to compromise their learning in order to fit into the social context of practice (Melia, 1987; Philpin, 1999; Cope et al., 2000; Neary, 2000) but this was only partially borne out in the findings. Howkins and Ewens' (1999) contention that individuals play an active, indeed proactive, role in transition is supported by the findings. It was evident that the participants were engaging with the process on a very individual basis, which aids transition (Meleis et al., 2000). The idea that transition requires a reappraisal of self-identity, including ways of seeing self, the social and environmental context and ways of presenting self (Meleis et al., 2000), is supported by all four overarching themes (table 3 and appendices 12–15).

7.4.2 Strengths and weaknesses of the theory used to explain the results

Meleis et al.'s (2000) middle-range theory has provided a broad framework within which the results could be considered. A strength of the model is that it is based on five qualitative studies involving different investigators. As an emerging theory it has the potential to be further developed with specificity for different client groups and situations such as work-role transition. The properties of transition, the framework for transition conditions and the patterns of response provided useful theoretical perspectives for examining the results of this study.

The theory helped to explain key elements of personal influences and, although the process indicators were not directly applicable to the nurses' experiences, it was possible to see how the findings demonstrated process indicators for a group of neophyte RNs (child). The outcome indicators were helpful as broad perspectives for considering the extent to which the transition was complete and areas in which the transition is on-going.

A weakness of using this model is that it is derived from studies of health clients in the USA and had no specificity to professional role transition. The decision to use this model rather than Nicholson's (1984) or Ibarra's (1999) was justified by its qualitative, interpretive basis. Nicholson's theory could have been applied to the findings but this theory was derived from quantitative studies in the business world rather than the 'lived experience'. Ashforth and Saks (1995) suggest that Nicholson's theory is more useful for measuring change rather than explaining the meaning of change. Ibarra's theory of 'provisional selves' appealed as a model derived from a qualitative study. However, it has a limited evidence base and as such was not considered to be an adequate model for the current study. The findings of the current study may contribute a new dimension, applicable to the transition experience of health professionals, to Meleis et al.'s (2000) theory.

7.5 Review of method

The application of a phenomenological interpretive design facilitated a focus on the experience of the individual, rather than on the situation or any objective measure of their progress. Using a longitudinal method avoided the risk of viewing transition as a single event (Meleis et al., 2000) and acknowledges the significance of time in transition (Kralik et al., 2006).

The sample was selected on the basis of their experience of the phenomena. Focused qualitative interviews allowed a flexible and adaptable approach to data collection. The outline interview topics (appendix 6) guided the first two stages, but by the third interview both myself and participants were more confident in the process and it was possible to use an introductory question inviting the participants to simply talk about their experience as a staff nurse. In interpretive phenomenology, application of the concepts of co-constitution and fusion of horizons brings together the context, the participant's perspective and the researcher's understanding as the basis for interpretation. During data collection I was able to use my own knowledge and experience of the transition to support and encourage the participants, but I was mindful that the purpose of the study was to understand the participants' experiences rather than compare them with my own. I therefore reflexively managed the use of personal experience to support and encourage the participant.

Data analysis posed the greatest challenge, as articulated in chapter 3 (see 3.9-3.10), but the combination of stages 1–4 of Colaizzi's (1978) method followed by an interpretive stage enabled me to go beyond a description of experience towards a deeper questioning of what the experience was like and what factors were influencing it.

Presenting the findings to the participants enabled me to gain confirmation that my interpretations resonated with their experience.

7.6 Reflections on my role in data production and data analysis

My interest in this study was both personal and professional. Having experienced a similar transition in the past, I was sensitive to the risk of looking at the data through my own particular 'prism of perception' (Rapport, 2004). I also acknowledged that, in choosing to use a hermeneutic phenomenological approach, my own pre-understanding and subjectivity could legitimately contribute within the context of co-constitution of data and the 'fusion of horizons' (Gadamer, 1989). However, because the focus of the study was on the transition experience of contemporary children's nurses rather than any attempt to compare my experience with theirs, I actively sought to focus on their story using what Munhall and Chenail (2008) describe as 'unknowing openness'. I used reflexivity and Ahern's (1999) tips for reflexive bracketing to monitor my influence at each stage of the research. As identified in this extract from my reflective diary, with reference to the trustworthiness of the descriptive stage of data analysis:

I think when trying to establish what the participant is saying I need to limit myself to their words and not introduce my perception of what I thought they meant to say. This tends to happen inadvertently rather than deliberately when transcribing and has really puzzled me; I frequently have to re-type sections after listening to the tape again.

I applied pre-existing knowledge and current awareness of the educational experience of the participants to hear and understand what they were articulating, i.e. they didn't have to elaborate or explain some of the jargon they used because they knew I had insider knowledge. During data analysis I was able to apply my personal experience of a similar transition in that I was able to empathise with the experience of the participants. This enabled me to apply the concepts of 'fusion of horizons' and 'co-constitution' during the interpretive stage of data analysis.

It is appropriate to acknowledge that I have played a key role in data collection and data analysis. Another researcher with a different background may have identified different themes and may also have failed to identify some themes.

7.7 What does this thesis contribute to the professional discussion?

This study aimed to fill a gap in knowledge of the experience of children's nurses making the transition from student to staff nurse. The application of a longitudinal approach, informed by theories of transition and existing empirical evidence of the transition from student to staff nurse, has revealed new insights into how the transition is experienced by children's nurses. With the exception of Dearmun (1997) there have been no substantial, longitudinal studies of the transition from student to RN (child). Dearmun (1997) described a chronological dimension to the stress experienced by neophyte children's nurses; from initial survival when support needs were high to a sense of equilibrium one year post qualifying, when stress remained but a lower level of support was required. This study has confirmed some of Dearmun's findings, in particular: the stress of dealing with anxious parents; coping with the death of a child; coping with a new job and the impact of contextual issues such as insufficient resources.

This study also supports the findings of some of the earlier generic studies in this field as identified in the discussion (for example, themes such as practise increasing confidence, the need for support and preceptorship, and the pattern of transition). In addition, it introduces new evidence in relation to children's nursing in several areas about which

there was limited knowledge: the experience of (the invisibility of) newness; the experience of working with parents and children and the influence of crisis moments in relation to the changing experience of newness.

Newness was experienced in terms of the multiple changes the nurses were experiencing. As students they had experienced a range of placements in a single health trust locality where they were known as a student. The transition to being a new RN in a new environment where they had not been known as a student, contributed to a sense of vulnerability; influenced by the new surroundings, differences in policies and procedures and the fact that it was not apparent to anyone else that they were not only new to the organisation but new to nursing. One of the major difficulties for the new nurses was the apparent blurring of the differences between a nurse who is experienced but new to the organisation, and a nurse who is newly qualified. In particular the findings in relation to 'Coping with crises' have demonstrated that significant new learning arises from these experiences in the first year of practice. The nurses needed opportunities to reflect on these experiences with more experienced nurses. The sense that their newly qualified status was invisible magnified the sense of exposure and caused the participants to feel they sometimes needed to remind other staff that they were 'new'.

The findings also suggest that the provision of preceptorship, which is recommended for a period of four months (NMC, 2006b), was very limited and primarily focused on orientation to the work environment. Where preceptor facilitated study sessions were provided the neophyte nurses found it a very supportive setting to discuss their feelings with other neophyte nurses. As the nurses progressed through their first year in practice they were constantly gaining new knowledge and skills, therefore it was a period of sustained learning, frequent challenges and limited acknowledgement of their newness; rather than a period of settling into a relatively familiar work experience, as it may have been for a more experienced nurse. The study has demonstrated that neophyte children's nurses are proactive in managing their own learning, seeking out good role models and asking for support. However, the sense of the invisibility of their stage of preparation and readiness to take on complex aspects of care lead to feelings of vulnerability and a sense of being abandoned within a few months of becoming an RN.

The steep trajectory illustrated in the themes of 'Working with Parents' and 'Seeing the Child' demonstrate that significant new learning was occurring in these complex aspects of practice during the post-qualifying year. As students the nurses had had limited exposure to dealing with parents' concerns and their brief placement periods limited the

extent to which they could form close working relationships with children or indeed to feel that their role in care delivery was significant. There was significant evidence of enhanced awareness of the child's needs and increasing levels of confidence in communicating with children during the first year of practice. This appears to be the result of the increased level of responsibility and accountability experienced post-qualification and was welcomed by the new RNs. However, this was revealed to be an area of continuing support needs, particularly in relation to coping with loss. The evidence of dilemmas created by their increased contact with parents and their exposure to meeting parents needs was also a particularly steep trajectory and one that revealed a need for more support and guidance.

Whether or not a student nurse can rehearse for some of these dilemmas is questionable. As identified by Dearmun (1997) it is virtually impossible to rehearse the experience of accountability during the pre-registration programme. Vicarious experience of decision-making is not a substitute for actually being an RN, responsible for the care of assigned patients. One of the key difficulties in this area appears to be the limited timescale of three years for the preparation of new nurses. During this period there are twelve weeks at the end of the programme when students become part of the ward team and fully experience responsibility for a group of patients under supervision. The findings of this study suggest this is probably inadequate as it only permits a limited sense of the reality of being accountable for assessment, care planning, care management and evaluation. There is no pre-registration panacea for preparing students for the transition; some things can only be learnt after qualifying, hence the need for more extensive transition programmes and internship models to facilitate and support professional development.

7.8 Limitations

The main limitation is that this is a small-scale study within a specific branch of nursing, with participants drawn from one HEI and using a single investigator. Therefore, the findings may not be transferable to other populations or situations. However, the fact that the participants all moved to employment in new locations and different clinical settings does strengthen the credibility of the themes of transition. Therefore, the findings may have some resonance with other neophyte children's nurses in the UK.

7.9 Implications for practice

Recommendations for child nurse education

- The pre-registration nursing programme should be lengthened to four years with the specific objective of introducing a clinical internship in the fourth year. This would enable the student to take more responsibility for direct patient care and gain more experience of working directly with parents and children prior to becoming a registered nurse. An alternative option would be the introduction of a post-registration internship as outlined below.
- Undergraduate programme planners and staff development programmes should recognise and nurture the role of the individual in engaging with the process of transition. This could be achieved by introducing a Personal and Professional Development Portfolio that commences during the pre-registration programme and continues to be built during the post qualifying years. This would facilitate: proactive planning for the transition; act as a guide for professional development during the early years in practice; avoid the current dichotomy between pre-registration and post-registration professional development.
- Student nurses and neophyte RNs require greater preparation for understanding and working with parents and children. This could be achieved in a number of ways, for example: increasing the involvement of parent and child service-users in the undergraduate programme; the use of case scenarios to facilitate vicarious experience of the parent and child's perspectives, experience and needs; the introduction of specific competencies in communicating with children and parents; opportunities to discuss difficult experiences with more experienced colleagues in practice.
- Student nurses should be allocated a period of time to shadow a staff nurse; similar to that currently recommended for medical students who shadow the person currently in the Foundation 1 role they will be taking up.

Recommendations for practice (the workplace),

- There are a number of actions that could improve the experience of the transition but arguably the introduction of an internship programme for newly qualified nurses would be one of the most effective way of recognising and making visible their 'newness'. The introduction of a foundation year programme for nurses; similar to the Foundation 1 and 2 programmes that are currently provided for newly

qualified doctors, would provide broad learning outcomes and a structure for professional development in the first two years of practice.

- In the absence of an internship programme the initial preceptorship support should extend beyond the first few months in practice and gradually evolve into a clinical supervision relationship. This should happen under current NMC guidelines but in practice its implementation is not widespread in children's nursing. Newly qualified nurses should discuss the availability of such preceptorship and clinical supervision at job interviews.
- RNs would benefit from specific support and supervision in developing their ability to respond to the needs of parents. This could best be achieved within the proposed extended preceptorship arrangements and continued as a core focus in clinical supervision.
- Specific support should be provided to new RNs when facing the death of a child. As a minimum this should include preparatory discussions and preparation where possible and debriefing and access to expert counselling
- More structured advice and support for prioritising care and managing time would aid neophyte nurses; this could be provided within either an internship or preceptorship programme for example, achieving a core competency in caseload management.
- Consideration should be given to the impact of rotation programmes on the neophyte nurse's experience of transition. This could be achieved by delaying the second rotation until the nurse has been in practice for a minimum of six months.

Recommendations for research

- Action research is recommended as part of new nurse induction programmes to identify, explore and resolve or respond to emerging issues experienced by newly qualified nurses.

7.10 Recommendations for future research

- A larger-scale study to compare the transition experience across all four branches of nursing would further enhance understanding of how the clinical branch influences the transition.
- A larger-scale study of children's nurses involving a number of HEIs and investigators would offer an opportunity to examine the findings of this study in a

wider context; particularly looking at the experience of working with parents as a neophyte nurse.

7.11 Conclusion

This chapter has reviewed the purpose of the study, the research method and the main findings. The findings have been discussed with reference to empirical studies and Meleis et al.'s (2000) theoretical framework for transition. The limitations of the study are acknowledged and the implications for practice are identified. Recommendations have been made for research that would further extend knowledge of the transition from student to RN

The study has demonstrated that for the sample of children's nurses studied there are signs that individuals play an active role in the transition from student to staff nurse. The process of transition is rapid but some aspects extend beyond the first year. The neophyte nurses felt that their status as RN was visible but their newness was invisible to others, leading to unrealistic expectations. They fully accept their legal and professional accountability as RNs but welcome support, encouragement and teaching by expert role models throughout the first year.

8 APPENDICES

Appendix 1: Methodological approaches used in earlier studies

Research method	Authors
Phenomenological (interpretive) approach	Jasper 1996; Whitehead 2001; Delaney 2003; Jackson 2005; Etheridge 2007; O'Shea and Kelly 2007; Standing 2007; Kelly and Ahern 2008
Phenomenography	Ramritu and Barnard 2001
Narrative	Andersson and Edberg 2010
Ethnography	Holland 1999
Grounded theory	Gray 1998; Smith and Gray 1999; Charnley 1999; Gerrish 2000; Mooney 2007
A broad qualitative enquiry approach	Dearmun 1997; Bradley 1998; Dearmun 1998; Maben and Macleod Clark 1998; Dearmun 2000; Amos 2001; Evans 2001; Whitehead 2001; Ellerton and Gregor 2003; Newton and McKenna 2007; Duchscher 2008; Wangensteen et al. 2008; Duchscher 2009
Mixed methods	Ross and Clifford 2002; Maben et al. 2006
Quantitative approaches	Heslop et al. 2001; Chang and Hancock 2003

Appendix 2: Timing of data collection in single-stage retrospective studies

Author	Timing of data collection after qualifying
Jasper, 1996	12 months
Maben and MacLeod Clark, 1998	6–11 months
Charnley, 1999	Within 6 months
Gerrish, 2000	4–10 months
Amos, 2001	1–9 months
Evans, 2001	At the point of qualification
Ramritu and Barnard, 2001	3 months
Whitehead, 2001	6–12 months
Delaney, 2003	3–4 months
Ellerton and Gregor, 2003	3 months
Jackson, 2005	10–12 months
Mooney, 2007	6–10 months
O'Shea and Kelly, 2007	6–7 months
Wangensteen, 2008	9–12 months
Andersson and Edberg, 2010	12 months

Appendix 3: Timing of data collection in longitudinal studies

Author/s	Pre-registration stages of data collection	Post-registration stages of data collection
Dearmun, 1997 and 1998	0	4 stages (3, 6, 9 and 12 months)
Bradley, 1998	1	1 (5 months)
Gray, 1998	0	3–4 interviews in the first year (stages varied)
Gray and Smith, 1999	5 stages during the pre-registration programme	0
Holland, 1999	Throughout the 3-year course	0
Dearmun, 2000	0	Every three months in the first year)
Ross and Clifford, 2002	1	1
Chang and Hancock, 2003	0	2 (2–3 months and 11–12 months)
Maben et al., 2006	1 (questionnaire)	2 (4–6 and 11–15 months)
Etheridge, 2007	0	3 (3, 6 and 9 months)
Newton and McKenna, 2007	0	3 (4–6, 10–12 and 16–18 months)
Standing, 2007	3	1
Duchscher, 2008	0	5 (1, 3, 6, 9, 12 and 18 months)
Kelly and Ahern, 2008	1	2 (1 and 6 months)
Duchscher, 2009	0	Meta analysis of 4 studies

Appendix 4: Stages of transition identified in earlier studies

Author	Stage 1	Stage 2	Stage 3	Stage 4
Gray, 1998	First day	First 3 months	Being in charge	Beyond the transition
Dearmun, 2000	Initiation 1–3 months	Consolidation 6 months	Out-growing the role 12 months	Promotion vs. stagnation 12 months +
Evans, 2001	Separation from student status	Transition to staff nurse status	Integration into the profession	
Duchscher, 2008	Doing 3–4 months	Being 4–9 months	Knowing 8–12 months	
Andersson and Edberg, 2010	Being a 'rookie' 6–12 months	Becoming a genuine nurse 6–18 months (overlaps with first stage)		

Appendix 5: Ten tips for reflexive bracketing

(Quoted from Ahern, 1999)

- 1) Identify some of the interests that, as a researcher, you might take for granted in undertaking this research.
- 2) Clarify your personal value systems and acknowledge areas in which you know you are subjective.
- 3) Describe possible areas of potential role conflict.
- 4) Identify gatekeepers' interests and consider the extent to which they are disposed favourably toward the project (Hanson, 1994).
- 5) Recognise feelings that could indicate a lack of neutrality.
- 6) Is anything new or surprising in your data collection or analysis?
- 7) When blocks occur in the research process, reframe them.
- 8) Even when you have completed your analysis, reflect on how you write up your account. Are you quoting more from one respondent than another?
- 9) In qualitative research, the substantive literature review often comes after the analysis.
- 10) A significant aspect of resolving bias is the acknowledgment of its outcomes (Paterson and Groening, 1996). Therefore, you might have to re-interview a respondent or reanalyze the transcript once you have recognized that bias in data collection or analysis is a possibility in a specific situation.

(Ahern. K.J. 1999. Pearls, Pith and Provocation: Ten tips for reflexive bracketing. *Qualitative Health Research*. 9. 407-11)

Appendix 6: Interview topics for each stage

Stage 1 interview: 3–4 months before qualifying as RN	Stage 2 interview: 3–4 months in post as RN	Stage 3 interview: 12–14 months in post as RN
<p>Tell me about your experience of your last (and previous) placement.</p> <p>What have you been doing?</p> <p>What aspects did you enjoy?</p> <p>What did you find challenging?</p> <p>Where there any aspects that you did not enjoy?</p> <p>Reflecting back, where would you place yourself on a scale of 1–10 in terms of your readiness to make the transition from student to staff nurse? (with 1 being not ready and 10 being entirely ready to make the transition).</p> <p>Tell me why you have placed yourself in this position i.e. what are you judging yourself against/how are you judging your readiness?</p>	<p>If we could begin by looking back to October when you received your results: How did you feel when you got your results?</p> <p>Tell me a little about your new post and the area of child health care you are working in e.g.</p> <p>First day on the ward?</p> <p>What have you been doing?</p> <p>What aspects do you enjoy?</p> <p>What do you find challenging?</p> <p>Are there any aspects that you do not enjoy?</p> <p>Reflecting back, was there anything specific about your experience as a third-year student that influenced your transition to staff nurse?</p> <p>When you were a student you were supported and assessed by a mentor. Now that you are a staff nurse what support do you think you need? And is that support available to you?</p>	<p>Today I am interested to hear about your experience as a staff nurse, so please feel free to tell me in your own words about your experience since we last met. I am particularly interested to hear about your actual experience; for example, a time when you felt like a staff nurse, or a specific experience.</p>

<p>What words would you use to describe how you are feeling at this stage in your course?</p> <p>What, or who, do you think has contributed to your progress and how (positive and negative influences)?</p> <p>Looking forward, what do you think you need to do or achieve to increase your readiness to practise?</p> <p>What help or support do you think you need to reach your goal/expectations?</p>	<p>What words would you use to describe how you are feeling about being a staff nurse at this stage in your career?</p> <p>What or who do you think has contributed to your progress in the early months of your career (positive and negative influences)?</p> <p>Looking forward, what do you think you need to do or achieve in your first year of practice?</p> <p>Is there anything else that you would like to tell me about your experience as a staff nurse?</p> <p>What advice would you give to third-year students about preparing to become a registered nurse?</p>	
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Appendix 7: Schedule of interviews

	Chris	Sam	Anne	Marie	May	Lee
Dec 08				3 H	3 U	3 T
Nov 08	3 home	3 T	3 home			
Oct 08						
Sept 08						
Aug 08						
July 08						2 T
June 08						
May 08						
Apr 08				2 U	2 U	
Mar 08						DCP
Feb 08	2 T	2 T	2 T			
Jan 08					DCP	
Dec 07				DCP		
Nov 07	DCP	DCP	DCP			
Oct 07						
Sept 07						
Aug 07						
July 07						
June 07	1 U	1 H	1 U	1 U		1 U
May 07					1 H	

Key to

schedule of interviews

Interview 1 = 1

Interview 2 = 2

Interview 3 = 3

Location

University = U

Hospital = H

Telephone = T

Home = home

Date

commenced in

post = DCP

Appendix 8: Information for prospective participants

Would you be interested in participating in a study which is looking at the transition from student nurse to staff nurse?

I am a senior lecturer in child health nursing and I am currently undertaking a research project for my Doctorate in Education at Southampton University; which is looking at the experience of nurses in the later stage of pre-registration education and during the first year of practice as a registered nurse. I am hoping to recruit a small number of third year child branch students to the study.

Taking part in the study would involve participants being interviewed by me at three stages; mid-way through the final year, shortly after qualifying to RN status and again 12 months after becoming a staff nurse. The interviews will take place at a time and venue convenient to the participants. You will not be expected to travel unless it is your preference to be interviewed at the University. The interviews will last approximately 60 minutes and will be taped so that the participants' views can be recorded accurately. All information gained during interviews will be kept confidential and participants will not be named in the final report. A written transcript of participants' interviews will be provided for them to read and correct any mistakes or add further comment.

The transcripts of interviews will be stored securely using pseudonyms or codes to identify participants. Transcripts will only be seen by me and possibly my research supervisor. However, only I as the researcher will know the identity of the participants. In the final report all views and comments will be presented anonymously.

Taking part in this study would be on a voluntary basis; participants can withdraw from the study at any time and do not have to provide a reason. If you are interested in taking part in the study please return the enclosed reply slip to me at the address below using the SAE provided. I will then arrange to meet with you to answer any questions you have about the study and provide you with a consent form.

Thank you for considering this invitation,
Helen

Helen Farasat, Senior Lecturer in Child Health Nursing

Appendix 9: Expressions of interest in participating in the study

Expression of interest in participating in a study of the transition from student nurse to staff nurse

Please circle yes or no for each statement

1. I have read the information provided and I am interested in participating in the study

Yes / No

2. I am willing to attend a meeting with the researcher to find out more about the study and discuss what it involves for me

Yes / No

Name:

Signature:

Date:

My contact details are:

Address:

Telephone: mob

Telephone: landline

Please indicate how you would prefer to be contacted by circling one of the above.

Appendix 10: Consent form

Consent form for participation in a study of the transition from student nurse to staff nurse

Please circle yes or no for each statement

1. I have read and understood the information sheet provided and I have had the opportunity to ask the researcher questions about the study

Yes / No

2. I consent to being interviewed by the researcher on three occasions and I understand that the interviews will be recorded and transcribed.

Yes / No

3. I understand that my participation is voluntary and that I can withdraw from the study at any time.

Yes / No

4. I understand that my identity will be protected and my views will be presented in the study using a pseudonym or code.

Yes / No

5. I would like to receive a summary of the results of the study when it has been completed

Yes / No

Name of participant:

Signature of participant:

Name of the researcher: Helen Farasat

Signature of researcher:

Date:

Appendix 11: Summary of the research process

Stages in the process	Actions	Purpose
Philosophical approach	Phenomenology	To provide a philosophical basis for the study
Methodology	Interpretive hermeneutic phenomenology	Allows the combination of descriptive and interpretive methods in the data collection and data analysis
	Ethics approval	Protection of participants and researcher
	Participant information	To inform and prepare for informed consent
	Informed consent	Protecting the participant and upholding their autonomy
Data collection method	Stage 1 interview	Gaining access to the 'final-year student' experience
	Stage 2 interview	Gaining access to the 'newly qualified nurse' experience
	Stage 3 interview	Gaining access to the 'no longer newly qualified nurse' experience
Data analysis phase 1	Thematic analysis using Colaizzi's steps 1–4: 1. Reading each transcript to gain a sense of the whole experience 2. Extracting significant statements 3. Formulating meanings for each significant statement 4. Organising formulated meanings into clusters of themes 5. Returning the themes to the participants	Identifying and verifying first order (participant) constructs
Data analysis phase 2	1. Interpretive analysis of themes using the concept of the hermeneutic circle 2. Development of 'themes of transition' 3. Synthesis of themes of transition into over-arching themes	Identifying second order (researcher) constructs
Findings	Themes and extracts reviewed against the participants' narratives	To complete the hermeneutic circle by bringing the interpretive themes back to the original data
Returning the findings to the participants for confirmation	Results presented at a meeting held with the participants	To allow participants to confirm or refute the accuracy of the findings

Appendix 12: Overarching theme 1: Personal and Professional Identity

Transition theme 1: Personal and Professional Identity	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
1.1 Self-image and professional identity	<ul style="list-style-type: none"> • Becoming a children's nurse • Orientating to the role • Rehearsing • Thinking and acting like an RN • Needing to be trusted • Self-rating of readiness to be an RN 	<ul style="list-style-type: none"> • (Dis)orientating • Wearing the uniform • New girl/boy again • Holding back 'traversing the route' • Feeling like a student again • Seen as a nurse but wanting to say 'I am a nurse but I am new' 	<ul style="list-style-type: none"> • Seen as a staff nurse but still feeling 'new' inside • Feeling valued • Feeling trusted in the team • Being new – not stupid • Asking, asking, asking – you never know everything so you have to ask • Knowing your limits
1.2 Maintaining motivation and vision of goals	<ul style="list-style-type: none"> • Promoting positive feelings • Self-awareness • Self-belief • Anticipation of change 	<ul style="list-style-type: none"> • Excitement of succeeding • Self-knowledge and self-belief. • Positive feelings about being an RN • 'Finding your feet' • Being where you want to be 	<ul style="list-style-type: none"> • Being where you want to be • Feeling that you are making a difference • Future planning
1.3 Using constructive review and feedback	<ul style="list-style-type: none"> • Using feedback to guide you • Feedback helps reassure you 	<ul style="list-style-type: none"> • Seeking feedback proactively • Seeking guidance 	<ul style="list-style-type: none"> • Being assertive in seeking support and advice • Supportive colleagues reassure you • Feeling encouraged but not pressured. • Pushing yourself and being pushed

Cont.

Transition theme 1: Personal and Professional Identity	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
1.4 Evolving roles and role models	<ul style="list-style-type: none"> • Reducing dependency • Discerning choice of role models; 'learning from the best' • Those who inspire and those who do not inspire • Testing yourself • Good mentors and poor mentors • Comparing current self to self as a first or second year 	<ul style="list-style-type: none"> • Mentor/guide/ preceptor • Knowing your limits and deciding when you need to seek help • 'Expert nurses' set the standard • Being supernumerary • Supervision support • Realising you can influence practice • Beginning to teach others 	<ul style="list-style-type: none"> • Teaching and supervising others • Becoming a mentor • Still needing guidance • Feeling you are influencing practice
1.5 Career focus	<ul style="list-style-type: none"> • Worrying about getting a job • Influence of third-year placements 	<ul style="list-style-type: none"> • Gaining specific training for the current job • Thinking about aptitudes 	<ul style="list-style-type: none"> • Looking ahead to future opportunities

Appendix 13: Overarching theme 2: Primacy of Practice

Transition theme 2: Primacy of Practice	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
2.1 Knowing what you need to know	<ul style="list-style-type: none"> • Knowledge is for practice • Feeling you ought to know everything • Tension between academic work and practice • Academic work is a distraction from the real focus of interest 	<ul style="list-style-type: none"> • Hunger for knowledge and experience • Relief that academic work is over • Awareness of what you don't know • Realising you have to keep learning • Learning focused on area of specialism 	<ul style="list-style-type: none"> • Knowledge sought for specific practice issues and teaching others • Thirst for information • Awareness of how much more there is to learn • Fear of not knowing enough • Learning seen as lifelong • Reflection helps you to see how far you have come
2.2 Measuring up: searching for authenticity and credibility	<ul style="list-style-type: none"> • Judging self and being judged • Identifying what you want to avoid • Making the grade • Meeting expectations • Not 'blagging' or waffling • Being valued 	<ul style="list-style-type: none"> • Comparing self to expert nurses • Awareness of poor practice • Resistance to 'know it all' or 'blagging your way' • Wanting to show what you can do • Adjusting to the increased pace of work • Increased expectations of others • Becoming assertive • Advice they would give to students 	<ul style="list-style-type: none"> • Strong sense of own progress – especially when teaching others • Using self-knowledge as support • Not wanting to 'bluff your way through' • Getting stuck in • Coping with your own uncertainty <p>Cont.</p>

Transition theme 2: Primacy of Practice	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
2.3 Skilling up: seeking opportunities to practise	<ul style="list-style-type: none"> • Confidence in your ability to be a nurse is rooted in practice • Seeking and embracing opportunities • Becoming aware of your own ability • Using HCA/NA experience to maintain skills 	<ul style="list-style-type: none"> • Experience boosts confidence • Absence of skills decreases confidence • Having to learn new skills • Responsibility for drugs • Advice for final-year students 	<ul style="list-style-type: none"> • Practise increases confidence • Feeling you are influencing practice • Wanting to be hands-on

Appendix 14: Overarching theme 3: Working with People

Transition theme 3: Working with People	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
3.1 Need for belonging and recognition	<ul style="list-style-type: none"> • Not belonging • Not wanting to be seen as awkward • Wanting to fit in as a student • Needing recognition 	<ul style="list-style-type: none"> • Sadness at leaving friends • Getting to know the basics • Social relationships emerging • Realising you can't get on with everyone • Recognition from other professionals • Reciprocal peer support 	<ul style="list-style-type: none"> • Socialising with colleagues important for settling in • Feeling accepted in the team • Feedback and recognition from senior staff and managers • not wanting to be seen as 'pushy'
3.2 Working with parents	<ul style="list-style-type: none"> • Competing for experience • Fearing their criticism • Feeling anxious practicing in front of parent • Becoming aware of the parents experience • Empathising with parents 	<ul style="list-style-type: none"> • Increased awareness of the parents' needs • Responding to angry or upset parents • Not wanting to appear stupid in front of parents • Developing professional boundaries 	<ul style="list-style-type: none"> • Identifying and empathising with parents • Understanding angry or upset parents • Family-centred care • Wanting parents to have confidence in you • Maintaining professional boundaries
3.3 Seeing the child	<ul style="list-style-type: none"> • A source of experience/learning • Sensitive to the child's needs • Feeling their needs were not always met 	<ul style="list-style-type: none"> • Work becomes more child-focused • Increased awareness of the fragility of life • 'Eyes and ears of the child' • Enjoyment derived from working with the child 	<ul style="list-style-type: none"> • Child becomes the focus • Advocate for the child • Coping with loss

Appendix 15: Overarching theme 4: Managing Newness

Transition theme 4: Managing Newness	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
4.1 Feeling exposed and over-exposed	<ul style="list-style-type: none"> Managing negative feelings and self-doubt Anticipating loss of the security blanket It's scary Feeling vulnerable Facing uncertainty about your ability 	<ul style="list-style-type: none"> Feeling scared Not being your usual self Leaving comfort zone Coping with uncertainty The burden of accountability and responsibility dawns 'Help, they think I know everything' 	<ul style="list-style-type: none"> Feeling you have to sink to swim Feeling the fear and doing it anyway Being 'new' is over Accountability increases Support diminishes as expectations increase Feeling abandoned
4.2 Learning and working in the real world	<ul style="list-style-type: none"> Limitations on opportunities Coping with time pressures Fluctuating demands 	<ul style="list-style-type: none"> (Limited) induction Coping with long, busy shifts and short staffing Getting used to new systems Adjusting to increased patient numbers Adjusting to the increased pace of work Becoming aware of the politics of health care 	<ul style="list-style-type: none"> Induction is over and cushioning diminishes Coping with stress Coping with short-staffing and high patient numbers Feeling you can't always give the care you want to <p>Cont.</p>

Transition theme 4: Managing Newness	Mid third-year student: Themes	3–4 months staff nurse: Themes	12–14 months staff nurse: Themes
4.3 Coping with crises	<ul style="list-style-type: none"> • Realising you can cope • Exposure to emergencies increases confidence 	<ul style="list-style-type: none"> • Coping with clinical incidents • Needing support • Relief when others validate his/her feelings 	<ul style="list-style-type: none"> • Facing crises: realising you can cope • Managing emotional responses • Seeking support and feedback • Critical illness • Emergency situations • Child protection • Child death • Relief when supported in these situations • Disappointment when unsupported in difficult situations

Appendix 16: Extracts from stage 1 interview transcripts

These additional quotes are referred to in chapter 4 using the numbers cited below.

- 1) 'Being with the children's nurses definitely helped, I don't think it would have helped as much if I was with an adult nurse – they put you with the children's nurses so you are with your speciality which really helps.' (Chris)
- 2) 'When you have your own patients you kind of feel like, well, I'm more of a nurse now. It just shows them how much I've progressed over the years as well, as I'd never have done...even in my second year I'd never have been comfortable having my own patients.' (Sam)
- 3) 'I had been having my own patients, three or four, and then they just asked me if I wanted to run the ward, which was really scary, but I did feel like it really helped me.' (Sam)
- 4) 'They definitely respect you more...it's always difficult at the beginning of the placement because if you're on with a mentor that's new to you, they don't know what to expect of you, and they kind of compare you to other third years which might have more experience, 'cause a lot of the girls do NA [nursing auxiliary] work, so obviously they've got that side of it, whereas I haven't done any work apart from my placement, so I always felt it was putting a bit more pressure on me, that their expectations are quite high, as third years.' (Sam)
- 5) 'You're thinking, do I apply for jobs or don't I apply for jobs, I need to do my personal statement, I need to do my CV and I need to write to companies, like hospitals to get application forms, I've got all this work to do, I've got that one to finish, that one to start...it's really hard to prioritise all your work.' (Ann)
- 6) 'I think it's been really good when you've got a mentor that gives you lots of praise and sort of leaves you to it, because if you think that you're not left to it as such, but they are always there in the background, as if they're watching you, but they know what you're doing because you've said it or, it's the third time you've done it that day and they know you're gonna be in there before them, that they just let you do it and afterwards they will say, such and such needs her IVs drawn up, "oh yeah, I've done that."' (Ann)
- 7) 'I felt like my confidence had gone and, I don't know...I think it's 'cause I've not had the same mentor throughout my placements, that they don't fully know who I am and what I am like, the way I am.....um, I don't know if they actually had higher expectations or not or just 'cause I was, I'm quite a quiet person so, and not like, some

people are more loud and say things whereas I just go along with it to a certain degree.' (Marie)

- 8) 'We've said that we're third years and that we want to do as much as what we are allowed to do.' (Marie)
- 9) 'Like an NG feed or something I hadn't done for such a long time I'd say, look I have done this, I do know the theory behind it but do you mind if I just observe this time, or you observe me this time to make sure that I'm competent before I do it. And they've all been really helpful like that.' (May)
- 10) 'I was quite enthusiastic about it and she could see that I was really strong about getting a lot from that unit...' (Ann)
- 11) 'I think it was better the fact that I didn't have a parent there really, nobody was watching me apart from my mentor and even she wasn't really watching me; she was just talking me through.' (Ann)
- 12) 'As a student you have actually got that time to spend with parents, a lot more time on your hands to do that. And that's my worry that when I am a staff nurse I am not going to have that time to do that or to do everything as well as I would like to.' (May)
- 13) 'There was a couple of babies that, um, came in the week before I started, so by the time I had finished I'd watched them grow and develop and go into the nursery and go home, and that was really nice.' (Ann)
- 14) 'I didn't really know what to expect and I was expecting to go there and all these babies be tubed up and ventilated and everything, so I was really excited about going on there, but I couldn't sleep the night before, I was excited, I didn't really know what to expect, I felt like a first year all over again, sort of, being put somewhere, and I didn't know any of the staff, and didn't know what I was supposed to be doing, kind of being chucked in the deep end, but then I thought well, that's kind of a good thing, 'cause it's a new experience.' (Ann)

Appendix 17: Extracts from stage 2 interview transcripts

These additional quotes are referred to in chapter 5 using the numbers cited below.

- 1) 'When I was a third-year student I was kind of taking more of the staff nurse role and taking my own patients and so to go back and be told to observe, and I was just watching, I felt I was going back to stage one...when what I really wanted was to start as a proper staff nurse.' (Sam)
- 2) 'You get an interview and they'd say have you got your PIN number yet? And I'd say "no still waiting for the piece of paper to come back" and then you'd be worried about whether that would affect whether or not you got the job.' (Sam)
- 3) 'I felt I could do a little bit of reading around what I would be doing and get myself prepared.....it sort of helps you to come to terms with "well I am a professional now, I'm a nurse".....if I had gone straight into it I think I would have felt quite anxious, I think I would have felt, "I think I needed a break."' (May)
- 4) 'It was exciting to get my results, very nerve wracking at first, but as long as I passed, I didn't mind what I got, as long as I passed.' (Marie)
- 5) 'I thought I probably did have 2:1 but to get a first I was really amazed because I didn't really know how to add it all up.....and also I wasn't trying to achieve that I was just trying to get through it.' (May)
- 6) 'To feel that it was all completed I couldn't believe it really, it was also a bit scary to think I am a nurse now when I have been just a student, just a student for three years.' (May)
- 7) 'It's a real confidence thing with me, when I first started I don't think I was confident at all but I'm getting that now and just feeling more like a nurse now. I think it only happened in the last month, it's taken quite a while, it is sort of up-and-down, up-and-down quite a bit...I think it makes you grow a lot as a person, you know having a lot more confidence in yourself and knowing that you can deal with new situations and cope within the new situations. I know I say confidence a lot but I think that was the big thing.' (Chris)
- 8) 'I've got where I've wanted to be...and I've achieved it.' (Marie)
- 9) 'Having family and friends supporting me, saying that you can do it and well, encouraging you to go out there and do it, and also the staff encouraging you to try something new, so if you haven't really looked after a patient before, they'll encourage you to try it, and go through what you might need to do and things...to encourage you to build up those skills that you need to be the staff nurse and improve your progress and confidence in other areas that you are not sure about.' (Marie)

- 10) 'I keep saying "you've got to remember I am newly qualified and I need support," so I have to keep saying that because it can be easily "oh you can run this, and you'll be fine"...but I do need guidance...it's about knowing my limits really isn't it, and knowing what I feel comfortable with, with what I know I've practised.' (May)
- 11) 'I was very fortunate I had eight weeks, I think it's an amazing transition because you're there, you're doing it, but not solely in charge, and you're with somebody, you can ask a question every 15 seconds if you want because that's what they fully expect you to do. Because anything...everything is new, every last...from what a ventilator does, to where can I find the blue needle! Everything, everything is new, so you can ask a million questions, and you have someone who is there with you for the entire day to do that with.' (Lee)
- 12) 'It felt quite strange her [student] coming to me asking me questions, and getting me to sign her off and things, 'cause only a few months ago, that would have been me! And I had to check and say, "is this ok for me to do this?" And they were like, "yeah you're a registered nurse, you can do that!" And that felt quite strange [laughs]...it seems that the student always seems to come to me and I don't know whether it's because I've only just qualified and I could kind of relate to what she was asking me, and I think I was like the youngest one there, so, that felt quite nice in a way that she felt that she could come and talk to me.' (Ann)
- 13) 'Even though the responsibility is quite scary; it is nice to be a staff nurse now and to get on and do things for my own patients now rather than when I was a student and had to ask and get everything checked.' (Sam)
- 14) 'They don't let you do anything you feel that you're not happy to do, I can't fault the support network that I've had, because, my erm, my nurse in charge, she wants me to move forward, but she doesn't like say, "well, don't do anything you feel uncomfortable with" but "just remember you will be supported with like, if we hand over in the morning, try and take ones that interest you, or more complicated, 'cause then, you can, and then you'll be supported by the person next to you.'" (Lee)
- 15) 'You get assigned to a supervisor, mine is [a senior nurse] and she sits me down every couple of weeks and we talk about anything we need to talk about. We set goals for what I want to achieve, any training that I might need.' (Chris)
- 16) 'When I qualified, I did really, really like neonates, but I thought, I won't apply to neonates, 'cause I wanted to get that extra experience behind me, but now I think, doing my rotation, I've come back to neonates and I really enjoy it, so I don't know whether maybe that's where I'll go.' (Ann)

- 17) 'I bought quite a few neonatal books that I come back and read after a shift and on the unit there are books and journals so if there is anything I am not sure about I can always read up about them.' (Sam)
- 18) 'I still am a newly qualified, and you do worry about these things, 'cause there are people on that unit who are so knowledgeable, it's unbelievable you know?' (Lee)
- 19) 'I find it really hard with things like breastfeeding. I was expected to go in and help a mum was breastfeeding but I didn't have any experience, and that's something that is quite hard to teach isn't it?' (Sam)
- 20) 'We're getting the first-year students in and I talk to them and suggest to them like, get in there, ask questions, make sure, if you get anything interesting, get in there and be a part of it and things...encouraging them not to leave things to the last minute and things, and just make sure that they're prepared and to always ask really if they're not sure about something.' (Marie)
- 21) 'If you're looking after their baby they expect you to know everything about the care that you're providing to their baby and there have been times when I haven't known everything and that's probably one of the peak areas that I found quite difficult.....but it is hard to explain to parents because they think you've done your three years training you know and they don't realise that you've only had like a five-week placement on NICU, you know and you don't want to say like "I am newly qualified" because then they might think "well they're not going to know if I asked them that" [rueful laugh].....but because they know that I have to go and ask somebody else I worry that they'll think less of me.' (Sam)
- 22) 'When you have the parents with you all the time as well, you need to have good communication with them because they, obviously are very, very worried and that sort of thing, and you're in liaising with the parents and you've got the child there as well, so make sure you have the parents really well informed and that you're liaising well with the doctors.' (Lee)
- 23) 'I can remember feeling really nervous. I was supernumerary, and so it was more observational...I was probably quite quiet, I mean I didn't know the staff or team I was working with and you feel like you're the new one.' (Chris)
- 24) 'I thought, well even though I've worked in an assessment unit, they seem to do things differently. So I wanted to help out but at the same time I wasn't quite sure what I was doing.....I felt quite embarrassed and quite shy, and I thought, well I don't want to be sat down doing nothing 'cause they're not really gonna think very much of me, so I wanted to try and get involved, but then I felt like I was in the way as they were rushing around, and I didn't know where anything was or anything like that.' (Ann)

- 25) 'It was quite scary, but it was quite good actually to get thrown into the deep end after such a long time, I think I slightly benefited from being able to just get stuck in there.'
(Marie)
- 26) 'The first time I went to theatre, 'cause as a student you had to take someone with you, whereas now you just walk down the long corridor and pick the patient up yourself and bring them back, so it's a lot more responsibility in case anything does go wrong with bringing them back.' (Marie)
- 27) 'My very first shift I was with my mentor, and I actually worked with a level three post-op cardiac, on my very first shift, which absolutely terrified the socks off me for a very first shift, and was probably not the best thing to do for my very first one but, I still did, and I thought, oh my god, in some ways, what the hell is going on here, this is unbelievable...it's like being a student, but not even like a student, it's like being, when you first start in year one, when you first get into the hospital you know, and you've never done it before in your life and your thinking oh my god! 'Cause even though you've got obviously a hell of a lot more experience, but it's like a different...it's a completely different, just because of the route that I took at the moment, being in intensive care, it's a completely different ball game.' (Lee)
- 28) 'You have your eight weeks to start with, then you go to supervised practice, you have your orientation programme, which that is ongoing, so basically it's ongoing. You're always, you permanently seem to be training and learning just permanently.' (Lee)
- 29) 'In our induction you get a whole week nine-to-five Monday to Friday and they go through everything possible, you know, mandatory training, and you just get different talks.....It was just really nice because obviously you start with the group of people who are all new, not all nurses and it's nice to get to know what other people are going to be doing. You don't feel like you are the only new one.' (Chris)
- 30) 'I didn't get my um, induction pack, um, 'til a couple of weeks later...if I was in a completely new place then I would have found it a hell of a lot more valuable, but 'cause I knew the majority of where things were, and understood what goes where, and what I didn't understand, I just asked anyway.' (Marie)
- 31) 'We had quite a few children in all over Christmas when I was on the assessment unit, and that was putting quite a lot of stress on the main ward, where they've been so short staffed it's made the whole atmosphere quite stressful, and I've come home really, really late, and that's made me feel really tired and really stressed.' (Ann)
- 32) 'They interviewed me and things, which is quite daunting, and they caution you...and that was quite scary actually. There was someone, a child protection officer from the police, and then there was our child protection officer, and then I had someone, a

representative of the RCN with me, which was quite scary, 'cause that was within the first couple of weeks...' (Marie)

- 33) 'It was nice to talk to someone from our family and to talk through it...and it's still not fully resolved yet, there's still processes going through, it's quite daunting, I do try to stick it in the back of my mind and make sure it doesn't affect what I actually do.'

(Marie)

- 34) 'I felt a little bit lost, if you know what I mean, I didn't know what I would do.....if it was me and I was the only one, I think I'd probably get on with it but because there was someone who knew better they were getting on with it and I was an outsider still learning what to do if it happened when I was on my own, but it did frighten me what can happen with our children.' (May)

Appendix 18: Extracts from stage 3 interview transcripts

These additional quotes are referred to in chapter 6 using the numbers cited below.

- 1) 'I think, do you ever see yourself as a staff nurse? Or do you ever forget that you were a student? I don't know if you ever do to be honest, I know I certainly don't feel that way. I think the fact that I'm learning stuff every day has that student-esque thing about it, it will always have that really.' (Lee)
- 2) 'I always point out the fact that I am newly qualified quite a lot, through the year, I'd say well you know what, I probably should know this but I don't, can you help me on this.....Of course now, I'm at a point where I can't really say, I'm newly qualified anymore, 'cause it's a year isn't it!' (May)
- 3) 'I feel that it's lovely to be able to give respite to the children and to their families, and it's really a worthwhile thing that I'm doing, I'm very proud of what I'm doing.' (May)
- 4) 'I was only happy looking after [child] because she was there, and she didn't actually come...that was an area where I felt unsupported when I'd asked and asked for support. And it was an area where I'd think well no, next time I wouldn't do it in the first place.' (May)
- 5) 'The majority of staff you can just go to them and ask but sometimes you are wary of them...somehow some people deal with situations, and some people don't work best when they are busy.' (Marie)
- 6) 'I remember the first day I took my student round, I was going, "this is there and that is there and this is here" and I looked at her and I went, "are you ok?" and she went, "yeah." And I went, "information overload?" And she went, "pretty much!" [Laughs]...so many time I'd turned around and she'd be like, "oh where did Ann go?" And I'd be like, "sorry I'm over here," 'cause you just feel helpless, until you sort of feel comfortable where you work, and it was her first day on a new ward and she's never been on placement before, and I think I just scared the hell out of her...It's quite nice being quite fresh I think 'cause I try not to do to her what I think I might have found a bit difficult or, you know, if everybody is rushing around, how I felt, if people don't realise...to try and make her feel a bit more comfortable, especially when you don't know anybody.' (Ann)
- 7) 'I was newly qualified and I wanted everything to be just so, and how I'd trained and how it should be and just some of the other nurses might have done things a bit differently, and so I made sure I did it my way and then some of them have picked up on things, and then I've learnt other skills from them.' (May)

- 8) 'I still see myself as doing A&E but I don't want to settle, I've got on my mind about specialising. But I don't know what I want to specialise into and obviously that involves heavy training so that thought has occurred to me but it's not definite.' (Chris)
- 9) 'I was looking to be a liaison nurse for blood transfusions, so we've got someone to liaise with people about blood transfusions, and teaching staff about blood transfusions and things, that was one of the areas that I liked.' (Marie)
- 10) 'It's nice to go and research that syndrome that they've been diagnosed with...' (Marie)
- 11) 'I have more confidence and determination in getting me to do new things, whereas I'd probably stand back and just observe and take note...I'm just getting stuck in now and learning as I do it.' (Ann)
- 12) 'I talk to parents about what the drugs do, how they work and stuff and why we try and wean them off and why they were on them in the first place and that sort of thing you know. So, in that way, that's another thing that's made me feel better about things to a degree, 'cause the fact that, well, just remember how you were 18 months ago, I didn't know anything about anything at all, and now I just, now I think well, you have come a long way since those early days.' (Lee)
- 13) 'We've had quite a few poorly children in, and we've not had anything to go on, and specialised children, which was really nice, 'cause in three days I specialised four different children, and it was nice just to stick to the one child and fully support them and the family.' (Marie)
- 14) 'It's things like, doing a cannulation, a doctor's doing a cannulation, and they're only allowed three attempts on the unit, whereas before, obviously I watched them to see how many attempts they have and they do, um, if after the third one they don't get it in, I can say, "no, I think you've had enough goes now, can you get somebody senior," um, it's like standing up and saying things like that, whereas before...even though I know it's the right thing to do, it would have been quite difficult for me to actually stand up and say, whereas now I feel I have the confidence and people look at me...that I have a bit more knowledge and skills, that I can actually say that.' (Sam)
- 15) 'I've got some good friends there now that I get on really well with, and I think the fact that we have teams as well helps, I think that the fact it segments up the large amounts of people there because we do stuff together, we're going wine tasting together next month as a team day out sort of thing, so you know, and that does help a lot as well, 'cause it means you feel part of something within something else.' (Lee)
- 16) 'They don't let you progress...you have six months in one place and you progress getting really involved in the team kind of building up certain roles in having more of a say and then you go to this unit and they don't let you do anything, they kind of take everything away from you that you've been doing. I had just passed a single checker

course for checking drugs and they went back to double-checking, they didn't want me to single check. They don't let you be in charge, they don't really like bring you into team meetings or anything like that.....They very much make you feel like they know everything about these children and they don't give you the opportunity to have your say or give any new ideas.' (Chris)

17) 'I think I got so much praise for carrying on and getting on with it, and support after the situation, you know.' (May)

18) 'I was trying to give her all the reassurance I could, but it wasn't really...well it worked a tiny bit but I had to get the doctors back, as it just wasn't working and I suppose that's because that's what she'd been through and you have to understand that.'
(Chris)

19) 'Where mums are in every day of the week and stay there for most of the day, they obviously pick up a lot of what the nurses do, and what's right for the baby and what's wrong for the baby, so I do find, along comes mum, and watch you, watch what you're doing, even like putting a tube down, they know how it should be measured, and whether you're doing it right or wrong, and I think that is quite difficult.' (Sam)

20) 'I'm fine working with parents and siblings, I really enjoy that...not in the beginning, especially not with children with complex needs, I almost felt like, frightened when they were on the ward 'cause the parents were so fed up with having to go through everything, you almost, you could just walk in the room and go, "I'm a student can you tell me all again," you know, and they...some of them are really good but you did pick up on...they were tense that they were in hospital, they didn't want to be there and wanted the child out as quick as possible, no-one could do right, you know. These parents are like that, they're very much...they have to put up with so much, they get very, you know, and I've learnt again from that, with [child's] Mummy, getting quite cross, and it's not with you, they've got so much to deal with, you've almost got to kind of let it go over, it's not directed at you, you're just, you know, someone they can take it out on.' (May)

21) 'I've heard of difficult parents in the past but not any that I've had any to deal with...It makes you aware that parents are anxious and they need to know what you're doing and why...and you try and spend a little more time with them 'cause you know they're that anxious and they need a bit more support from others, especially with young mums, that they don't always understand, it's nice to go in and talk to them.' (Marie)

22) 'So it's quite hard because you have to keep your cool, sometimes, when they're swearing and whatnot down the phone and try and remember what they've been through you know but that was quite difficult because one minute he'd be really nice and the next minute if something little went wrong, like something small, might have

gone wrong like a [machine] broke then that was blown up into something massive.’
(Chris)

23) ‘You do miss the grass roots interaction with the kids that you don’t get in PICU as you do on the wards because obviously they’re a lot sicker. So I miss the mucking around, and the being stupid and that sort of thing.’ (Lee)

24) I think with ‘T’ the baby that really brought us all together as a team. Because everyone really, really, all the carers, all the nurses, who whatever role, everyone just came to...like a big family, like a big huggy family, I think that made me feel like, well yeah, I’m really part of a brilliant team.’ (May)

25) ‘I did occasionally get the chance to go in and see the nurse that was looking after that baby that day, but because I had my own baby to look after as well, it’s quite difficult to actually have the time.’ (Sam)

26) ‘I’ve got to now, because we’ve been here a year, now look at doing more, like take over running the shift and things...I’ve done it once or twice but, not as in the busiest time when I should be doing it...so, that’s my next thing to look at. Look at running the ward, and saying yes, saying to people, yes I’d like to run it with your help.’ (Marie)

27) ‘I just try to have as good a social life as I can, to de-stress and to talk about it and to try and spend time out of, not being in the work environment.’ (Ann)

28) ‘Sometimes I find that, because it’s been that busy, you get stressed and, because you don’t know when to stop, and prioritise, then I learn that I’ve got to sit back a minute, work it all out before I go ahead and do something.’ (Marie)

Appendix 19: Paradigm case

Extract from Chris' second stage interview

'I've had some bad shifts where I felt I hadn't really done very well at all, but you do really criticise yourself (1), you look at the nurses who have been there for years, and you think 'you're really good', and I want to be like that.(2) But you sometimes look at them and you think I'm not like that yet, it's a bit of the criticism being of yourself and you are always trying to be a bit better and feeling like your thinking on your feet like they are (3). And thinking like you've done everything you possibly could for the kids you've got (4) and you are working well within the team,(5) making the others you are working with feel you're working well with each other [laughs] if that makes sense.' (Chris)

Analysis

- 1) Has had some bad shifts and has felt self-critical. **Wanting to measure up.**
- 2) Identifies nurses who she considers to be 'really good'. **Expert role models**
- 3) Uses role models to self-motivate. **Expert role models**
- 4) Fitting in/meeting expectations **Meeting the child's needs.**
- 5) She wants others to see that she/he is working well in the team. **Wanting to measure up.**

'I think I had a couple of bad shifts with one of the lads we've got, he needed one-to-one care and if you're with him you're on your own. He has complex needs, [diagnosis removed]...I was put with him one day and had never been with him before (7) so for one thing we didn't really know each other, because you're never really put with him unless you're caring for him. So we didn't really know each other and I think that stressed us both out. I just didn't know how to handle his care because I've never been with somebody else to watch them and find out what they had to do (8). So I was a bit on my own and wasn't really getting much support because everybody else was busy (9) 'cause the morning shift was very busy and the other staff are getting the children up to their sessions at school and things like that, but I was a bit alone and I didn't get much support and it got to a stage where I think I should have asked for help sooner, and you just get to a point where you think 'I just can't cope any more' (10). I ended up getting taken out of the situation which in a way made me feel worse (11) [rueful laugh] I think it took about two weeks for me to get my confidence back because I totally lost it because I got pulled out the situation and in a way that made it even worse. It knocked my confidence completely and I thought if I can't cope in that situation, you know, should I be here? (12) And I think if you have a bad shift like that is it really knocks your confidence and it just took it back to start all over again (13).

Analysis

- 6) Had a couple of bad shifts and found she was assigned to a child whose care she/he was unfamiliar with. **Exposure.**
- 7) Found this situation caused stress for her and the child. **Becoming child focused**
- 8) Feeling **exposed**
- 9) Didn't feel supported. **Increased expectations of others**
- 10) Thinks she/he should have asked for help sooner. **Recognising the need to seek guidance**
- 11) Got 'taken out of the situation' and that made her feel worse. **Feeling you didn't measure up**
- 12) 'In at the deep end' Crisis of confidence. **Absence of skills decreases confidence.**
- 13) Confidence was knocked and she felt she had to start over again. **Coping with uncertainty**

I have had really good support here and after that happened they put me with this particular lad with another nurse and I got to learn all about him. I just needed to get to know him and I think the fact that we didn't know each other stressed us both out. I mean he got stressed out he's a [adolescent age] lad, you know he feels he needs to know the person, and now I get put with him a lot, we get on like a house on fire, he's great and I feel I can manage his care now (14). So you look back and think well I couldn't care for you then but obviously I can now so it's been a positive experience. It wasn't obviously a nice shift but it's been a good thing to reflect upon and there can be situation you can't deal with at the time but obviously you've got to reflect on it. And if you learn from it and learn what you have to do you can come through it.' (15)

Analysis

- 14) Was able to get to know the client and learn about his care and could see that that was what she needed to do. **Knowledge for practice, Experience boosts confidence and Seeing the child**
- 15) Can look back now and see that it was a positive experience. **Learning from difficult experiences reinforces the Primacy of Practice.**

Chris recognised that asking for help earlier was an option but had delayed doing this. She explained that it was about showing that you can do the job you trained for:

'I mean you're newly qualified, you just come into the post and you want to prove yourself to somebody else that you can cope, you can do things, so in a way probably I did try to, you know, cope with it...because you don't want to look like you're failing (16). You want to

look like you're good at your job and that you can do it because that's what you train for.'

(Chris)

Analysis

16) Wanting to prove herself. **Measuring up, wanting to be seen as credible**

Appendix 20: Advice for third-year students

May

'I would say take every opportunity they get and if they're on a ward, get to various areas of the ward, like sometimes you can arrange to like go on day surgery, it wasn't hard but I just arranged to go in day surgery, just get out there and get everything you can.'

Lee

'Just to say like at the end of the day, it might seem all a bit strange and a bit like I'm never gonna get through this but all the pieces will fit eventually, and you'll be surprised how well you do by the time you get to the end of the third year, it's like a big jigsaw!'

'You start the first year and you don't have a clue what's going on and you hear how much work you've got to do, and you think oh my god, I'm never gonna get through this, and.....but you do get there, and you will get there, and it will just, it will make sense eventually.'

Marie

'I found that doing a little booklet of little pieces of advice, like what we saw on the ward, if you go back to that scenario, what you learnt, and what you mainly get in as your cases, so that you have a knowledge of what you could see on the ward, or something unusual – like learning about it beforehand.'

'Make sure you learn from it, still don't be afraid to ask questions if you're not sure in a particular area – then to ask questions and things, which is good.'

Chris

'Not to be worried about qualifying and take every opportunity they can, don't be afraid to ask for help, don't be afraid if you don't know something, I think that's the most important thing.'

'Now that you are qualified don't feel you have to know everything and don't be afraid to ask for help and don't be afraid to admit it if you don't know something.....you can never have every experience in your training, I know I haven't experienced half of the things I'm going to experience in my career.'

Ann

'Look for jobs in advance, just keeping your eyes open at the beginning of the year like May. Work hard, and just sort of prepare yourself in your head for what you want to do and where you're going to go, and just get all you can out of the last placement, if there's anything that you don't know, then ask to go over it.'

'If there's things that you don't know, go and ask if you can do it, or go over the areas which are weaker.'

Sam

'I think having some idea about the type of area you want to go into and apply for jobs quite early – although there's not many jobs around it is good to keep your eyes open earlier. Get as much clinical experience as you can and obviously on the last placement try and get as much experience as you can, because it's your last chance really.'

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