University of Southampton

Faculty of Environmental and Life Sciences

School of Health Sciences

Preceptorship of New Graduate Nurses in Saudi-Arabian Intensive Care Units – An ethnography of Relationship Dynamics

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Abstract

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This exploratory qualitative research aims to provide an in-depth understanding of current practice within the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship in an intensive care setting in Saudi Arabia. Fieldwork was conducted to gather information on the day-to-day working practices of 5 pairs of new graduate nurses (NGNs) and their preceptors in the hospital ward (ICUs) of King Abdulaziz Medical City. Each pair was observed for a period of 5 hours per day over the course of 4 days. Formal and informal conversations with the respondents were also captured as part of the data collection process in addition to face-to-face semi-structured individual interviews. A thematic analysis of the data revealed that the practice of professional values reflects social structures in the Saudi context, which shapes perceptions about professionalism and workplace relations. There were also tensions in the understanding of preceptors clinically and educationally, in terms of what needed to be done and what needed to be learned. In addition, the lack of institutional support and formal processes undermined the value of preceptors' work. This also had implications for commitment and required both preceptors and preceptees to make additional efforts to ensure that the preceptorship is successful. There were no formalised systems for training preceptors to make the preceptorship process more effective. Even preceptors who had been performing their role for more than a decade tended to have chaotic and informal approaches to preceptorship which veered between good practice and being actively unhelpful to preceptees. Preceptors perceived as successful by preceptees relied on their interpersonal skills and nursing ability to provide space and time for preceptors to learn, but this depended on the ability of the preceptor rather than any institutional system to produce effective preceptors. As well as the lack of appropriate training for preceptors, there was also minimal support from the administration for the preceptorship process. This study also revealed that the exertion of power and authority can have negative impacts and caused barriers to effective communication in the workplace, particularly between preceptor and preceptee. Language was used to facilitate learning and provide pastoral care and constructive feedback. Language barriers, on the other hand, played a role in undermining communication and relationships. Communication was used to exert power, humiliate, and reinforce hierarchical roles in ways that hindered the success of the preceptorship relationship via conflict. Some preceptors developed friendly relations with their preceptees, mediated by trust. This study establishes important findings regarding the tensions produced in the preceptor-preceptee relationship by differences of language and culture, as well as the tendency for the Saudization policy to lead to divisions between Saudi and non-Saudi nurses.

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Research Thesis: Declaration of Authorship

Amal Ali Alasmari

Preceptorship of New Graduate Nurses in Saudi-Arabian Intensive Care Units – An ethnography of Relationship Dynamics

I declare that this thesis and the work presented in it is my own and has been generated by me as the result of my own original research.

I confirm that:

1. This work was done wholly or mainly while in candidature for a research degree at this University;

2. 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;

3. Where I have consulted the published work of others, this is always clearly attributed;

4. 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;

5. I have acknowledged all main sources of help;

6. 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;

7. None of this work has been published before submission;

Signature: Amal Date: September 2022

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In the name of Allah, the Most Beneficent, the Most Merciful, my sincere gratitude goes to Him for His support and guidance throughout my life.

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Abbreviations

CRN	Clinical Resource Nurse
CVC	Central Venous Catheter
GCC	Gulf Cooperation Council
ICU	Intensive Care Unit
MoHE	Ministry of Higher Education
MoH	Ministry of Health
NGNs	New Graduated Nurse
OMP	One-Minute Preceptor Model
PP Relationship	Preceptor-preceptee relationship
RN	Registered Nurse
SA	Saudi Arabia
ZPD	Zone of Proximal Development

Chapter 1: Introduction

1.1 Project Background

My work within an Intensive Care Unit (ICU) in Saudi Arabia has exposed me to some of the challenges that are concomitant with preceptorships. My experience at the unit was wholly a difficult one. A newly-qualified nurse at the time, I became flustered in the clinical setting because I lacked a supportive learning environment. My interest in this topic was inspired by one particular incident which indicated the need to develop a good understanding of the relationship between preceptors and preceptees in Saudi Arabia. One day, I was working in the ICU when a patient presented with acute leukaemia. The clinical decision taken by the multidisciplinary team was that a central venous catheter (CVC) should be placed to provide intravenous administration of medication. This was placed in sterile conditions, and the patient was discharged a few hours later. The following day, the patient returned to the hospital experiencing extreme pain at the insertion site of the CVC and showing symptoms of a severe infection with chest and neck inflammation.

My preceptor and I began to manage the infection to prevent further deterioration of the patient's condition, but I felt that she did not provide sufficient support to me as I cared for the patient. Until then, I had never cared for a seriously ill patient thus I was under extreme pressure to act quickly, concurrently avoiding serious clinical errors. Instead of being a calming influence, my preceptor became flustered and began taking clinical actions without communicating what she was doing either to me or other staff members. This meant that I could not plan for the patient's care effectively and these actions diminished the trust between me and my preceptor. I felt that the situation could have been a positive learning experience if my preceptor had slowly taken me through the process. Instead, it became a very negative one.

I found the preceptor-preceptee relationship to be inadequate for providing the learning outcomes which I needed as a newly-qualified nurse. I had anticipated that through the preceptorship relationship, I would be initiated into the professional nursing environment. It was my expectation that via the constructive feedback, guidance and monitoring of my

preceptor, I could receive a toolbox of resources and practices that would ensure that I was successful and confident in my professional role. It was also my expectation that through the experience and feedback of my preceptor, I would be guided to assimilate seamlessly into the clinical environment. My expectations did not align with my first-hand experiences of the relationship. I thought that my preceptor was a good nurse and a good co-worker, however, I also felt that these qualities were not transferred into her preceptor role. As a newly qualified nurse, I required guidance, support and practical opportunities to develop my skills. Rather, I was largely ignored and used as an extra pair of hands to perform mundane tasks. I did not feel supported or encouraged and I lacked access to the fundamental resources that could promote my learning. My preceptor was pessimistic, detached, and lacked an intuitive understanding of her role.

My experience was especially perplexing because some of my colleagues experienced constructive preceptorships that encouraged their professional development and learning. Inevitably, I was compelled to ask myself: how are preceptors and preceptees able to work together so well in high-acuity settings? What makes the preceptorship experience so productive? Aside from my experiences of preceptorship as a new graduate nurse (NGN), I have also experienced this relationship as a lecturer and clinical instructor in charge of Bachelor of Science (BSc) Nursing students in hospitals associated with my college. I was also a member of the internship committee as part of my duties, and these roles have given me valuable insights into the strengths and weaknesses of the preceptorship process. I have observed occasions where NGNs are overly reliant on their preceptors in treating high acuity patients and where preceptors do not allow novices sufficient freedom to perform tasks independently or do not give them time to make proper assessments of acute care patients.

Nursing practice in the acute care unit setting, where I provide clinical supervision to my nursing students, is complex. High patient acuity, technological advancements and the electronic health record can overwhelm even expert nurses. Through my interactions with NGNs, I have witnessed complex issues associated with preceptorship. I have listened to their concerns, fears, and accomplishments. Consequently, my interest in the quality of the relationship between preceptors and preceptees during their preceptorship period in acute care units has been piqued immensely. I believe that trained nurse preceptors are pivotal in

initiating a transition to offer the ongoing support required for new nurses to transition smoothly during their first year of practice. The limitations of the preceptorship relationship which I have witnessed as a preceptee, lecturer and clinical instructor nurse, have motivated me to ask pertinent questions.

Against this backdrop, my thesis explores the relationship between nurse preceptors and preceptees (NGNs) in the context of Saudi Arabia. It specifically focuses on the nature of the preceptorship relationship and deliberates upon how Saudi NGNs can be supported during their preceptorship in ICUs, to safeguard and enhance their learning and professional development. Through this thesis, I will further explore the intricacies of preceptorships in Saudi ICUs, to draw out the prevailing issues while also uncovering the parameters, inter-personal, and contextual processes that shape these relationships and make some more successful than others.

1.2 Research Rationale

Preceptorship constitutes a component of clinical training in nursing. Preceptorship has been conceptualised as a developmental relationship that involves a knowledgeable and experienced preceptor who constructively guides and supports new graduate nurses to attain key skills and competencies integral to their field of study (Enyan et al., 2021). Precepting is, therefore, an important intervention that prepares NGNs for practice (Enyan et al., 2021; Greene and Puetzer, 2002). Grossman (2013) has shown that the preceptorship period in the clinical setting is critical to the experiences of NGNs, as it influences their motivation to acquire full qualifications. Moreover, preceptors have been shown to play a key role in enabling preceptees to transition from having a theoretical understanding of key nursing principles to applying them confidently in clinical settings (Corlett et al., 2003). In many cases, preceptors shape not only how much their preceptees learn during the clinical practice period, but also the quality of their experience and their confidence as professionals (Neary, 2000a). The quality of a preceptorship has been shown to influence the time it takes for preceptees to meet professional nursing standards (Hodges, 2009). Thus, preceptorships are invariably linked to the career trajectories of NGNs. High-quality preceptorships have been found by studies to motivate preceptees, increase their self-

esteem and confidence, assist in their socialisation process within institutions, improve their future career prospects and support the maximisation of their capabilities (Neary, 2000a; Irwin et al., 2018; Black, 2018; Quek and Shorey, 2018; Aboshaiqah et al., 2018).

Despite the centrality of the preceptorship relationship for developing the skills and competencies of novice nurses, my personal experience of the relationship, the feedback I have received from my students and some existing studies in the literature (Matua et al., 2014; Oosterbroek and Myrick, 2017; Valizadeh et al., 2016), suggest that it is fraught with challenges. The quality of the relationship between preceptors and preceptees can affect preceptees' learning, especially when the two parties have different expectations (Hodges, 2009; Spouse, 1996). Studies by Quek and Shorey (2018) as well as Smith and Sweet (2019), for example, have pointed to the difficulties experienced by newly qualified nurses when settling into new healthcare systems.

1.3 Research Context

It is important to provide a broad overview of social relations in Saudi Arabia, as the wider context and relations, perceptions, expectations, and resources external to healthcare settings impinge upon how preceptorships work. Saudi Arabia comprises a heterogeneous mixture of ethnicities from around the Gulf Region and further abroad (Maisel and Shoup, 2009). These include Syrian (9.7%), Indian (7.8%), Pakistani (4.6%), Filipino (4.6%), Bangladeshi (4.0%), Egyptian (2.7%) and Yemeni (2.4%) groups (CIA World Factbook, 2021). Saudi Arabia remains a developing nation and has historically relied on an immigrant workforce for professional knowledge and skills in the health sector (Alsadaan et al., 2021). It is estimated that between 60 and 70% of nurses working in the Kingdom are immigrants, mainly from Indian, Malaysian and Philippine backgrounds (Alsadaan et al., 2021). In the past decades, the Saudi government has sought to encourage Saudi nationals to take up the roles occupied by immigrants as part of efforts to provide localised and high-quality healthcare (Tumulty, 2001). Domestic nursing shortages however present severe challenges for ICU facilities. Engaging NGNs to work in the acute care setting has been conceptualised as an option to address existing shortfalls. NGNs are drawn to critical care areas, however, they typically do not remain in the ICU after completing their new graduate/transition to

practice program (Alboliteeh 2015). Consequently, organisations must provide guidance and support for NGNs transitioning into practice, to prevent high attrition rates.

Facilitating the transition from graduate registered nurse (RN) to functioning ICU nurse requires nurturing, guidance, and skill-building from experienced nurses. Day-to-day relations between co-workers are however influenced by the diversity of ethnic and cultural backgrounds within the nursing workforce (Adahl, 2009). Ethnicity, culture, identity and belonging, access to social and professional opportunities, and the underlying structures of power shape nursing practice as healthcare professionals, and preceptees and preceptors, from different backgrounds must work together. According to Nowottny (2008), culture is a concept that consists of various aspects, including the assumptions, customs, practices and beliefs governing the lives of a particular group of individuals. All people possess their own distinct culture that is the sum of their personal experiences and experiences shared with other individuals (Hofstede et al., 2010). As noted by Hofstede et al. (2010), such experiences relate to the immediate social groups that individuals belong to and the broader society within which they belong. Therefore, the culture that individuals identify with influences their views and attitudes towards other people, depending on whether or not they are ingroup or outgroup members (Triandis, 2003). Consequently, individuals rely on their culturally-shaped beliefs, conventions and outlook to create a social hierarchy, according to which they label the people they come into contact (Triandis, 2003). Existing studies have focused on how cultural differences and misunderstandings shape nursing relationships (Alshammari et al., 2019; Albougami et al., 2019, 2020; Alzahrani et al., 2018), however, this study also explores the underlying relations of power that accompany cultural practices (Ybema and Byun, 2009). In this study, relationship dynamics between preceptors and preceptees refer to the behavior patterns that exist between them as they communicate, relate and interact with each other (Enyan et al., 2021).

As regards to organisational or institutional level processes, the structure of preceptorship depends significantly on the norms, values and practices that are enforced by the institution responsible for initiating the preceptorship. These norms, values and practices are rooted in relations of power and cultural practices that exist within organisations; they are manifested in professional hierarchies, boundaries and perceptions (Kochan and Pascarelli, 2003). The areas in which the effect of organisational norms, values and practices is felt most strongly

are the goals and objectives of preceptorship, how the two parties in the preceptorship relationship communicate and interact with one another, and the outcome of preceptorship (Kochan and Pascarelli, 2003). Furthermore, according to Chikunda (2008), the relationship between the preceptor and preceptee can be disrupted by cultural discrepancies that permeate the social context in which this relationship unfolds. Kochan and Pascarelli (2003) also draw attention to the fact that, in addition to organisational values, norms and practices, preceptorships are shaped by the culture associated with the society in which it is initiated, particularly concerning the amount of funding given, the aims of the programme and the level of control imposed by the preceptor. Further, every society is governed by a series of aims, rules of conduct, norms, practices and customs that influence the organisation's culture (House et al., 2004). Moreover, House et al. (2004) add that individuals in positions of power, the other people involved, and the nature of the interaction between them have a decisive effect on organisational culture. Similarly, Kochan (2013) argues that both individual and organisational cultures are subject to a process of integration/exclusion and absorption/rejection into the societies in which they exist. The way that preceptorship is organised reflects how the society within which the preceptorship is undertaken functions (Kochan, 2013). Therefore, it is essential to adopt a culturally-sensitive perspective to understand the processes and mechanisms that influence preceptorship relationships (Kochan, 2013).

Each culture also includes a series of intrinsic elements that are not readily visible or accessible to individuals who do not belong to that culture. These hidden elements are the assumptions, beliefs and customs that arise from and shape it (Rosinski, 2003). Despite being hidden, intrinsic cultural values are often reflected in extrinsic acts, but, even so, they cannot normally be deciphered by individuals from a different cultural background (Rosinski, 2003). The misunderstandings that can emerge from the inability of people from different cultures to read each other's intrinsic cultural elements are an additional source of contention in the context of preceptorship relationships (Rosinski, 2003). This is a crucial point, given the cultural heterogeneity of workers in Saudi Arabia's health sector, due to its historic reliance on immigrant labour.

Daloz (1986) describes preceptors as translators of the environment as they help preceptees understand the culture in which they work. Invariably, the workplace is characterised by

overlaying cultures which relate to broader national, societal and religious cultures that enmesh with organisational cultures. Effective communication is vital to the success of care in the ICU (Gauntlett and Laws, 2008) and skilled communication is one of the standards for establishing and sustaining healthy work environments. Nurses must be as proficient in communication skills as they are with clinical skills (The American Association of Critical-care Nurses, 2005) but communication issues can arise during preceptorships because of cultural and language differences between the preceptor and preceptee (Jirwe, et al., 2006). In addition to potential communication problems due to language difficulties, there is also the issue of how non-verbal communication varies depending on cultural background (Anderson and Wang, 2009). For example, in Muslim culture, touch between individuals of the opposite sex is generally considered inappropriate (Feghali, 1997).

The process of allocating preceptees to preceptors is influenced to a considerable extent by societal and demographic factors. Although compatibility within preceptorship relationships is not guaranteed by this (Johnson-Bailey, 2012), Gonzáles-Figueroa and Young (2005) argue that preceptees prefer to be precepted by someone of the same ethnicity. Moreover, Campbell and Campbell's (2007) US study found that preceptees matched with preceptors of similar ethnicity were more satisfied and successful, resulting in better group cohesion and preceptorship. In addition, male preceptors favour male preceptees, while female preceptors favour female preceptees as they both feel more comfortable working with a partner of their own gender (Kalbfleisch, 2000; Sands et al. 1991; Ragins, 1989; Kram and Isabella, 1985). Another cultural issue relevant to nursing preceptorship in Saudi Arabia is gender-segregated hospital care and nursing education (Falatah and Conway, 2019; Alluhidan et al., 2020). This means that female Saudi nurses may not be willing to nurse men (Almutairi, 2012; Tumulty, 2001; Hamdi and Al-Haidar, 1996). Given the potential challenges of these social structures, and their capacity to create power imbalances, preceptors must address such issues in the preceptorship process (Donetto, 2010).

Although the preceptorship system is intended to provide an opportunity for less experienced nurses to be guided through clinical decision-making when taking their first steps in the profession, several practical barriers exist to the successful implementation of preceptorship programmes in Saudi Arabia. The concepts of culture and power are

fundamental in framing social relations and the communication between preceptors and preceptees in the clinical environment.

1.4 Research Aim, Question and Objectives

This qualitative, ethnographic research aims to provide an in-depth understanding of current practice within the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship in an intensive care setting in Saudi Arabia. Specifically, this thesis explores the following research questions:

1. What are the individual, organisational and structural factors and processes that shape the relationship between the preceptor and preceptee?

2. What are the experiences of preceptors-preceptees relations, and what factors indicate successful preceptorship?

3. How does the relationship between preceptor and preceptees impact the perceived success of the preceptee?

The research objectives that underpin each of the abovementioned questions are as follows:

- To undertake an observation of the preceptorship relationship by recording field notes.
- To understand how a preceptorship relationship is conceptualised through semi-structured interviews of preceptors and preceptees.
- To understand how preceptorship relationships shape the development of preceptees by conducting pre- and post-observation interviews and fieldnotes.

1.5 Purpose of the Study

The nature of the preceptor-preceptee relationship has been studied in various country contexts as will be shown in Chapter 3. It is increasingly being studied in Saudi clinical settings, however, the majority of the emergent studies are quantitative (Al-Harbi et al., 2021; Alahmed et al., 2022; Baker and Alghamdi, 2020; Al-Arifi, 2021). How Saudi graduate nurses interact in the ICU with their preceptors is missing in the literature. Focusing on these dynamics can offer unique insights into the complex challenges, dynamic relationships and stressors NGNs face. This could guide the development of retention strategies to effectively retain nurses in ICUs and assist them in their professional development. In addition, the research outcome may inform the development of orientation programs for NGNs, improve their job satisfaction and retention, and enhance professional relationships in the intensive care setting. There is a need to understand how to improve the preceptorship experiences of Saudi NGNs in the ICU as it is integral to their professional training and transition to functioning ICU nurses, against the backdrop of the workforce challenges noted above. New studies can inform effective training programmes and strategies aimed at improving professional relations and the professional development of NGNs.

This requires a qualitative approach that can elicit nuanced and contextually sensitive understanding of these relations but thus far, the majority of studies in the literature are quantitative, except one. The present research attempts to add to the evidence base for the nature of preceptorship in Saudi Arabia and focuses on the qualitative experience of the relationship itself rather than the clinical competency outcomes from the process. In doing so, the research will provide valuable knowledge for nurses in Saudi Arabia hoping to understand the factors for forging successful preceptor-preceptee relationships. This knowledge can also support the development of NGN's thereby maximizing positive outcomes in the areas of delivering patient-centred care and developing good professional practice, while also minimizing negative occurrences such as communication challenges, medication errors, inadequate record keeping, improper documentation and the disregarding of risk management procedures.

Investigating current practice within the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptors can assist in pointing to areas where new nurses in Saudi require support, education and training to perform their roles independently. Thus,

this study will provide knowledge to inform the practical decisions of nurse educators and nurse administrators about NGN preparation and role transition support in Saudi Arabia. It is hoped that the findings of this study will inform the Ministry of Health (MOH), the Ministry of Higher Education (MOHE) and multicultural healthcare systems about the status and challenges of preceptorships, therefore leading to improvements in the preceptor–preceptee relationship. By exploring the individual experiences of preceptors and preceptees in clinical settings, these conclusions can also highlight the factors contributing to positive-preceptorship experiences, especially as the healthcare workforce continues to become more internationally mobile.

Although there is extensive research about the preceptor-preceptee relationship (Staykova et al., 2013; Windey et al., 2015; Vernon, 2017), these are primarily situated within Western cultures and the impact of a multicultural workforce has not been addressed. The societal and cultural approach to nursing varies from country to country, and the specific nature of the culture and social norms in Saudi Arabia do not easily fit with Western solutions. The number of immigrant nurses in healthcare settings might also impact preceptorship in the Saudi nursing profession, as differences in language and culture might affect the preceptor–preceptee relationship (Aldossary et al., 2008). Therefore, obtaining a better understanding of the preceptor–preceptee relationship in Saudi Arabia will help to ensure that solutions derived from the findings are culturally appropriate, nuanced, effective and acceptable. It can also promote a more adapted focus on the Saudisation policy, which can assist in making amendments where necessary to improve its effectiveness.

Another significance of this study lies in the pioneering nature of its approach, where service consumers (preceptees) and providers (preceptors) were each invited to express their perceptions of the preceptorship relationship. I believe that helpful insights could emerge from exploring preceptorship practices in Saudi Arabia through the perceptions of these NGNs and their preceptors. The insights generated from this research has broader implications beyond Saudi Arabia, as the world becomes increasingly characterised by an internationally mobile workforce where multicultural working has become commonplace. The methodological focus on hermeneutics in such a study on the preceptor-preceptee relationship provides a way to see beyond the known empirical data to understand their lived experiences in context. In addition, this is the first study to undertake an ethnographic

study using fieldwork observations to explore, first-hand, the nature of the relationship between NGNs and their preceptors during their period of preceptorship in the context of one government hospital in Saudi Arabia. Such research has been conducted in other parts of the world, such as Taiwan, Sweden and Ghana. It is also the first study to examine the interplay between culture and social attitudes on the newly-qualified graduate nurses-preceptors relationship during their preceptorship in ICUs.

This study is particularly relevant at this time because of the rapidity of change that is occurring in Saudi Arabia including the out-migration of foreign workers. This rapid change has many potential consequences for education, recruitment and importantly the retention of Saudi nurses. There are concerns that although the number of nursing graduates has increased recently, a shortfall of job vacancies in Saudi health services does not match the number of people graduating (Al-Hanawi et al., 2019). In addition, the retention of Saudi nurses appears to be an issue of concern (Al-Hanawi et al., 2019). An understanding of the experience of Saudi nurses may provide an insight into how the situation might be better managed.

1.6 Thesis Structure

This thesis has been organised into seven chapters, as follows:

Chapter Two, Background; describes relevant aspects of nursing in Saudi Arabia. It also provides an overview of the demographic characteristics of nurses in the country. This Chapter presents an overview of what is known about the history of nursing in the Kingdom to contextualise this study and examines contemporary issues that have informed the conduct of this research.

Chapter Three, Literature Review; will critically analyse the research evidence in the field of nursing preceptorship, which has been conducted in the area of preceptorship relationships to identify any knowledge gaps at the end. This Chapter establishes how the present study adds to the body of knowledge relating to preceptorship.

Chapter Four, Methodology; provides a comprehensive overview of the methodological approach to study design. It presents in detail the methodological framework which includes the research epistemology, ontology, design, research setting, data collection methods, sampling strategy and ethical considerations.

Chapter Five, Research Findings; this chapter specifically presents the themes and sub-themes that emerged from the observation field notes and interviews. The findings are explored and supported by selected quotations from the interviews, which illustrate the study participants' views regarding the preceptorship relationship. In this chapter, a detailed overview of the demographic characteristics of the study participants is also provided.

Chapter Six, Discussion; presents and discusses the study findings in relation to the research questions and existing studies in the literature. At the end of this chapter, the implications of this research are discussed. Recommendations are specifically made regarding the Saudi nursing workforce.

Chapter Seven, Conclusion; provides a summary of the research findings and discusses the contributions of the present study to the existing body of knowledge. It also discusses the limitations of the study in addition to its strengths. The chapter further offers an introspective reflection of the research process and the overarching experience of a PhD journey.

Chapter 2: Culture, status and inequalities: Understanding nursing education and practice in the Saudi Arabia context

Preceptorships and how they are experienced and positioned within organisations, are shaped by wider societal processes including culture (Pere et al., 2022). Thus, this chapter begins with an overview of the Saudi Arabian context, focusing on its economic and population characteristics, as well as the Kingdom's trajectory of development. It subsequently presents an overview of Saudi culture and society, after which diversity and social stratification in the country are discussed. In this study, Geertz's (1973) definition of culture is adopted. Geertz (1973) defined culture as "a system of inherited conceptions expressed in symbolic forms by means of which men communicate, perpetuate and develop their knowledge about and attitudes toward life" (p.23). This chapter begins by examining the societal trends and relationships that impinge upon relations within the Saudi healthcare system. Following this, it explores processes that are relevant for understanding the development of the nursing workforce, after which preceptor-preceptee relations are explored. These relations are conceptualised within the context of inequalities, access of women and non-Saudis to the labour market, and the healthcare system in particular. This focus is important because it illustrates the multiple workforce complexities as regards development and retention.

2.1 Overview of Saudi Arabia

The Kingdom of Saudi Arabia (KSA) is a relatively young country unified by King Abdulaziz Al Saud, the founder of the country, in 1932 (Mufti, 2000). The Kingdom is a wholly Muslim country. KSA is located in the Middle East in the furthermost part of southwestern Asia and is one of the largest countries in the region, occupying about 2,218,000 square kilometres (Ministry of Economy and Planning (MOEP), 2013). The country includes 13 separate administration areas, with multiple emirates and governorates (MOEP, 2013), as shown in Figure 1.

FIGURE 1: COUNTRY MAP OF SAUDI ARABIA AND ITS NEIGHBOURING STATES

KSA has approximately 35.8 million inhabitants (United Nations Population Fund (UNFPA), 2022). A significant percentage of the nation's inhabitants are immigrants in search of economic opportunities and make up 38.3% of the total Saudi population (United Nations (UN), 2019). In contrast to most Western nations, Saudi Arabia has a young population with 36.7% of citizens represented by the 15-34 age group (General Authority for Statistics (GASTAT), 2020). Those below 15 years of age constitute 24% of the population (UNFPA, 2022). In 2021, the population increased by approximately 1.62 % (UN, 2019).

The economic environment in the KSA has been shaped by a highly formalised system of planning (Cordesman, 2003). Meanwhile, the main basis of the economy is oil, and in recent years intense efforts have been made to increase diversification in a bid to make the economy less dependent on natural resources (MOEP, 2013; Saudi Arabia Information Resource, 2013). The discovery of oil in Saudi Arabia was made by a US firm in 1938, and

this has since driven the country's economic development and political influence. The KSA has the largest economy in the Middle East and Arab world (MOEP, 2013). In 2021, Saudi Arabia was the second largest contributor of oil in the world at 10 million barrels per day, representing approximately 11% of total petroleum liquids production globally (OPEC, 2022). In 2020, it was the largest crude exporter and held 15% of oil reserves in the world (OPEC, 2022). According to the World Bank (2020), the oil and gas sector accounts for 70% of the country's export earnings and 50% of its gross domestic product. The development of oil resources has enabled the KSA to develop its economy and living standards (Mufti, 2000).

The KSA is undergoing a significant national transformation through a reform programme known as Saudi Vision 2030. The overarching goal of the programme is to reduce economic dependence on the oil sector and foreign labour, modernise and professionalise government institutions, and revitalise private investment. In the health sector, this translates into a system-wide transformation involving corporatisation, expansion of the health care system, and improved efficiency, focusing on value-based healthcare. The reforms form part of policies to diversify away from the oil sector and are in response to increasing demands on the Saudi healthcare system that arise from a population that is growing as well as rising expectations of improved healthcare for all citizens (Al-Hanawi et al., 2019). The population of the KSA is expected to rise from its current level of 34.8 million, adding five million by 2025 and reaching 54.7 million by 2050 (Alluhidan et al., 2020).

2.2 Saudi Culture and Society

Saudi Arabian traditional culture is similar to that of its neighbouring countries, yet it retains its unique character and style (Alquwez et al., 2018). Many factors have impacted and shaped the lifestyle of the Saudi people, including politics and geography. Restrictions on foreigners entering the country, strong tribal and family bonds, and strict adherence to religion have made the KSA an insular country regarding cross-cultural interaction, except in the case of its Gulf Cooperation Council (GCC) neighbours (Wheeler, 2020; Long, 2005; Vogel, 2000). The resultant effect has also been cultural conservatism in Saudi society, particularly in Riyadh due to its geographic location in the Najd region where Wahhabism, a

Sunni fundamentalist movement, was first formally expressed (Wheeler, 2020). With one third of the Saudi population living in Riyadh, Islamic conservatism plays a role in shaping public culture in the area of dress, business ethics, amongst others (Wheeler, 2020).

The practices of Islam fundamentally shape the daily activities of Saudi citizens and their social perspectives, which follow Islamic principles (Wheeler, 2020). Thus, Saudi citizens' lives involve moral duties such as almsgiving (*zakat*), principles such as strict self-discipline, and knowledge of the Qur'an which are all shaped by the scientific, academic, physical, and spiritual understanding that underpins Islam (Hamidaddin, 2019). In the healthcare setting, Islam influences beliefs about predestination and life after death, which play a role for patients who are coping with the diagnosis of a terminal disease (Al-Shahri, 2002). Further, in reflection of their faith, dying patients might want to face the Holy Mosque in Makkah thus, a patient's bed might be moved in this direction, to support this desire. For terminally ill patients, chapters of the Qur'an may be recited by their bedside (Al-Shari, 2002).

Ayoob and Kosebalaban (2009), Al-Shahri (2002), Long (2005), and Aldossary et al. (2008) have also described how Saudi culture is influenced by economic standing, educational attainment and environmental conditions. As Al-Shaikh (2007) emphasised, the infrastructure of Islamic principles has underpinned all socio-economic changes that have taken place in the KSA. One commonly finds that Saudis have a strong sense of their moral code and the righteousness of their faith (Hamidaddin, 2019). This is reinforced by the education system and the country's laws.

A crucial foundation of Saudi society is the family. Al-Khraif et al. (2020) and Mebrouk (2008) have described how family bonds are regulated by principles of conduct and ethical norms such as benevolence, integrity, obedience, reverence, sympathy, compassion, loyalty, and honesty. A visit to grandparents and other elders within the extended family at least once a week, typically on a Friday, is often considered requisite. Elderly people are usually helped by younger relatives and are shown significant respect. When dealing with the elderly in healthcare settings, professionals are encouraged to adopt a humble, patient, soft-spoken and gentle approach (Al-Shahri, 2002). As Rawas et al. (2012) have explained, care provision and homemaking are crucial societal roles traditionally assigned to Saudi females and thus, women are often confined to the home. Nevertheless, women are

assuming an increasingly essential role in wider Saudi society (Al Alhareth et al., 2015). Some women in sectors such as banking, the media, higher education, schools and medical facilities are afforded the same employment rights as males (Wheeler, 2020; Metcalfe, 2011).

In recent years women's rights have been expanded, giving women a foothold in areas where males traditionally had an advantage. Al Alhareth et al. (2015) reported that Saudi females were given the right to vote, run for municipal elections, and stand for the Shoura Council, which is the Consultative Assembly of Saudi Arabia, in September 2011. In addition, since 2018, women are permitted to drive. Before 2018, women were required to travel to school and places of employment accompanied by a male guardian or chauffeur (Nassir et al., 2019). The ban on women driving in 1957 led many Saudi families to employ Asian chauffeurs on work visas (Kay, 2015).

The increasing liberalisation of women's position, especially since 2017, has influenced the Saudisation process in health. The number of female Saudi nurses have increased from 9% in 1997 to 37% in 2016 and 38% in 2018 following an increase in funding to support women's education (Alsadaan et al., 2021). While there has been an increase in the number of Saudi female nurses, overall, there is a shortage of Saudi nurses. Low levels of enrolment in nursing courses, poor working environments and a negative image of the nursing profession underpins difficulties in recruiting nationals to undertake nursing education programs (Alsadaan et al., 2021). Education programs also lack the capacity to train nurses at high levels so that NGNs who are absorbed into the labour market have sub-par clinical skills which is not conducive to remaining in the profession for the long-term (Alluhidan et al., 2020). Consequently, between 60-70% of nurses in Saudi Arabia are immigrants (Alsadaan et al., 2021).

2.3 Diversity and Social Stratification

The Saudi population is characterised by a high degree of cultural homogeneity and a high degree of social inequality. There is a general societal acceptance that power and wealth are distributed unequally, with many seeing it as an inevitable fact of Saudi Arabian society (Al-Rajhi et al., 2012). A distinct class system is particularly obvious between Saudi citizens and

foreign workers. Saudi Arabia has been described as a country without a national working class as the majority of the manual and domestic labour force is made up of foreigners (Achoui, 2009). In addition, 87.2% Saudi families have a personal maid and/or driver (Arab News, 2014), usually of Asian or South Asian descent. Such migrants tend to comprise the lowest social class. Many arrive from India, Bangladesh, Pakistan, the Philippines, Egypt, Palestine and Sri Lanka (Arab News, 2014).

In the KSA, nursing is stereotyped as low class due to its association with foreign nationals, who constitute approximately 62% of the nurses in the country (MOH, 2018). Saudis typically view foreign nurses as comparable to the domestic servants who are familiar in middle-class and upper-class homes, represented by 44.91% and 11.01% of the population respectively (Al-Omar et al., 2018). These servants perform household tasks, such as cleaning, childcare, care of the elderly, and driving (Parrenas, 2021). They are recruited into the country in the same way as foreign nurses (Parrenas, 2021).

There are also subtle divisions between Saudi citizens themselves, sometimes based on tribal affiliations, levels of education, religious affiliation (i.e. Sunni or Shi'a) and location (i.e. rural or urban). The majority of Saudi Muslims are Sunni, with the Shi'a minority which is concentrated mainly in the Eastern province of the Kingdom (Caruso, 2021) estimated at between 10 and 15% of the population (Pew Research, 2018). Most Saudi nationals generally belong to the middle or upper classes. Members of the elite class are often distinguishable by conspicuous displays of wealth (such as owning luxury cars) or by their family name. They may be more religious, educated, wealthy or hold positions of power in industries such as oil.

There is awareness that Saudi Shi'as are underrepresented in government and in the healthcare sector (Constantin, 2016), however, statistics concerning their representation in these sectors are missing from the literature. There are no Shi'a Saudis in cabinet but there is record of one Shi'a being appointed as ambassador to Iran, which is a Shia-majority country (Neo, 2020). Further, Neo (2020) reports that certain government branches prohibit the employment of Shi'a citizens. Out of 150 members of the Shura legislative Council, only four representatives are Shi'a, thus, they are denied equal access to avenues of legislative, judicial and executive power (Neo, 2020). Shi'as live mainly in the Eastern Province, the

heartland of Saudi Arabia's petroleum industry. Shiite Muslim minorities have a history of being consistently stigmatised and treated as second-class citizens (Syed and Ali, 2021). As a result, the Shi'a are near the low end of the social ladder concerning the distribution of development-related resources and access to power (Syed and Ali, 2021). It is important to however note that the status of the Shi'a is in flux; they have begun to be drawn into positions of responsibility in government service and, since the 1980s, have received an increased share of government funding for development but they are still underrepresented (Khan, 2019). While the Shi'a have experienced social mobility, taking up senior positions in oil companies that are active in the Eastern Province, they have not been allowed to rise to the top in business, diplomacy or politics, because of the glass ceiling of sectarianism and distrust (Khan, 2019). Employment discrimination against the Shi'a minority is prevalent within the public sector of modern Saudi society (Khan, 2019). For example, Shi'as are denied state employment in positions of seniority within the public sector (Clarkson, 2014). Clarkson (2014) highlights how Shi'a citizens face perpetual discrimination in the workplace and are not considered for employment in certain public sector jobs, routinely passed over for promotions.

Since 2018, Saudi Arabian Crown Prince Mohammed bin Salman has launched a series of major social reforms which seek to target some of these issues (Beling 2019). Mohammed bin Salman's program of forced-pace modernisation—known as Vision 2030—goes further than just social reforms. He promises a return to "moderate Islam," one that would also promote equality and coexistence rather than the sectarianism, hatred, and division that have long hampered social cohesion in Saudi Arabia and the wider Middle East over the last decades (Beling, 2019).

2.4 Cultural and Gender Issues

Issues around gender in Saudi Arabian culture are complex and have been changing recently, in line with lifestyle transformations and modern technology (Eum, 2019). In Saudi Arabia, social changes begin from the top whereby formal decrees create new standards of behaviour (Pilotti et al., 2021). For example, the decree issued in 2017 permitted women to drive while a decree issued in 2019 permitted women over the age of 21 to travel without the permission of a male guardian. These decrees specifically target norms and behaviours,

however, they are also influenced by changing moods within society. Pilotti et al. (2021) explain these changing moods by noting that "as the distance between outside models of societal norms, mostly of Western import, and traditional standards increases, the pressure to shift away from habits and values previously endorsed also increases" (p.342). While the decree issued in 2017 ushered in changing gender norms, these norms have also been influenced by the reshaping of the economy, which is increasingly being integrated into the global sphere (Le Renard, 2014). Women can thus now pursue jobs and professions that they hitherto could not and they have greater mobility and independence (Pilotti et al., 2021).

Gender difference emanates from Saudi culture and socialisation, which encourages the segregation of women and men in the majority of social settings, including workplaces, leisure facilities, mosques and schools (Al-Rasheed, 2020). There are many female-only and men-only buildings in Saudi Arabia which is the case for most public facilities such as schools and universities. Banks and government institutions have separate entrances for men and women; some restaurants are segregated, and there are also "families only" spaces (such as malls) that exclude single males.

More so than before, women are involved in fields such as medicine, nursing and education (Al-Rasheed, 2020). In the field of education, religious academics typically stipulate the requirement for females and males to be segregated, although they do not challenge female work and education (Alotaibi, 2021). Notably, Islamic teachings do not prescribe any specific restrictions on the education or employment of women (Alotaibi, 2021). Further, the legislation affords women and men equal opportunities in the workplace (MOEP, 2013). However, some Saudi families prefer for women to be separated from men in this setting and this has obvious implications for the Saudi nursing workforce within which women participate (Alotaibi, 2021).

While Saudi women have acquired greater access to all levels of education, there are only a few job opportunities in Saudi Arabia that are gender-segregated and thus, encourage their inclusion (van Geel, 2018). Consequently, their participation in the workforce has been relatively low but it is improving with women now constituting 33% of the KSA's labour force (Tamayo et al., 2021). Women's employment rate has also been increasing steadily

from 68% in 2018 to 76% in 2020 (Tamayo et al., 2021). The female unemployment rate has also decreased from 32% to 24% during this time period (Tamayo et al., 2021). Saudi society has struggled to accept working women, but this has also started to change recently (Elmorshedy et al., 2020; Alsadaan et al., 2021). There is a prevailing cultural assumption that women's fundamental character and innate nature will be undermined when they participate in work traditionally reserved for men. Proponents of this view, such as the religious academic Ibinbaz (1985), suggest that this will culminate in the fall and subjugation of women. Such ideas and thoughts have led many Saudi parents and some Saudi women to consider nursing an unsuitable career, particularly concerning aspects of nursing that are quite intimate. Many Saudis prefer, and even insist on, single-gender nursing care (Alsadaan et al., 2021). In Saudi Arabian healthcare, single-gender care is highly preferred; it is not socially or culturally acceptable for women to care for male patients or work with male staff (Alsadaan et al., 2021; Elmorshedy et al., 2020; Falatah and Conway, 2019). This may have slowed down the Saudisation of nursing and promoted the recruitment of an increasing number of immigrants.

There is also a broad gender separation throughout Saudi Arabian society that influences and determines different ideas of privacy and space. According to the religiously-based view, most Saudi Muslim women choose to wear a head or hair covering whenever in the presence of a man that is 'non-mahram' (of whom marriage is permissible) (Alharethi, 2019). It is also a cultural norm for some women to veil their face – usually with an abaya (long robe) and a niqab (hair and face veil). This means that many Saudi women are veiled whenever in public, as this is a domain where they mix with men. The tradition has been changing recently as more women are choosing to reveal their faces or not to wear a hijab (Anishchenkova, 2020). This is especially the case with younger women in cities (Anishchenkova, 2020). It is important to note that these rules of gender separation are not strict laws but rather social norms. While these social norms prevail and govern Saudi society, there are notable contexts where they are less evident such as in hospitals where staff are culturally heterogeneous. Non-Saudis are not usually held to the same standards and generally have more ability to mix across the genders. For example, male foreign domestic workers may be allowed in some family-only spaces (Anishchenkova, 2020). Female immigrant nurses may also choose not to wear the abaya, niqab or hijab. However,

inter-gender exchanges are expected to be kept to a minimum in all situations out of modesty.

Whether female or male, most nurses in Saudi Arabia face a significant challenge in the form of gender segregation (Meijer, 2010). El-Gilany and Al- Wehady (2001) conducted a quantitative study of 243 nurses working in Saudi hospitals to assess the degree of satisfaction of Saudi female nurses with their working conditions and found that the majority of female nurses preferred not to provide care for male patients. In a later cross-sectional survey assessing the satisfaction of Saudi nurses in the work environment, it was argued that mixed-gender staffing and caring for the opposite gender had caused dissatisfaction amongst approximately 40% of Saudi nurses (Almalki et al., 2012). However, anecdotal evidence suggests Saudi nurses are given the option to choose to care for the opposite gender, and if there is a lack of nurses to complete tasks, immigrant nurses cover the shortage. Further, in high dependency areas such as intensive care and emergency departments, gender segregation does not occur to the same extent.

Existing studies that investigate the issue of gender balance in the nursing workforce in Saudi Arabia are sparse. However, with gender segregation in Saudi hospitals, combined with the cultural needs of Saudis, gender balance in the nursing workforce is a significant challenge for healthcare providers in the country. Globally, nursing remains a female-dominated industry, with male nurses accounting for approximately 11% of the workforce (Cottingham, 2019). Religion and culture in Saudi Arabia are intertwined. Thus, when dealing with such sensitive issues, religion cannot be ignored. Saudi Arabia is the birthplace of Islam, and original, traditional Islamic values still shape Saudi culture (Littlewood and Yousuf, 2000; Al-Shahri, 2002; Long, 2005).

2.5 The Culture of the Nursing workforce in Saudi Arabia

There is broad agreement that culture influences effective cooperation between nurses and between nurses and patients (Cruz et al., 2017). One of the major issues relating to Arab Muslims in hospitals is understanding the cultural context of providing them with nursing care (Rassool, 2015). Almutairi et al. (2015) have pointed out that understanding culturally-

specific nursing care increases with nursing expertise. Leininger and MacFarland (2006) have defined cultural care as multiple aspects of culture that assist an individual or group to improve or deal with their health condition, including illness. New Saudi graduate nurses are hired in an attempt to address the shortage of experienced nurses and boost the number of nurses who can deliver culturally competent care for Arab Muslims (Alsadaan et al., 2021; Aldossary et al., 2008; Alamri et al., 2006). Cruz et al. (2017), Saleh et al. (2014), Aldossary et al. (2008) and Alamri et al. (2006) suggest that care delivery is more efficient if nurses and patients share the same culture, gender and language. A qualitative study of cardiovascular patients in a Saudi hospital found that patients who were handled by non-Arabic-speaking nurses had higher stress and anxiety than those handled by Arabic-speaking nurses, as their needs were not understood (Almualem et al., 2021).

It is argued that culture is an essential determinant of contextualisation. Culture is shaped by factors including but not limited to religion, environmental factors, race and economic status (Al-Shahri, 2002). In Saudi Arabia, Islam is the main influence on Saudi culture although other factors play a role. Islamic teachings require that permission is gained from inhabitants before entering a room, thus in the healthcare setting, a patient may feel disrespected if a healthcare professional who is unaware of this cultural requirement, does not observe these cultural teachings (Saleh et al., 2014; Al-Shahri, 2002; Halligan, 2006). In terms of the behaviours, values and beliefs that are shared between Saudis, laughing in front of patients is understood as a sign of disrespect or may be perceived as a lack of empathy (Al-Shahri, 2002). It is therefore discouraged in the healthcare setting and professionals must take cues about humour from the patient (Saleh et al., 2014; Al-Shahri, 2002). Therefore, in the patient/nurse relationship, Saudi nationals might be better able to understand what is required and pick up on non-verbal cues than nurses from other nationalities (Aldossary et al., 2008).

Within the workplace, nurses speak English because it is the official language of healthcare professionals. However, Arabic is the predominant patient language (Mahran and Nagshabandi, 2012), meaning that there are problems with communication. Crucially, a large number of nurses, both Saudi and immigrant, do not speak English as a native language, and many immigrant nurses are not fluent in Arabic either (Almutairi et al., 2015). Whilst these language problems create a clear barrier to communication between patients

and nurses and nurses and their trainers, there are also other potential communication issues related to how non-verbal communication can vary between different cultural backgrounds (Almaki et al., 2011). For example, hand and arm gestures, touch and eye contact can be culture-specific. Whereas eye contact is considered appropriate by people in Western culture as a sign of being attentive and honest, in Middle Eastern cultures, it can be deemed disrespectful, rude or a sign of sexual interest (Almutairi et al., 2015).

As a result of the diverse nature of the workforce, all nurses need to develop essential knowledge, abilities and a keen sensitivity to their workplace, including an awareness of linguistic and religious sensitivities related to gender and normative practice (Burnard and Gill, 2009). Since most of Saudi Arabia's population are Muslim and practise an Islamic way of life (Al-Shahri, 2002), immigrant nurses need to appreciate the significance of Islam for Saudis. In addition, they need to understand local constructions of honour, the ties of the extended family and how women are protected within the culture (Mahran and Nagshabandi, 2012; Almutairi et al., 2015).

In keeping with such requirements, nurses who come to Saudi Arabia from other countries to work in hospitals are given orientation training to help them gain basic knowledge of Saudi family dynamics, language, and culture (Alamri et al., 2006; Almutairi et al., 2015). In addition, a wide range of strategies is employed to enable them to acquire skills related to language, such as participation in Arabic language classes. This helps to mitigate the extent to which language creates obstacles to care within the patient/nurse relationship and the colleague relationship. It also facilitates a better understanding of the cultural aspects that must be considered when working in the Saudi context (Almutairi et al., 2015). Language barriers have been shown to be a source of anxiety for non-native health care providers in Saudi hospitals in a qualitative study by Almualem et al. (2021). This study found that language education is vital for mitigating against miscommunication which can cause negative outcomes such as increased stress and anxiety to the patient. Albagawi (2014) found that nurses who had not participated in specialist language courses perceived greater barriers to communication than those who had attended such courses. Alshammari et al. (2022) in their qualitative study on the other hand, reported that Saudi nurses effectively overcome language barriers, via the use of alternative communication strategies such as

sign-language or by using an interpreter. The scholars made similar findings in a systematic literature review (Alshammari et al., 2019).

The diversity of the profile of the professional nursing group, in terms of culture, religious affiliation, ethnicity and education, has led to complexities in nurse identity and the quality of care offered, thus making it harder for Saudi nurses to enter the professional setting. New, local nurses also struggle to work in this complex cultural and social environment. Furthermore, professional nursing practice in Saudi Arabia has been secular from its inception, based not only on the composition of its workforce but also on its structure and regulation (Tumulty, 2001). This did not change until the Saudisation policy was implemented to expand the Saudi influence on directing, running and legislating for the profession via the provision of education and training programmes and by filling posts with nationals (Al-Mahmoud et al., 2012).

2.6 The Saudisation Policy

The term Saudisation is defined in the literature as replacing the immigrant workforce in Saudi Arabia with suitable national workers (Al-Mahmoud et al., 2012; Madhi and Barrientos, 2003). Saudi Arabia has a long-standing policy of Saudisation which aims to increase the proportion of jobs in Saudi Arabia occupied by Saudi nationals. The Saudisation policy first emerged during the 1991 Gulf War as a government response to the shortage of nurses during this period (Aboul-Enein, 2002). This shortfall was mainly a result of the fact that 7 out of 10 nurses in Saudi Arabia were immigrants, and when they returned to their home countries, the nursing profession was severely affected (Al-Mahmoud et al., 2012).

The Saudisation policy, involving both the government and the private sector, was issued in 1992 by royal decree from the monarchy of Saudi Arabia. All workforce sectors would be subject to Saudisation, including nursing, to reduce reliance on the immigrant workforce and in response to the escalating salaries of immigrants (Tumulty, 2001). Saudisation also aims to reduce the unemployment rate of Saudi nationals by restricting the employment of foreign workers, reserving some jobs for Saudi citizens only, and creating new jobs for Saudis (Al-Mahmoud et al., 2012). However, annual targets for the number of Saudi citizens

filling positions have repeatedly not been met by the healthcare industry, which is the biggest employer covered by the policy. As nurses comprise the single biggest group of healthcare workers, the Ministry of Health's policy has focused mainly on Saudisation among this group (Al-Homayan et al., 2013).

The current target is for Saudi nationals to occupy 171,000 health sector jobs by 2027, increasing from 74,900 in 2017 and achieving more than 95% Saudisation in some areas such as dentistry (Saudi Gazette, 2018). However, the Saudi Commission for Health Specialties (SCHS) report only expects Saudi nationals to represent 12% of nurses by this period (Saudi Gazette, 2018). Nursing in Saudi Arabia is therefore expected to experience long-term recruitment difficulties compared with other health care specialities. There are however inconsistencies in the data because Alsadaan et al. (2021) report that the number of Saudi nurses has increased from 9% in 1997 to 37% in 2016 and 38% in 2018. Disparities in the data set may be the result of differing methodological approaches. Several research projects have nevertheless considered possible approaches to attracting and retaining Saudi nurses in greater numbers, in line with the drive towards Saudisation. The main recommendations involve improving access to nursing education, raising salaries, and creating better workplace conditions (Al-Mahmoud, 2013; Alghamdi, 2014; El Gilany and Al Wehady, 2001).

The shortage of Saudi nurses is largely a result of labour market shortages and high attrition rates within the profession. The literature suggests that the suboptimal generation of new nurses is largely due to inadequate training slots to become nurses (Alluhaidan et al., 2020). In part, because high-quality foreign-trained nurses have in the past been readily available, there has been little pressure or incentive for nursing schools in the Kingdom to expand their enrolment. Even among nurses of Saudi nationality, many seek government scholarships with return-of-service obligations to continue their studies abroad (SCFHS, 2018). As of 2018, 895 students were enrolled in nursing programs mainly in the USA, Canada, UK, or Australia (SCFHS, 2018). A substantial proportion of those who do train at home do not complete their studies. Once trained, many new nurses are not adequately supported to enter the labour market or to remain in it (Al-Mahmoud et al., 2012). During their careers, national and immigrant nurses have a high rate of exit from the profession in Saudi Arabia (Falatah and Salem, 2018). While measures differ, a recent review identified turnover rates

of between 17 and 60% per year, with registered Saudi nurses working for an average of around four years (Falatah and Salem, 2018).

This high turnover is driven by unfavourable working conditions and low social status (Falatah and Salem 2018; Almalki, 2011). The principal barrier to Saudisation in nursing is the negative perceptions of this profession amongst both Saudi nurses and the wider Saudi community (Al-Homayan et al., 2013; Al-Mahmoud et al., 2012). Studies in this area connect the perceptions of nursing held by Saudi nurses to religious, social and cultural beliefs and attitudes, a challenging working environment, limited flexibility to achieve an effective work-life balance, and the poor image of the profession (Al-Mahmoud et al., 2012; Miller-Rosser, 2006). In addition, the profession has a low social status in the country, is considered akin to domestic servitude (Alsadaan et al., 2021; Miller-Rosser et al., 2006). In a study by Gazazz (2009), interviews with Saudi female nurses revealed the pressures they face in social terms because of long and antisocial working hours and gender mixing in the workplace. There is a lack of respect for nurses on the part of Saudi society. This forms a barrier for young women in choosing nursing as a career. It has also led student nurses to leave their studies or get married due to family disapproval of nursing or a reluctance on the part of the family to tolerate women working antisocial hours.

Furthermore, the nurse's role has historically been viewed as an extension of the physician's role (Alsadaan et al., 2021). This perception may still exist today. However, despite the poor image of nursing, there are now large numbers of Saudis entering the profession as a result of ongoing policy reforms and more opportunities inspired by the Saudization programme (Alluhidan et al., 2020). Thus, the poor image is not preventing people from entering the profession; it is impacting whether they stay.

Previously there have been few Saudi nurses, including males, in the workforce, compared with immigrants, until recently when Saudi nationals started to join the profession in large numbers. Overall, 80% of nurses working in the KSA in 2018 were female (MOH, 2018). As Figure 2 shows, however, the proportion of male nurses among the minority that are Saudi nationals was much higher, at around 40%, compared with fewer than 10% among foreign nurses (MOH, 2018). A large number of men in nursing is a relatively unique phenomenon in Saudi Arabia. Although men are also increasingly joining the nursing profession in Western

countries (Martinez-Morato et al., 2021), the numbers are not as significant. There have been calls to encourage more men to enter the profession to provide more gender balance and widen the pool of talented candidates for recruitment. However, it is important not to lean on the recruitment of men as a solution to the profession's image being low status and unfriendly to family life, as these issues must be rectified for all participants. With the ongoing reforms, Saudi nursing has the opportunity to transform into a global model and leader in the region for a career path, which provides efficient, high-quality healthcare to every Saudi citizen.

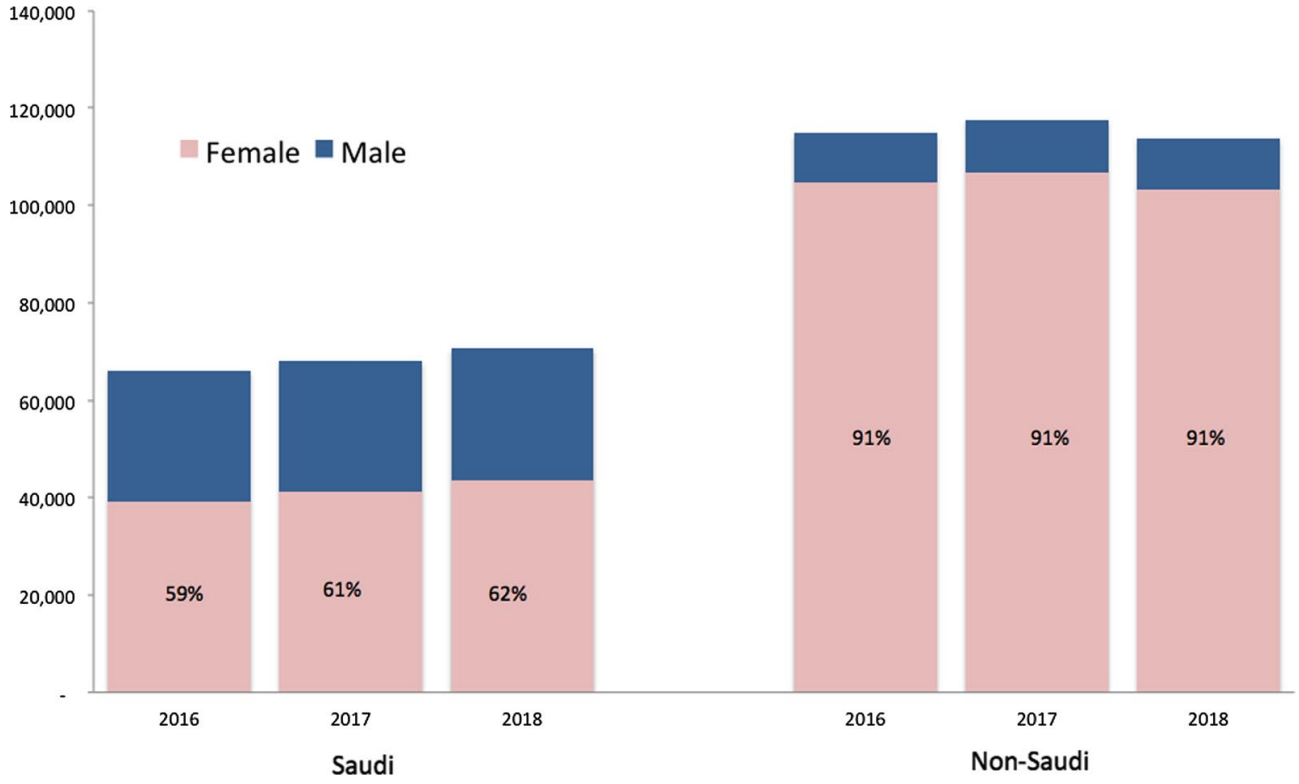

FIGURE 2: NUMBER OF NURSES IN THE KINGDOM OF SAUDI ARABIA, BY GENDER AND NATIONALITY 2016–2018 (MOH, 2018)

2.7 Healthcare System in Saudi Arabia

Reforms in the health sector have aimed to enhance the Saudi system of healthcare in response to the rising demand for health services among the population (Aldossary et al., 2008). This involved massive investment on the part of the government, developing healthcare provision that is free at the point of use for both Saudi citizens and others employed by public sector organisations. Meanwhile, privately employed workers generally receive sponsorship for their health costs from their employers. The budget for the Saudi health service comes from governmental budgets, mainly based on income generated by the oil and gas sector (Al Yousuf et al., 2002). In 2010, this accounted for 6.5% of the country's gross domestic product (Almalki et al., 2011).

The Ministry of Health (MOH) provides healthcare services to the government and public institutions, such as the Ministry of Defence, Ministry of the Interior, university teaching hospitals and the National Guard (Al Yousuf et al., 2002). It is estimated that the MOH provides approximately 60% of all healthcare, with the remainder provided through either private or different government organisations. More specifically, primary care facilities and hospitals are generally managed by private or other governmental providers, while the MOH has overall responsibility for services. These include prevention and curative treatment and rehabilitation, with healthcare offered via primary care facilities spread across the country (Aldossary et al., 2008).

The MOH in Saudi Arabia is the main government agency responsible for enacting health laws, regulations, policies and planning for health. In Saudi Arabia, there are 13 administrative regions, including 20 health regions, administered by general directors responsible directly to the Minister for Health (Al Yousuf et al., 2002; MOH, 2012). In each health region, the authority of the Directorate of Health Affairs is responsible for the operation and management of all hospitals, healthcare centres and human resources (MOH, 2012).

2.8 Nursing Education in Saudi Arabia

The 20th and 21st-century history of nursing education in Saudi Arabia includes separate initiatives led by the MOH and the Ministry of Higher Education (MOHE), which merged in

2008. In cooperation with the World Health Organisation (WHO), the MOH set up the first Health Institute Programme in 1958, launching modern nursing education and training in Saudi Arabia (Aldossary et al., 2008).

Nursing education in Saudi Arabia has evolved since the first year-long course was introduced by the MOH in 1960 which was for males only (Alhusaini, 2006; Al Thagafi, 2006). This was the first Health Institute program for Saudi nurses, and only a few nurses enrolled and graduated in 1961. Training was later extended to a three-year course open to both genders. Male and female students were separated throughout the program. Upon completion, students were awarded a Diploma in Nursing, which was the equivalent of a licensed practical nurse in the United States of America (Miller-Rosser et al., 2006; Phillips, 1989).

As socio-economic development occurred throughout Saudi Arabia, the government realised that the needs of the nursing workforce exceeded the supply of Saudi nurses. Thus, the first Health College was established under the supervision of the MOH in 1972 to meet the demand for qualified health professionals and nurses (Miller- Rosser et al., 2006; Tumulty, 2001). This was followed four years later by creating two female-only nurse education colleges at Jeddah's King Abdul-Aziz University and Riyadh's King Saud University. These were established by the Higher Education Ministry, and courses were provided first at the undergraduate level (Tumulty, 2001) and from 1987 onwards at the postgraduate level (Tumulty, 2001).

A Master of Science in nursing (MSN) programme was initiated in 1987 at King Saud University in Riyadh (Mebrouk, 2008; Tumulty, 2001). A PhD programme was established as a limited programme through cooperation between King Abdulaziz University and certain British universities in 1994 (Abu-Zinadah, 2004; Almalki et al., 2011), offering a limited number of places for holders of post-graduate degrees in Nursing (Abo-Zinadah, 2006). All of these postgraduate programmes were established for female students only. The nursing education system in Saudi Arabia is totally segregated by gender, as is the general education system; however, there is interaction between males and females in the work environment.

By 1990, the MOH had established multiple health institutes which offered nurse education programmes (El-Sanabary, 1993). These were gender-segregated and 17 were initiated for women and 16 for men (El-Sanabary, 1993). In 1992, junior colleges were set up to improve Saudi nurses' educational standards and teach high school graduates (Abu-Zinadah, 2006; Alhusaini, 2006). Participants of such programmes received a diploma in nursing and were classified as technical nurses (Saudi Commission for Health Specialties, 2014).

The MOH used to graduate nurses through its health institutes and junior colleges (Aldossary et al., 2008). However, about ten years later, in 2006, the government, represented by the Ministry of Higher Education, launched a major revolution in public higher education in Saudi Arabia. It established 18 new universities around the country, adding to the seven existing universities (Ministry of Higher Education, 2014). All the universities were equipped with health sciences and/or nursing schools. Only Saudis are accepted in these educational programmes. According to the MOH (2012), in the 2012–13 academic year, student nurses in various universities numbered 3,961. Nearly 99% were of Saudi nationality, 86% (n=3397) of which were Saudi females, while Saudi males represented 13% (n=525) and foreigners 1% (MOH, 2012). In addition, the King Abdullah Overseas Scholarship Program was started at that time in order to fill the gap in academic and clinical places and to enhance educational outcomes. This has led to a situation where the government provides support to large numbers of Saudi citizens to study abroad, with over 150,000 doing so across 25 countries in 2014 (MOH, 2014).

To obtain a Bachelor's degree in nursing in Saudi Arabia, student nurses have to complete a five-year programme, compared to only three years in many other developed countries (Almalki et al., 2011). Four years are spent studying at university, with clinical placements starting in the second year. The final year, which includes training and rotations in the hospital, is called the internship year. It is important to note that there are variations between mentorship, internship and preceptorship. Mentorship is a programme for nursing students during their BSc nursing study while an Internship constitutes a compulsory year for nursing students prior to graduation. During an Internship, students are rotated in a unit for a month. Preceptorship or residency, on the other hand, is for NGNs who choose to work in speciality areas such as ICU, CCU or haemodialysis.

Clinical placement of nursing students starts in the second semester of their second year at the university. In clinical settings, mentorship is practised and follows a procedure in which RNs are identified as mentors and assist in student nurses' learning. First, the head nurse of the hospital staff is consulted by the college staff about the placement of students for two days a week (7 hours per day) for two semesters. The head nurse then assigns the student to mentors who are changed every week. Given the limited availability and significant time commitment of the mentors, nurses working in the system do not believe retaining the same mentor for the entire mentorship period is feasible (Alluhidan et al., 2020).

Upon completion of the program, graduates will be called nursing intern students, and they will spend a year of internship rotating through different units in several different hospitals. Each rotating group comprises three nursing intern students who will spend two weeks in each ward. In addition, nursing intern students may focus on simple routine work in each unit, such as participation in patient care and procedures such as those related to blood culture, blood transfusion monitoring, or administration of antibiotic medications. These rotations mean that nursing intern students spend a total of one month in both adult surgical and adult medical units when both male and female nursing units are considered. Moreover, nursing intern students spend two weeks in the ICU, which is not gendered, and stay for a total of one month in both paediatric wards, which are non-gendered.

2.9 The Residency or Preceptorship Programs

To increase the standard of nursing in Saudi Arabia and concurrently facilitate the Saudisation process which attempts to introduce more newly-qualified Saudi nurses, it is essential to provide adequate clinical training. In part, due to the fact that high-quality foreign-trained nurses are readily available, there has been little incentive for local nursing schools to expand their capacity for training Saudi nurses (Alluhidan et al., 2020). The majority of advanced nurses and speciality care nursing positions are taken up by foreign nurses in areas such as ICUs, oncology units and operating rooms (Alluhidan et al., 2020).

Training must target the transition between the largely academic education offered by diploma and BSc courses and the demanding clinical environment of a hospital. The increase

in the complexity of nursing means that the transition to the high-stakes environment of hospital nursing is more complicated than it has ever been, and some studies have demonstrated that the first few months of nursing practice are the most stressful time in a nurse's career (Watt and Goh, 2003; Duchscher, 2008; Fink et al., 2008). During this period, a nurse not only has to get to grips with the practical application of knowledge gained during their education but also become comfortable within the hospital's multidisciplinary team, adapt to the pressure of the workload and continue to learn new skills which have not been touched on in their training (Cunnington and Callejah, 2018).

In order to provide this transition, the preceptorship model used in many other countries such as Taiwan and Ghana is employed in Saudi Arabia (Bukhari and Rogers, 2012). The nursing residency programs in Saudi Arabia are six to 12 months in duration. A preceptor is expected to help the NGN bridge the gap between the classroom and the clinical setting where they are employed following graduation (Alfahd, 2020). The preceptor should be an experienced registered nurse who desires to teach younger nurses a variety of skills. The preceptor role may vary from setting to setting, but in general, it involves the creation of learning opportunities for NGN preceptees to enable on-the-job learning, which remains safe and supervised. For example, in some scenarios, the preceptee might observe a difficult procedure before attempting it themselves. In contrast, in others, the preceptor may allow the preceptee to try a procedure and make controlled mistakes if necessary to allow for learning from experience (Alfahd, 2020). Preceptors promote a workplace culture, support the graduates' professional growth, and supervise new nurses in all nursing activities. However, according to the literature, preceptors still need more comprehensive training to manage the orientation programs for NGNs effectively (Friedman et al., 2011, Rush et al., 2013**;** Marks-Maran, et al., 2013; Zigmont, 2015**;** Kimery, 2016).

Residency or preceptorship programs provide NGNs with guidance and support through mentoring and expanding their experience in managing complex and changing patient conditions, failure to rescue, and in numerous nursing speciality areas such as oncology, critical care, obstetrics and gynaecology, and hemodialysis (Alluhidan et al., 2020). Residency programs have been implemented in many practice settings, with acute care being the dominant setting where new graduates are working (Alluhidan et al., 2020). Also, residency programs vary by program components such as educational content and

approach, type of preceptorships, mentorships, and unit-specific orientation (Alluhidan et al., 2020). They also differ by program length and the number and type of clinical rotations (Rush et al., 2013).

The changes and improvements in patient management, both clinically and technologically, in intensive care nursing increase the need to adapt quickly, effectively and efficiently. This may cause additional pressure on the new graduate nurse, still grappling with the transition from student to the role of the registered nurse. The delivery of care in the ICU demands a team effort, and without the support and collaboration of the whole ICU team, little can be achieved (Vincent, 2006). Novice registered nurses in their transition to the professional role in the Intensive Care Unit (ICU) have a variety of experiences with patients, families, doctors and their preceptors. Casey et al. (2004) identified that the NGN might feel unaccepted by their preceptors and experience difficulty communicating, as a new team member, in an acute care setting. These experiences give rise to perceptions and feelings that may negatively impact NGN's professional development, job satisfaction, and retention. McKenna and Newton (2007) conducted research that involved 21 NGNs from four hospitals in Victoria, Australia. In this phenomenological study, it was recognised that NGNs felt a sense of belonging to a particular clinical setting after completing the new graduate program.

Benner, in 2001 put forward a model that described how new nurses adapt and familiarise themselves with the work environment and how they, eventually, grow to be professionals in their nursing field. The model illustrates that orientation is the key to incorporating new nurses into an innovative reality learning environment, and Benner (2001) theorised an unlimited time for five learning levels in this orientation. First, the new graduate pattern of recognition is focused on observing and learning from job situations and integrating it with the earlier acquired data in each real case to develop intuition, knowledge and skill acquisition (Gardner, 2013). Second, this level is characterised by more experience resulting in more self-confidence, but new graduates still rely on other nurses to assist them in some situations. Nurses can deal with conditions and cope well based on previous similar experiences (Tomey and Alligood, 2006). Third, advanced beginners are aware of long-term goals and show abstract, analytical and conscious thinking to demonstrate nursing activities. They can manage patient care effectively (Tomey and Alligood, 2006). Fourth, advanced

nurse employees have a comprehensive insight into the situations faced on the job and have learned what to be prepared for in other comparative conditions (Andersson and Edberg, 2010). Finally, the nurse has a physically powerful grasp of each situation and can function with high fluency, flexibility and proficiency (Tomey and Alligood, 2006). Benner's (2001) novice to expert theory provides an important framework for preceptors and orientation program planners, to inform tailored programmes for NGNs that have the necessary instructions to support their transitional experience (Benner, 2001).

2.10 The Preceptor - Preceptee Relationship

Transition programs for new graduate nurses may be called internship, fellowship, preceptorship, mentorship, post-baccalaureate residency programs and/or residency programs. Regardless of the name, these programs have emerged as a mechanism to support new graduate nurses as they assume their professional roles within the hospital setting (Aldossary et al., 2008). Additionally, the preceptorship program targeted at new nurses with transient experience provides adequate support in occupational adjustment, building supportive relationships, decreasing work exhaustion, and empowering peer relationships (Hoffart et al., 2011). Therefore, an effective preceptorship program is a fundamental method for the healthcare organisation to determine and meet the new graduated nurses' learning needs and attain a valuable transition instance with a better quality of nursing practice. (Strauss et al., 2015; Kiel, 2012; Sorrentino, 2013).

There is evidence that the preceptorship experience in Saudi Arabia has faced some inadequacies in preparing Saudi nurses for clinical practice. Alboliteeh et al. (2018) found in their cross-sectional study of Saudi nurses who had undergone preceptorship that they did not feel well prepared to cope with complex and serious illnesses following the end of their preceptorship. Another quantitative survey measured the ability of nurses who had been through preceptorship to respond to three clinical scenarios involving deteriorating patients, using interview simulations to 'think aloud' their responses to the available clinical data (Al-Thubaity et al., 2018). The results of the study showed that nurses were not equipped to deal with these scenarios, with more than half of nurses failing to recognise

clear signs of patient deterioration, and this has also been confirmed in a literature review on the same subject (Purling and King, 2012). The results of Simmens (2009) add to these findings. This qualitative descriptive study shows that Saudi nurses lacked development in critical thinking and reflection skills, focusing too much on their own performance in their role rather than the patient's needs. Low levels of complex patient understanding and critical thinking were also found by Almazwaghi (2013) among Saudi nurses. Taken together, this body of evidence suggests that preceptorship is not wholly fulfilling its function for nurses within the Saudi health care system.

An important aspect of whether preceptorship is a success in terms of the preparation of the preceptee for independent clinical practice is the relationship between the preceptor and preceptee. Previous ethnographic research has been carried out to explore this relationship and its key features to better understand the needs of both preceptors and preceptees. Carlson (2013) synthesised primary data from nurses involved in preceptorship and theoretical approaches. This study found that the relationship between preceptor and preceptee was very complex, and precepting was an advanced role for nurses they needed to be adequately prepared for.

The study also found that some common features of preceptor-preceptee relationships can lead to problems with achieving positive learning outcomes from preceptorship (Carlson, 2013). The first of these is that the responsibilities of the preceptor almost always exist on top of existing responsibilities, with very little attention given to the time pressure placed on nurses who take on the preceptor role. This can lead to conflicts between the desire of the preceptor to give their preceptee the best learning experience and the need to provide safe care for patients. The latter almost always comes first when there is a direct conflict, leading to preceptees feeling let down or undervalued. Carlson (2013) has suggested that such problems are partly caused by a lack of support and partly by a lack of understanding of the roles of preceptor and preceptee. It is evident in many situations that there is inadequate administrative support given to preceptors to help them plan and execute learning opportunities for preceptees, which has also been found in other studies (Hautala et al., 2007). This can lead to a breakdown in trust between the preceptor and the preceptee, who feels that the preceptor is not interested in their training (Valizadeh *et al.*, 2016).

The other factor which Carlson (2013) found was particularly important in the relationship between preceptor and preceptee was the ability of both parties to assume an appropriate role. The basic structure of preceptorship ensures that there are universal, basic roles for the preceptor and preceptee in which the preceptor is the responsible party and the preceptee is in a position of needing to receive guidance. However, Carlson (2013) argues, based on a detailed theoretical analysis of a primary ethnographic study of nurses involved in preceptorship (Carlson et al., 2009), that these roles need to be better defined at the beginning of preceptorship with agreements of the expectations and responsibilities of both the preceptor and preceptee. In this scenario, the relationship should begin with 'role-making', followed by 'role-taking', in which both preceptor and preceptee can explicitly understand each other's roles, rather than implicitly negotiating these roles during preceptorship as often happens.

Other research has focused on the learning aspect of the relationship or how preceptors can bring about advances in a preceptee's knowledge and skills. Ohrling and Hallberg (2000) found that there were four key aspects to this part of the relationship. The first was creating a space that was appropriate for learning without excessive pressure and with space to think. The second was providing concrete illustrations of what needed to be done in a particular scenario, rather than more general advice. The third was that the preceptor needed to exercise the appropriate amount of control over the preceptees actions to allow meaningful learning to take place safely. The final aspect was the need for reflection, something which several studies have found was lacking due to time pressure on preceptors (Duffy, 2009; Lewis and McGowan, 2015; Myrick et al., 2010). The available research is mainly situated in the context of health systems where preceptees have more clinical experience than in Saudi Arabia, but these dynamics are even more important in Saudi Arabia.

2.11 Summary

This chapter has provided a contextual background to inform the subsequent sections of this thesis. This chapter has shown how culture, social status (or perceptions of it) as well as

norms and expectations regarding gender roles, impinge upon relations within the Saudi healthcare system. It has also critically discussed the immigrant-dominated nature of the nursing workforce, providing a historical explanation for this pattern. This discussion was explored alongside a focus on government efforts to localise healthcare via its Saudisation policy. In analysing preceptor-preceptee relations, this chapter considered contextual factors such as inequalities, access of women and non-Saudis to the labour market, and the healthcare system in particular. The salience of preceptorships for NGNs' professional development was highlighted throughout this chapter, however, there are a range of challenges that have been documented about this relationship in the literature. In addition to this evidence, which remains limited, the unique ways in which cultural factors peculiar to the KSA may impinge upon preceptorships, makes further research highly pertinent. The present research attempts to add to the existing evidence base for the nature of preceptorship in Saudi Arabia and focus on the qualitative experience of the relationship itself rather than the clinical competency outcomes from the process. In the next chapter, a critical overview of the literature is presented to further highlight the original contributions of this study.

Chapter 3: Review of the Literature

Introduction

Before proceeding with the design of the research, a systematic review was conducted to assess the scope of the existing research into nurse preceptor-preceptee relationships. The Cochrane handbook notes that a systematic review "uses explicit, systematic methods that are selected with a view to minimizing bias, thus providing more reliable findings from which conclusions can be drawn and decisions made" (Higgins and Green, 2011, p.5). Systematic reviews constitute a pre-defined process which necessitates rigorous methods for reliable and meaningful results (Munn et al., 2018). A systematic review was conducted because it is used purposefully to identify gaps, trends and deficiencies in the current evidence which then informs and underpins future research in the area (Munn et al., 2018). It was crucial to unpack the trends and gaps in the literature, to contextualise and frame my research so that it could contribute to the existing scholarship in a meaningful way. A systematic review was conducted as opposed to a scoping review because scoping reviews are typically more useful for examining emerging evidence where there is a lack of studies about a topic, to determine what new research questions can be posed (Munn et al., 2018).

The use of a detailed, transparent search strategy reduces the risk that a systematic review will be subject to the selection biases which affect narrative reviews and allows other researchers to reproduce the searches used in the review. In this chapter, the methods used to conduct the systematic review of literature relating to the nurse preceptor-preceptee relationship are described, including the research question, databases used, eligibility criteria, critical appraisal tool and the data analysis methodology selected.

3.1 Literature Review Aims and Objectives

The aim of the systematic review of literature was to determine common features of the nurse preceptor-preceptee relationship in the existing literature. In order to meet this aim, a number of research objectives were identified for the review:

- To determine whether there are consistent themes in the perceptions of preceptor-preceptee relationships from the point of view of both the preceptors and preceptees, and if these differ.
- To identify the contextual factors, conditions and challenges that shape relationships between preceptors and preceptees.
- To comment on the methodological features and quality of existing studies investigating the preceptor-preceptee relationship, including the setting, sample, data collection and methods of data analysis.
- To identify any gaps in the existing literature.

3.2 Search Method

3.2.1 Research Question for Literature Review

In order to develop the research question for this systematic review of literature, the PEO (Population, Exposure, Outcomes) method was used (Seidler et al., 2013). The PEO method is similar to the PICO (Population, Intervention, Comparisons, Outcomes) method used by the Cochrane Collaboration for their high-quality systematic reviews (Higgins & Green, 2011), but is more appropriate for research where there is not a specific intervention being tested. The population for the present review consisted of nurse preceptors and preceptees, the exposure was considered to be the nurse preceptor-preceptee relationship and the outcomes were any qualitative themes regarding that relationship. The results of the PEO analysis are shown in Table 1 below. The use of a structured method such as PEO or PICO is advised for systematic searches because it allows the creation of a highly specific research question which is also sensitive to the maximum number of relevant studies in a database search. For the purposes of the research question and search, a preceptee was defined as any new graduate nurse, novice nurses or student nurse undergoing preceptorship with a preceptor.

PEO Domain	Analysis
Population	Nurse preceptors and nurse preceptees worldwide
Exposure	The nurse preceptor-preceptee relationship
Outcomes	Any themes identified in qualitative studies such as challenges of the relationship, common features of effective relationships or contextual factors shaping the relationship and other outcomes such as professionalism and learning.

TABLE 1: PEO (POPULATION, EXPOSURE, OUTCOMES) ANALYSIS OF THE RESEARCH AIM TO ASSIST IN CREATING A FOCUSED RESEARCH QUESTION FOR USE IN CLINICAL DATABASE SEARCHING.

Based on this PEO analysis, the following research question was developed for use in the systematic search:
What are the factors, contexts and processes identified in studies of the preceptor-preceptee relationship from the perspectives of nurse preceptors and preceptees?

3.2.2 Database Search Methods

Three clinical databases were chosen for use in the literature search for the present systematic review: Cumulative Index to Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE) and PsycINFO. The CINAHL database is specific to nursing disciplines and other literature relevant to nursing and has been shown to be particularly important when conducting systematic reviews including qualitative literature (Wright et al., 2015). MEDLINE is one of the largest general clinical databases of peer-reviewed literature, and PsycINFO searches abstracts of studies in the field of psychology, which was thought to be relevant as the research question dealt

with interpersonal relationships. All of the three databases additionally allow keyword Boolean searching which makes database searching more efficient and effective (Holly et al., 2016). The 'snowball method' was also used to identify studies missed by database searching. The bibliographies of studies found on databases were hand searched to determine whether any other relevant studies were present (Greenhalgh and Peacock, 2005).

3.2.3 Boolean Keyword Combinations

Using the research question and PEO analysis, keywords were generated to conduct the database searches. Synonyms of these keywords, such as relationship/interaction were also generated and these search terms were combined using the Boolean operators AND and OR, and the wildcard symbol * (Table 2) (Hjorland, 2015). These were then combined into Boolean search strings such as *nurse AND (preceptor* OR preceptee* OR "preceptor-preceptee") AND (relationship OR relation) AND (perception OR experience* OR "lived experience").* Due to the wide range of possible qualitative outcomes, different sets of similar outcomes were included in search strings across multiple searches.

Search domain	Boolean keyword combinations
Nurse preceptor/preceptee	Nurse AND (preceptor* OR preceptee* OR "preceptor-preceptee")
Relationship	Relationship OR relation OR interrelation OR interrelationship OR rapport OR cooperat* OR collaborat*OR partnership*
Outcomes	Perception* OR experience* OR "lived experience" OR performance OR satisfaction OR engagement OR experienc* OR effective* OR competent OR competence OR education OR role OR assessment OR benefits OR rewards OR challenges OR support OR drawbacks OR fail* OR critic* OR conflict OR theme

TABLE 2: KEYWORDS WERE GENERATED FROM THE RESEARCH QUESTION AND COMBINED USING THE BOOLEAN OPERATORS AND OR INTO SEARCH STRINGS.

3.2.4 Eligibility Criteria

Strict inclusion and exclusion criteria were developed (Table 3) to ensure that the only studies included in the literature review were those which could effectively answer the research question. Studies published more than 14 years ago were excluded from the review to ensure that only the most recent evidence was considered. Health services develop and change rapidly with new legislation, technologies and clinical guidelines meaning that research into preceptor-preceptee relationships prior to 2008 may not be relevant to practice today. Only peer-reviewed primary studies with nurse preceptors or preceptees in their sample were included, as the purpose of conducting this literature review was to inform the thesis more broadly. Secondary literature including reviews, editorials and

unpublished studies were not included. In order to allow more coherent conclusions from the review only qualitative studies were included as these made up the bulk of studies found in a brief scoping search.

Inclusion Criteria	Exclusion Criteria
Published 2008-2022	Published prior to 2008
Peer-reviewed primary studies	Secondary literature including reviews and editorials, unpublished or grey literature
Study sample consists of nurse preceptors, preceptees or both	Studies investigating nurses who are not preceptors or preceptees
Qualitative studies	Quantitative studies
Any outcomes related to the preceptor-preceptee relationship	Outcomes (e.g. clinical performance) not resulting from the preceptor-preceptee relationship.
Published or available in English	Not available in English. Studies published in Arabic were excluded to avoid biases in the translation and interpretation process which may skew the research findings
Full text available	Abstract or title-only

TABLE 3: ELIGIBILITY CRITERIA USED TO EXCLUDE STUDIES WHICH ARE NOT RELEVANT TO ANSWERING THE RESEARCH QUESTION.

3.3 Critical Appraisal

Research bias can be introduced into a study in a number of ways (Noble and Smith, 2015). In qualitative research, the influence of the researcher's own personal bias about the topic investigated can be strong, especially if the methods of data collection, such as interview

questions or questionnaires, are skewed in favour of one particular outcome (Galdas, 2017). To ensure that the studies included in the review did not contain significant bias, the Critical Appraisal Skills Programme (CASP, 2017) checklist for qualitative studies was used to critically appraise those studies which met all other inclusion criteria. The CASP checklists is a 10-item tool providing a structured approach to bias identification in qualitative studies which has been recommended for use in nursing reviews (Smith and Noble, 2016). The quality of each study was appraised using the CASP checklist and the results of the appraisals are summarised in Appendix 1.

As with other CASP (2017) checklists, two screening questions ask whether there is a clear statement of aims and if the methodology is appropriate, and the following 8 questions then allow analysis of features including data collection methods, researcher-sample relationship and ethical considerations. Studies were not excluded on the basis of low sample size (<20) alone as qualitative studies tend to use smaller samples with large qualitative datasets, and larger sample sizes are generally of greatest important when drawing statistically significant conclusions from a quantitative dataset (Button et al., 2013).

3.4 Search Outcome

A total of 1513 studies were identified in the initial database searches of CINAHL, MEDLINE and PsycINFO, with an additional 8 studies identified using the snowball technique (see Figure 3). A total of 830 duplicate studies were removed, and the titles and abstracts of the remaining 691 studies were screened to determine if they met basic relevance criteria, with 649 studies being removed at this stage. The remaining 45 studies were read in full to apply the detailed inclusion and exclusion criteria, with 29 studies excluded. The CASP checklist for qualitative studies was used with the remaining 16. Out of the 29 studies that were excluded, four studies were found to have a significant risk of bias due to the use of quasi-experimental methods and so were excluded. These studies had attempted to compare two experimental groups qualitatively without using random assignment of participants, which is considered to present a high risk of bias by the CASP (2017) tool. Further, they were excluded because their methodological approaches did not align with the inclusion criteria

of the present study. The remaining 16 studies were included in the review (summarised in Table 4 below).

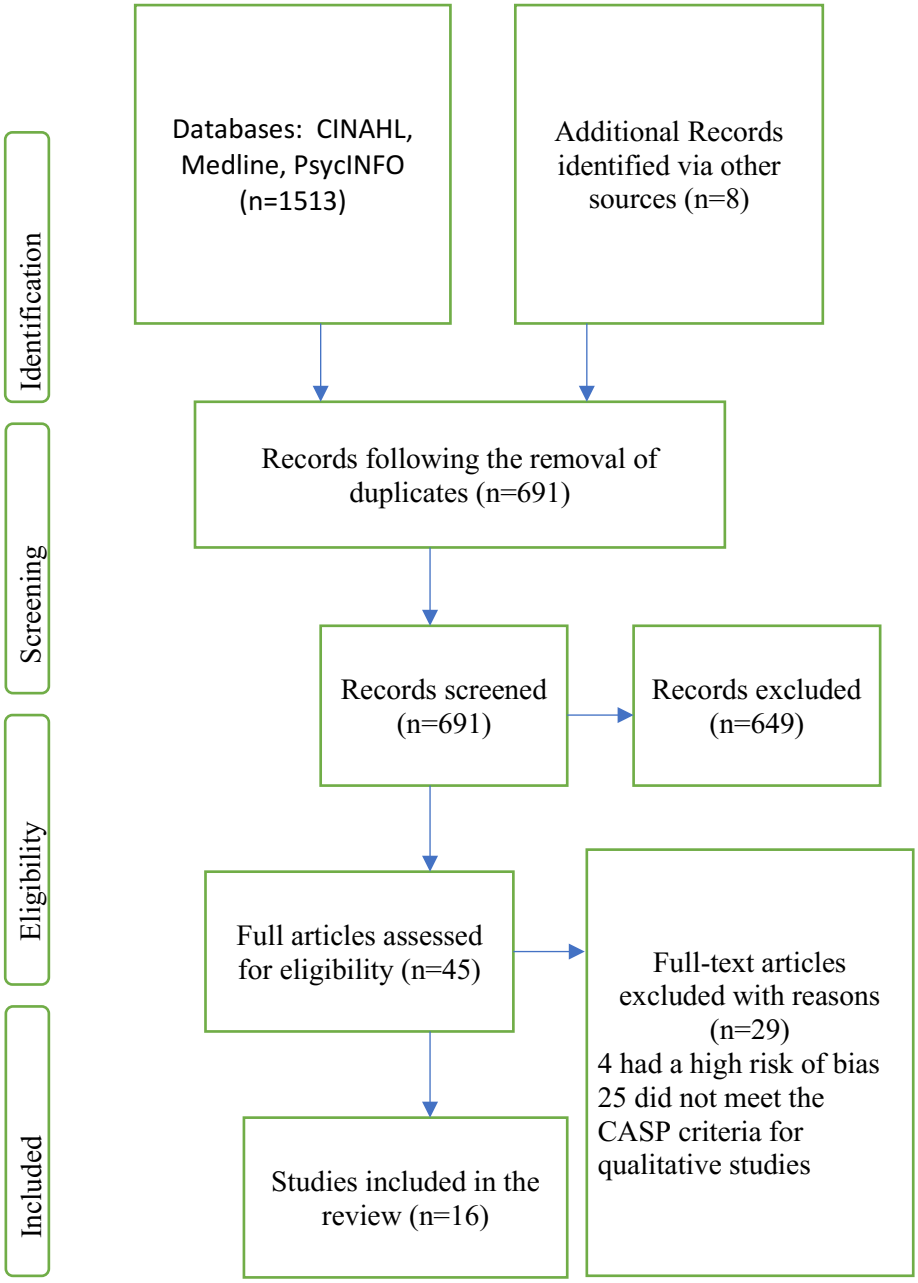

FIGURE 3: PRISMA CHART

3.5 Data Management and Extraction

Systematic reviews of qualitative data can use an aggregated or interpretative approach to data analysis (Seers, 2015). An aggregated approach to review data summarises the available evidence found in the systematic search to give an overview of the state of the available literature. An interpretative approach, on the other hand, attempts to combine the results of the studies found to reach deeper conclusions about the qualitative data available. The advantage of this approach is that it can strengthen arguments from individual studies by showing their presence in multiple studies.

Meta-ethnography is one example of an interpretative approach to a qualitative systematic review (Campbell et al., 2012; Lee et al., 2015). Meta-ethnography is an approach in which the common findings of the included studies are identified through comparison and 'translation' of the findings. In the present review, the method described by Toye et al. (2013) was followed to allow meta-ethnographic analysis of the studies found by the review. The common features of the studies were identified and, where necessary, names for common concepts were developed. This process resulted in the development of the four themes presented in the results section below.

Author(s) and year	Sample size and population	Data collection	Data analysis	Conclusions
Aboshaiqah and Qasim (2018)	92 nursing preceptees in Saudi Arabia	Survey questionnaires with two open-ended questions.	Descriptive analysis	The approachable attitude, trustworthiness and availability of preceptors were seen as important to the preceptor-preceptee relationship by preceptees.
Bengtsson (2015)	64 preceptors in Sweden	Use of a single, open questionnaire question "What further knowledge and skills do you need to develop as a preceptor?"	Adapted Burnard's (1991) framework	Preceptors felt they lacked knowledge of teaching and learning strategies and activities, ability in communication skills and felt they should know more about preceptorship from a scientific perspective.
Chen et al. (2011)	15 nurse preceptors in Taiwan	Interpretive phenomenological study – semi-structured interviews	PHENOMENOLOGICAL: Transcripts were analysed using a hermeneutic circle approach.	The preceptor-preceptee relationship could be put under strain by the excessive workload of preceptors, leaving them feeling alienated and stressed.

Della Ratta (2016)	8 preceptees in USA	Semi-structured interviews	PHENOMENOLOGICAL Qualitative interpretive analysis	"Building me up" one of three themes – preceptees felt the need for trusted relationships with preceptors when dealing with deteriorating patients.
Della Ratta (2018)	11 nurse preceptors in USA	Semi-structured interviews	Diekelmann's (1992) method	Preceptors had to balance their role as an educator of preceptees with their role as a nurse caring for deteriorating patients. The relationship was informed by the preceptor's memories of their own experience as a novice.
Duffy (2009)	8 student nurse preceptors in Ireland	Semi-structured interviews (20-40 minutes) on experience of preceptorship.	Burnard's framework for data analysis.	A lack of organisational support for preceptors was available; a lack of theoretical knowledge among preceptors; guided reflection not a process preceptors were comfortable with.

Ebu-Enyan et al. (2021)	22 preceptors in Ghana	Semi-structured interviews	PHENOMENOLOGICAL data collection and analysis in parallel using field notes and thematic analysis	Student factors undermine the effectiveness of preceptorships. This includes absenteeism, unwillingness to learn, truancy and idleness, as well as the inability to take instructions.
Ewertsson et al. (2017)	17 nursing students in Sweden	Ethnographic case study with 82h observations, informal conversations and interviews.	ETHNOGRAPHIC data collection and analysis in parallel using field note elaboration and memoing. Interviews transcribed and themes emerged in discussion.	Overarching theme of "Learning about professional identities with respect to situated power" - subthemes showed that preceptees varied in their assessment of preceptors' skills and their trust in them. Preceptees learn to make independent decisions in relation to their preceptors.

Hunter et al. (2008)	32 nurse clinicians in Australia	Observational data collection, digital recordings and interviews over a period of 12 months in a neonatal intensive care unit.	ETHNOGRAPHIC approach with inductive analysis using ETHNOGRAPH 5.0 software to identify themes.	Four dimensions, only one relevant to the present review ('preceptoring – moving up the ladder'). Finding that senior medical staff contradicting preceptors can be difficult for preceptees. The preceptor-preceptee relationship is influenced by the relative skill levels of both parties.
Jonsson et al. (2021)	Ten preceptors and six ward managers from different health care specialties in Sweden	Semi-structured interviews	Qualitative content analysis guided by Graneheim and Lundman (2004)	Nurses conceptualised preceptorship as extra work but did not tolerate discourses of students as a burden out of respect for them. There was a lack of clarity about how preceptorship is organised and preceptors took a lot of individual responsibility. Responsibility for preceptorship was invariably linked to planning and communication.

Lewis and McGowan (2015)	8 newly-qualified preceptees in Northern Ireland	Semi-structured interviews	Burnard's framework (six-stage)	There was a perceived lack of understanding of the expected relationship between preceptors and preceptees, especially the level of type support which should be provided
Marks-Maran et al. (2013)	44 newly qualified preceptees in the UK	Mixed-methods. Qualitative data collection through questionnaires, reflective journals and personal audio recordings.	Descriptive analysis	Preceptees found preceptors were able to alleviate stress, impact positively on development of clinical and communication skills, although there was significant availability pressure. Preceptees expressed a desire to become preceptors.
Myrick et al. (2010)	10 preceptees and 12 preceptors in Canada	Grounded theory approach with semi-structured interviews, field notes and journaling.	GROUNDED THEORY: Open coding immediately after data collection, followed by theoretical coding and selection of main themes.	Authentic practice allows preceptors to build trust with preceptees, instil confidence and foster respect. A student who was assigned two preceptors had a strongly negative experience.

Quek et al. (2019)	20 participants (10 preceptor-preceptee pairs) in Singapore	Audio recorded semi structured interviews	Thematic Analysis	Preceptors who are relationship-oriented develop close working relationships with their preceptees which in turn, mediates power relations and helps to build trust and understanding. Concurrently, close working relationships can undermine the independence of preceptors.
Valizadeh et al. (2016)	6 nurse preceptors in Iran	Hermeneutic phenomenological design, semi-structured interviews.	PHENOMENOLOGICAL: Diekelmann's seven-stage method.	The preceptor-preceptee relationship is affected by the challenges and stresses of the preceptor role, their perceived lack of support and lack of appreciation.

Yonge (2012)	7 nurse preceptees in Canada	Grounded theory approach with semi-structured interviews.	GROUNDED THEORY: Transcripts coded and themes extracted.	The relationship between preceptors and preceptees must be professional but also personal in order to work successfully. However, if this becomes friendship then it is less effective. Communication and honesty important. Preceptees bought gifts for preceptors to express thanks.

TABLE 4: SUMMARY OF THE STUDIES INCLUDED IN THE SYSTEMATIC REVIEW

3.6 Critical Evaluation of Published Studies

A total of 16 studies were identified which fulfilled the inclusion criteria. These are summarised in Table 4 above. Following analysis of the studies and extraction of common features, a total of four themes were identified, all of which were found to describe or influence the preceptor-preceptee relationship: *Power balance and preceptee independence; Trust, honesty, confidence and friendship; Preceptor availability and lack of organisational support and Experience and knowledge of preceptors;.* In this chapter, the themes are explored critically with reference to the included studies.

Theme 1: Power balance and preceptee independence

Five studies (Ewertsson et al., 2017; Hunter et al., 2008; Marks-Maran et al., 2013; Lewis and McGowan, 2015) demonstrate that there is a power imbalance between preceptors and preceptees, although each of these studies approach the importance of this power balance in different ways. Both Ewertsson et al. (2017) and Hunter et al. (2008) focused on power differentials which emerge during clinical practice and the application of practical skills, but Hunter et al. (2008) found that power differentials exist among preceptors themselves according to their tacit knowledge and experience. Preceptors that delivered the best quality of care and that knew the infant best, primarily, the clinical nurses, were at the top of the hierarchy (Hunter et al., 2008).

The scholars found that there were tensions in the socialization of nursing students into clinical practice when practical skills were enacted differently as compared to how they had been taught at the university (Ewertsson et al., 2017). How students navigated these power differentials varied greatly, emphasising the importance of preceptors' gaining a nuanced understanding of how clinical practice hierarchies shape the behaviours of students in the clinical setting. Explicitly, the scholars found that preceptees' trust of their preceptor is contingent upon the former's assessments of the latter's skills. Although Ewertsson et al. (2017) highlighted clinical tensions and how they relate to power, it is possible that these findings are limited to the research context of the study which was limited to Sweden and a small sample of nurses. Consequently, the findings of the study cannot be generalised to larger populations. Further, the study did not discuss the role of cultural norms, which could have influenced how power differentials are enacted in the clinical setting.

This balance between doing things as preceptors do them versus following one's own training was also explored by Hunter et al. (2008) in another ethnographic study. Both Ewertsson et al. (2017) and Hunter et al. (2008) found that the power balance between preceptors and preceptees is not fixed. Hunter et al. (2008) found that preceptees (n = 32) were taught 'how we do things here' by preceptors as they were instructed in practices specific to the neonatal intensive care unit where the study was carried out. The authors also found that preceptees come to learn that preceptors themselves exist in a hierarchy and can be overruled by doctors in clinical decision making, which can be confusing for preceptees. There was a conflict observed between the sometimes collaborative nature of clinical decision making in this relationship and the sometimes top-down order giving, which was not easily resolved. What this study demonstrates is that the preceptor-preceptee relationship is not an isolated microcosm but exists within the wider power structures of the hospital and is necessarily influenced by those structures. When preceptor authority is challenged by doctors, this can make the preceptor-preceptee relationship more difficult to navigate. Thus, power differentials reflect the tensions that exist during the translation of abstract knowledge to concrete practice and represent the hierarchies between preceptors based on their level of experience, decision-making capabilities and ability to deliver high quality care. Hierarchies also exist between preceptees based on learning capabilities, experience and other factors. These hierarchies are embedded/collaborative on one hand, and organisation-centred or bureaucratic on the other.

Lewis and McGowan, (2015) revealed some power differentials within the relationship which were not found in the other studies. Preceptees had the expectation that preceptors would keep up with the paperwork that they needed to fill in to complete their preceptorship. However, in many cases it was difficult to get preceptors to fill in paperwork and in some cases preceptors were not aware that it was their responsibility. This finding demonstrates how preceptors hold organisational power over preceptees as preceptors fill out the paperwork and, in many cases, preceptees had to put in extra work to ensure that their preceptors did this. The study does not, however, investigate whether this led to preceptees feeling as if they had to act differently in order to get their preceptors to cooperate in filling out paperwork, nor is there an investigation of preceptors' own views on this power imbalance. Nevertheless, Lewis and McGowan’s (2015) finding links to the theme of preceptor availability and lack of organisational support, which is highlighted further in the subsequent parts of this chapter. Despite the power differentials that

exist between preceptors and preceptees, Quek et al. (2019) found that these can be mediated by a trusting relationship as this facilitates effective communication.

A final study by Marks-Maran et al. (2013), which is discussed in greater detail in a later theme, noted that many preceptees wanted to become preceptors themselves, demonstrating a desire to be on both sides of the power balance that they find themselves in as preceptees. All the studies produced data derived from context-specific research settings and thus have limited transferability to other contexts.

Theme 2: Trust, honesty, confidence and friendship

Five studies focused on the characteristics of a good preceptorship and highlighted the importance of trust, honesty, confidence and friendship. The majority of these studies employed a Grounded Theory approach pointing to a gap in the literature in the form of research studies that employ alternative methodologies. It is possible that alternative findings may be established using different methods. One of the key themes which emerged in Yonge's (2012) study was the trust which preceptees placed in their preceptor and also that preceptors placed in preceptees due to their team-oriented behaviours and favourable attitudes to work. In Duffy's (2009) study also, the participants described how they relied on trust based relationships with preceptors and other members of staff such as preceptee nurse colleagues in order to cope with the challenges of dealing with deteriorating patients in intensive care, the emergency department and acute care. In contrast to Yonge (2012), Duffy (2009) highlighted that the trust built between preceptor and preceptee can be broken down, with one of the participants finding that preceptees could be extremely difficult and stating "you feel angry; you think 'what are you doing here then". This shows how trust must be built in both directions and that it is not a guarantee in the preceptor-preceptee relationship. Further, there is the suggestion that trust is inherently fragile and contingent upon the rapport between preceptors and preceptees. Duffy (2009) thus suggests that trust alone cannot sustain preceptorships.

Further Quek et al. (2019) highlighted how friendship between preceptors and preceptees can undermine the independence of preceptees since they become accustomed to the consistent guidance offered by their preceptor. Against this backdrop, Yonge (2013) highlights the importance of boundaries to this personal relationship in order to make the preceptorship an effective

experience for students. When the relationship moves from 'friendly' to 'friends', it is no longer professional. However, Yonge (2013) concludes that small acts of friendship such as giving of gifts to preceptors is appropriate when done within a professional context. This study shows that friendliness is perceived to be an important part of successful preceptorship by preceptees. This is especially seen in the pastoral care given to preceptees by preceptors and the development of a trusting relationship as a result which fosters a community ethos that breaks down power barriers between preceptors and preceptees. It is however limited in its transferability because the research was conducted in the context of a rural setting and alternative observations may be established in non-rural settings. These findings were nevertheless, also confirmed by Quek et al. (2019) who showed that preceptors who are relationship oriented are able to develop close working relationships with their preceptees involving consistent support and guidance, which creates a sense of accountability within the preceptorship. This is crucial because it enables mistakes to be identified quickly, thus safeguarding clinical safety (Quek et al., 2019). Aside from close working relationships, authentic practice, which involves the application of conventional wisdom, was established as an important factor in building interpersonal trust in Myrick et al.'s (2010) study.

Myrick et al. (2010) examined the same phenomenon from the perspective of the preceptor, to discover how preceptors perceive the development of trust and friendliness in the preceptor-preceptee relationship. The most unique aspect of the findings of this study was the theme "Being sensitive to the unspoken", which examined the ways in which the participants were able, as part of their close relationship, to intuitively understand each other without speaking. Myrick et al., (2010) also found that there were two essential features to the preceptor-student relationship: affirming the student role and realising student potential. Affirming the student role was seen by preceptors as the need for them to establish trust with students in order to provide confidence and foster mutual respect, which they considered to be the basis of any educational outcomes of the preceptorship experience. As part of this, preceptors practised empathy and encouraged preceptees to be honest and open about their preceptorship experience. This illustrates how the setting up of power can positively impact preceptorships. Also drawing from the study of Yonge (2013) discussed above, it is clear that preceptors consider an important part of their role to be breaking down the barriers that exist between a novice nurse being assessed and a more experienced nurse by first building trust and confidence.

This idea that preceptees need to be 'built up' was explored in more detail in the study by Della Ratta (2016) in a phenomenological study of 8 graduate nurses working in acute care environments and caring for deteriorating patients. The study used semi-structured interviews with the participants to explore their experience of transition into full time professional care, and one of the three themes identified in the phenomenological analysis of the data collected was “Building me up”, which described the relationship between preceptee, preceptor and other staff during this period of their professional lives.

The only previous study of the nurse preceptor-preceptee relationship found in Saudi Arabia also reached conclusions about the importance of building a trusting relationship. A recent study by Aboshaiqah and Qasim (2018) used a mixed methods approach, with a survey instrument collecting both qualitative and quantitative data. As quantitative data were excluded from this systematic review, only the qualitative results will be considered. The authors included two open-ended questions in their questionnaire asking former preceptees (n = 92) about how their preceptorships could have been improved and what influenced their development of competence. A number of qualitative responses were obtained from the participants, who reported that approachable attitude and trustworthiness were the crucial factors which determined whether the preceptor was able to help them improve their clinical competence. It should be noted that although this partially confirms the findings of the other studies in this theme, the use of two open-ended questions in a questionnaire is unlikely to elicit the same depth and quality of responses as semi-structured interview data. Student factors can also culminate in a breakdown of trust that undermines preceptorships. Ebu-Enyan et al. (2021) found that students’ unwillingness to learn introduces tensions in preceptorships. Preceptors in the study documented students’ truancy, absenteeism, idling, and inability to obey instructions. The inability to manage students who display untoward behaviours interrupted the ability to supervise them effectively.

Theme 3: Preceptor availability and lack of organisational support

Perhaps the most consistent finding across all the studies selected for this systematic review was that the availability, or lack of availability, of preceptors was one of the defining features of many preceptor-preceptee relationships, and in some cases, this was explained by a lack of organisational support for preceptors. Valizadeh et al. (2016) found that preceptors faced significant pressures on their time which often translated into stress. Preceptors included in the

study admitted that at times they compromised on their responsibilities to their preceptees due to excessive workload, with patients given higher priority than students. They also claimed that the specifications of the preceptor role in their hospital were too ambiguous and inconsistent, and that there should be clearer goals and objectives to help clarify their relationship with the preceptees. In the study by Yonge (2013), some preceptors solved the problem of lack of availability by making their contact time with preceptees "very informal" and capitalising on all opportunities for learning (Yonge, 2013).

Duffy et al. (2009) found that availability of time was a significant barrier to fulfilling one's duties in the role of preceptor, and that managerial support was a critical factor in creating that time. In this study, only one of the participants claimed to be supported well by the managerial staff in their preceptorship, and in some cases the removal of preceptees from wards actively degraded the preceptor-preceptee relationship.

Other studies also identified the lack of organisational support and lack of appreciation as an important determinant of the quality of the preceptor-preceptee relationship. Bengtsson et al. (2015) found that the preceptors felt that their organisation did not prepare them adequately for their role, leading to difficulties in developing a satisfying and successful relationship with preceptees. Similarly, Valizadeh et al. (2016) reported that preceptors perceived their training for the role as inadequate, with poorly developed knowledge and low confidence in their abilities, and therefore felt under-prepared to take on the responsibility of the role. In spite of these difficulties in making time for preceptorship due to organisational pressures, Marks-Maran et al. (2013) discovered that preceptees were satisfied with the whole relationship and did not blame preceptors for their lack of availability to engage in education tasks.

Preceptor Availability

A subtheme identified regarding preceptor availability was the development of alternatives to the standard one-to-one preceptor-preceptee relationship in hospitals where the demand on resources is too great to allow one preceptor to focus solely on one preceptee. In the study by Myrick, Yonge & Billay (2010) described above developed a theme called "The exception: the negative case" in which they described the lived experience of a preceptee who had been assigned

two preceptors as each preceptor could not devote enough time to her individually. The student found this to be a “disquieting” experience which interfered with her ability to learn effectively.

Specifically, the two preceptors had very different approaches to preceptorship, with one being more 'holistic' and the other being very detail-oriented and procedure focused. While one of the preceptors “nurtured” (Myrick et al., 2010) the confidence of the student, the other “completely lacked confidence” in her, and there were regular conflicts between the two styles which ended with the preceptee being criticised. This example demonstrates that each preceptor-preceptee relationship is individual and that significant thought must be given to whether the use of multiple preceptors is appropriate. Further, it suggests that a more structured approach to preceptorships which targets the training of preceptors and clearly demarcates expectations while providing consistent support is required. The study by Valizadeh et al. (2016) confirmed this finding, as preceptors participating were not allocated the same shifts as preceptees and so preceptees were shared between preceptors, a situation they felt was highly undesirable.

Institutional Support for Preceptorship

Another subtheme that emerged concerned the undervalued and unsupported nature of the educator/mentor role. For example, Bengtsson (2015) found that preceptors conceptualised their role as stressful and as a burden due to the lack of institutional support they received. Institutional support for preceptors, pertained to having concrete teaching strategies and tools that could assist in alleviating their pressures. Additionally, preceptors reported lacking knowledge and understanding of the expectations of their role. Consequently, they felt undervalued because they were not placed in a position to be innovative and use new methods that could improve the flexibility of the preceptorship while providing support to challenging students. Preceptors also reported a lack of organisational support in managing their role concerning the evaluation of students in relation to expected goals. They conceptualised their educational role as burdensome, particularly with regard to supervising students that had weak theoretical knowledge. The lack of formal guidelines and teaching strategies in addition to the difficulties linked with their role exacerbated the pressures on them. Chen et al. (2011) in their research, also focused on this theme, however, institutional support was conceptualised in terms of colleague support and how a lack of this support caused preceptors to feel the pressure of training progress and paperwork overload. Further, due to the lack of institutional support, some preceptors reported fear of failing

in their roles (Chen et al., 2011) and the resultant anxiety and feeling of being unappreciated were also found to adversely impact the preceptor-preceptee relationship (Valizadeh et al., 2016).

Experiencing role conflicts/ unrecognised work

The lack of institutional support goes hand in hand with role conflict which arises because of the lack of clarity about preceptors' roles (Chen et al., 2011; Bengtsson, 2015; Lewis and McGowan, 2015; Marks-Maran et al., 2013; Ebu-Enyan et al., 2021; Jonsson et al., 2021). Chen et al. (2011), as well as Marks-Maran et al. (2013), reported tension between the provision of care and education. Since patient care is time-consuming, sensitive, physical and requires collaborative work, preceptors experienced significant pressures which meant that they did not have control of their teaching. Role conflict culminated in time constraints and preceptors thus did not invest in the teaching of new nurses. The pressures of filling the dual role of preceptor/nurse left some preceptors feeling guilty and upset (Chen et al., 2011). Due to their heavy workload, preceptors could not also provide timely feedback concerning the performance of new nurses, resulting in poor teaching and learning quality (Chen et al., 2015). Alternately, preceptors who prioritised the preceptor role reported a deterioration in their quality of patient care and consequently made negative evaluations of their role as nurses (Chen et al., 2015). Role conflict was especially difficult for some preceptors, due to the *a priori* experiences of some of their students and the lack of clarity concerning their roles.

Similar findings were made in Jonsson et al.'s (2021) work, where nurses indicated that preceptorship meant additional work, which became especially burdensome when not planned and well-organised. Preceptors were careful about conceptualising the students themselves as a burden, recognising the importance of treating them with respect. The crux of the matter was that preceptors were not always clear about how preceptorships should be organised. This meant that many preceptors took up individual responsibility to achieve some structure and compensate for the lack of planning (Jonsson et al., 2022).

Theme 4: Experience and knowledge of preceptors

As well as the organisational support provided to prepare them for their role, the experience and knowledge of preceptors was seen to be an important influencer of the preceptor-preceptee relationship by five studies included in the review. A study by Della Ratta (2018) found several ways in which the previous experience of the preceptor influenced the preceptor-preceptee relationship using a phenomenological approach and semi-structured interviews. Preceptors in this study reported that one of the key influences on their professional relationship with their preceptees was their intuition about when to step in.

Several studies, such as Yonge (2013), found that preceptees' confidence was reduced when preceptors stepped in too early to correct mistakes made by the students, and Della Ratta (2018) found that preceptors were aware of this and used their clinical experience to delay stepping in until the moment that they thought it was essential for the patients' outcome. Ewertsson et al. (2017) reported that preceptors frequently did not discuss teaching points after a task, and Della Ratta (2018) noted that preceptors felt debriefing was an essential part of good teaching, allowing both parties to vent emotions, review the technical aspects of the care provided and give feedback. The final finding of Della Ratta (2018) was that nurse preceptors drew on their own experience of being novices to empathise with the experiences of their own preceptees. There is a potential difference in the context of Saudi Arabia since there is less continuity in this case. Although this study only collected data from the perspective of preceptors, it is clear that in this sample experience of preceptors had a significant impact on their relationship with preceptees.

The study by Valizadeh et al. (2013) found a different perspective on preceptor experience, with this experience seen as a commodity to be shared with preceptees, not always positively. In their study, preceptors noted that when they were alone dealing with patients, they were able to silently draw on their experience to perform an action and provide care. However, when a preceptee was present and wanting to understand why the preceptor was performing a particular action, there was a pressure on the preceptor to slow down and explain each action, which the preceptors described as having to explain “every single thing”. In this way of thinking, the preceptee is seen not to be passively drawing on the experience of the preceptor, but actively drawing on both their experience and energy sometimes to the perceived detriment of the preceptor.

Other studies included in this systematic review focused on the experience gained by preceptors in preceptorship and how this influenced their performance in the preceptor-preceptee relationship.

Duffy (2008) found that preceptors had received only minimal training for preceptorship in the form of a two-day course, although some participants had a different experience and saw the training as informative and positive. The preceptors in this study all agreed that the training they had received impacted on their ability to guide preceptees, and that it was not a case of being able to take on the role with no preparation. In part, this was due to knowledge and experience gained from the course but also because they had gained confidence in their teaching ability.

3.7 Discussion

The aim of this systematic review was to determine the common themes in existing studies of the nurse preceptor-preceptee relationship. The four themes extracted from the 16 studies included in this review provide very different perspectives on the preceptor-preceptee relationship and can be placed into two broad groups. The themes *'Power balance and preceptee independence', 'Trust, honesty, confidence and friendship'* and *' Experience and knowledge of preceptors'* all deal with the internal aspects of the relationship between preceptor and preceptee which develop from the professional and personal characteristics of both nurses. The theme '*Preceptor availability and lack of organisational support'* deals with external influences on the relationship between preceptor and preceptee. It also pertains to the subthemes '*Undervalued and unsupported educator/mentor role'* and '*Experiencing role conflicts/ unrecognised work'.* In this section, the identified themes will be explored in the context of the broader literature to determine which features of the relationship remain underexplored.

3.7.1 Development of the preceptor-preceptee relationship

The review highlighted the development of the relationship between preceptors and preceptees and how this can change from the first meeting to a successful or poorly-functioning professional and personal relationship. A previous study by Carlson (2013) which integrated primary results from other studies argued that precepting had to be built on a trusting relationship between the preceptor and preceptee. Carlson (2013) found that preceptors believed this relationship had to begin with the first meeting of the preceptor and student, at which the tone of the relationship could be set. None of the studies included in the present review assessed the first meeting of the preceptor and student, but there was widespread agreement on the importance of trust in the

relationship. Ohrling (2000) has described this trusting relationship as a 'space for learning', with the space created by the trust between both parties. If the relationship lacks trust, then the student is unable to learn effectively from the preceptor and the preceptor cannot put faith in the student to effectively and safely put into practice what they have learned. It is clear from some of the studies in the present review (Duffy, 2009) that some preceptors do not develop this trusting relationship and come to resent their preceptees.

Once the trusting relationship between preceptor and preceptee has been developed, there remains the issue of the power balance between the preceptor and preceptee. Research into other professions which use preceptorship have noted a number of ways in which power is held by preceptors over their students. MacLellan and Lordly (2008) found that preceptors were able to exercise power through withholding information, controlling confidence and assessment of competence. The present systematic review also found that preceptors held power even when they did not appreciate it, such as not filling in paperwork that the preceptors needed to complete their training. Imbalances in the power dynamic between preceptors and preceptees may lead to conflict, and other research has found that more than 25% of nurses have experience conflict with their preceptor (Mamchur and Myrick, 2003; Myrick et al., 2006; Selomridge and Walsh, 2006). In another review by Omansky (2010), it was seen that interpersonal conflict between preceptors and their student nurses could be a considerable source of stress among preceptors and that was closely related to the idea of overload, in which the role of precepting becomes too much for the preceptor.

3.7.2 Organisational influences on the preceptor-preceptee relationship

The environment in which preceptors and preceptees find themselves appears, in the included studies, to have a significant impact on the relationship between both roles. In a previous study by Hautala et al. (2007), the authors found that lack of organisational support was one of the three main stressors affecting nurse preceptors when trying to establish an effective relationship with their preceptee along with the skill level of the preceptee and their own confidence in the role. As noted by Whitehead et al. (2013) in a previous systematic review of literature, preceptorships can be of great value to newly-qualified nurses in transitioning to greater responsibility, but only if there is appropriate managerial support to make this role work for all involved. In the included studies, it was frequently noted that organisational support, and the lack of it, made life difficult

for preceptors, including feelings of isolation and stress. However, other studies have also noted how this lack of support can impact on the preceptee experience as well. A recent systematic review by Walker et al (2017) identified organisational support as one of the key determinants of successful transition of graduate nurses, with unavailable preceptors frustrating the preceptees themselves.

This review found that in two studies (Myrick et al., 2010; Valizadeh et al., 2013) in which the issue of multiple preceptors with a single preceptee had been raised as a potentially detrimental effect on the preceptor-preceptee relationship. Luhanga et al. (2010) have previously conducted a literature review to determine whether the one-to-one relationship is essential to the preceptorship experience, or whether in situations where there is pressure on resources it is possible to achieve similar outcomes with one preceptor and multiple students or multiple preceptors for each student. They analysed a number of primary studies which investigated the efficacy of the preceptor-preceptee relationship with regards to student outcomes, and found that the one-to-one relationship was “pivotal to the success of the preceptorship program.” A number of factors were seen to influence preceptor effectiveness including expertise, teaching experience and availability, but the presence of the one-to-one relationship had the largest bearing on preceptor success.

3.7.3 Building nurse preceptor experience and confidence

The issue of knowledge and training being developed through organisational support was present in a number of studies included in this review to varying degrees (Valizadeh et al., 2016; Yonge, 2013; Duffy et al., 2009; Bengtsson et al., 2015), with the overall conclusion that training is available but largely inadequate. This agrees with previous research investigating preceptors' views which has found that training was not extensive enough, that courses were too theoretical and that they were stressful (Chang et al., 2015).

The training of nurse preceptors to be effective in practice has been discussed in a number of previous reviews and theoretical articles. Workshops have been developed to enhance the effectiveness of nurse preceptors, such as the course studied by Horton et al. (2012) which consisted of 1-day workshops developing specific preceptorship skills including assessment, communication, feedback and conflict resolution. Other training programmes, such as that

described by Jeggels et al. (2013) consist of much more training time (>80 hours) spread out over a longer period of time and following academic structure with the award of academic credits. Although studies investigating such training programmes are numerous (Lee et al., 2009; Duteau, 2012; Singer, 2006; Charleston and Goodwin, 2004), there is currently no universally-accepted model for nurse preceptor training to develop the skills needed for an effective preceptor-preceptee relationship.

In conducting this systematic review of the literature investigating the preceptor-preceptee relationship, several key features have become clear. The first of these is that this is a relationship that both parties treat seriously as an educational experience and which can, as a result, be extremely demanding for both. When the relationship is functioning successfully, it is built gradually on trust as the preceptor demonstrates their experience to the preceptee and places trust in the training of the preceptee to give them autonomy. In many cases it appears the relationship can develop a professional friendliness and operate intuitively without speaking. In cases where it is not operating successfully, it is emotionally taxing for both the preceptor and preceptee. Preceptors tend to react badly to preceptees who require constant explanations and input, while preceptees may identify non-standard practises used by preceptors as 'old school' and therefore suspect, diminishing their trust. The power balance between the two roles is a natural part of the process of teaching and learning, but can lead to conflict in some cases, and this conflict is exacerbated in cases where the preceptor is frequently unavailable. When preceptor availability is low, this is often due to lack of organisational support, suggesting that preceptor-preceptee relationships could be improved by hospitals treating the role more seriously and devoting more resources to it. While these general features of successful and unsuccessful preceptor-preceptee relationships have been identified in this review, it was also clear that each relationship depends on both the individual preceptor and preceptee and the relationship can change with time, making individual relationships difficult to predict.

3.8 Conclusion

Using strict inclusion and exclusion criteria, this systematic review found a relatively limited number of studies investigating the preceptor-preceptee relationship published in the past 14 years. The 16 studies included in the review are fairly heterogeneous in terms of their sample sizes, setting, geographical location and methodological approaches, although there are some common

features in the literature found. Twelve studies used semi-structured interviews as the primary method of data collection. Semi-structured interviews, in which a series of topics or open questions are used to prompt the interviewee, are a popular choice in qualitative methodologies because they collect a large amount of data while requiring relatively little time with the participants, although they are much more arduous for the researchers when transcribing and coding interviews (Palinkas et al., 2015). Some studies used additional data collection methods such as field notes, informal conversations and ' artefact' recording, especially those studies which followed an ethnographic approach.

Over half of the studies included (n = 7) did not state a particular methodological approach, instead just apparently being descriptive qualitative approaches. The remaining studies described themselves either as ethnographic (n = 2), phenomenological (n = 4) or Grounded Theory (n = 2) studies. In these studies, more detailed descriptions were generally given of the methods of data collection and analysis and how these related to the wider research philosophy. Authors of these studies (Myrick et al. 2010; Hunter et al., 2008) commonly gave the reasoning for choosing their particular method as wanting to provide deeper, multifaceted analysis of a particular setting, although they accepted that their results may only be applicable to that setting. This is a pertinent point as preceptorship programmes and even the role of the nurse are different between countries and so findings from a single-country study are likely to be specific.

A key feature of almost all of the included studies was that they were not investigating the preceptor-preceptee relationship as their primary aim, and the data collected for the review was often a minor theme which appeared in the research. There appears to be very little literature which specifically investigates the features and nature of this relationship without focusing on either the preceptors' experience or the preceptees' experience. The studies by Myrick et al. (2010) and Hunter et al. (2008) were the only scholars who included both preceptors and preceptees in their sample, meaning that other studies were unable to analyse the relationship from both sides. There was also, in general, a strong focus in studies on the professional aspects of the relationship and how it affected individuals, such as lack of organisational support causing stress in preceptors. How these organisational stressors impact interpersonal relationships between preceptors and preceptees was rarely discussed.

In addition, by taking all the studies carried out on the preceptor-preceptee relationship into account, this review has identified a further gap in the research as it relates to Saudi Arabia. For

example, although there are a number of studies investigating the roles and experiences of preceptors and preceptees, only one previous study has been carried out investigating this in Saudi Arabia (Aboshaiqah and Qasim, 2018) which aligns with the inclusion criteria and adopts a qualitative research approach. This study focused on the clinical competence outcomes for preceptees following their period of preceptorship. In addition, there has been no research investigating the nature of the relationship between new graduate nurses and their preceptors during their period of preceptorship in this country. Studies that consider preceptorships in the context of multicultural workforces and against the backdrop of cultural influences are also missing. As a result of this review, it is clear therefore, that future studies should focus specifically on the qualitative experience of the preceptor-preceptee relationship, rather than the clinical competency outcomes from the process. Exploring preceptor-preceptee dyads and how they evolve over time is likely to offer additional insights because the nuances of preceptorships can be better understood. This will fill the research gap that has been identified, and in particular will focus on the particular situation as it stands in Saudi Arabia.

Chapter 4: Methodology and Research design

4.1 Introduction

The purpose of this chapter is to provide a comprehensive overview of the qualitative methodological framework for this study that has been employed to address the overarching aim: to provide an in-depth understanding of current practice within the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship in an ICU setting in Saudi Arabia. An ethnographic qualitative research design grounded in hermeneutic philosophy for data collection and analysis have been adopted. According to Pickard (2013), all research is predicated upon a specific philosophy, which comprises three primary elements: ontology or the nature of reality, epistemology, or the relationship between the knower and the known, and methodology or how to obtain knowledge. In this chapter, I discuss these elements of my research, starting with its ontological and epistemological basis, after which I present my research approach and design. I also present the sample selection process and conclude with a discussion of the ethical challenges and considerations associated with this research.

4.2 Ontology

Ontology refers to the nature of reality (Bryman and Bell, 2015; Pickard, 2013). The ontological position adopted by a researcher affects the assumptions they make and the questions they ask about social phenomena because these draw upon how the nature of reality is perceived (Saunders et al., 2012). As Phillimore and Goodson (2004) explain, ontology is the belief system that influences a person's interpretation of knowledge and facts. There are two primary ontological traditions: objectivism and subjectivism (Al-Ababneh, 2020; Crotty, 1998; Creswell, 1994). In this research, I seek to understand, contextually, the nature of the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship in an ICU setting in Saudi Arabia. Therefore, I am interested in the lived experiences and subjective understandings of my research subjects. I consequently draw upon the ontological tradition of subjectivism. Subjectivism focuses on social activities and the interactions between individuals, phenomena, and processes. It is used to understand social situations, including how various phenomena influence people and their causes. Subjectivism is linked to interpretivism

(Saunders et al., 2012) and posits no one fixed reality, unlike objectivist and positivist approaches. Subjectivism subscribes to the view that our social worlds are made up of multiple realities, as perceived by different individuals (Sexton, 2003). In contrast, objectivism encapsulates "the position that social entities exist in reality external to social actors" (Saunders et al., 2009: p.110) and is typically associated with positivist research, which relies on deductive logic and scientific enquiry (Creswell, 1994).

The interpretative approach assumes that members of any social system create their particular worlds through social interaction (Silverman, 2010). Interpretivists attempt to discover and understand how people feel, perceive and experience the social world, aiming to gain in-depth meanings and particular motivation for their behaviours (Ryan, 2018). They hold that it is necessary to understand how people's subjective interpretations of reality affect the formation of their reality to obtain complete explanations of social reality (Prasad, 2005). In other words, the priority is to understand meaning and intentionality rather than casual explanations (Tashakkori and Teddlie, 2003; Creswell, 1994). This ontological leaning supports the tenet of my research and its focus on the experiences of preceptors and preceptees to understand the realities of preceptorship in the context of a Saudi ICU. Due to the fact that subjectivism focuses on unique and context-specific experiences, it is devoid of a scientific approach and methodological rigour cannot be measured in the same way as positivist approaches. Subjectivism, however, does not concern itself with scientific enquiry because reality is understood as subjective and not universal (Creswell, 1994). Thus, the priority here is on the subjective constructions that individuals have about their world (Creswell, 1994).

4.2.1 Personal Philosophical Perspective's Role in Interpretation

To fulfil the role of an active participant in the interpretive process, careful reflection was necessary. Self-reflection enabled me to converge participant-generated data with my presuppositions during the data analysis period to unpack possible biases. Before data collection, I reflected, in writing, on several experiences I encountered during the research process and the meanings that I had ascribed to them. Co-constitution represents the blending of participant data and the experience of the researcher. To that end, my background, reflective journal data, and selected literature ultimately influenced the analysis of the narratives. Furthermore, the reflective process served as an important reminder that experiences are unique and subjective.

I began my research by reflecting on my experience as a preceptee, which I have summarised in Chapter 1. My current role as a nursing faculty member in an undergraduate nursing program also influenced my perspective in addition to my professional awareness of how preceptorships work in Saudi Arabia, by my role as a member of internship committees. It is my worldview that humans are inseparable from the worlds in which they live and that it is through language that existential ontological understanding may occur (Gadamer, 1975, 2004; Heidegger, 1962). As a result of my direct and indirect experiences with the preceptorship process, I developed a richer understanding of the preceptorship process. Participant language, in the form of narrative text, and constitutive prejudices of this researcher, a fusion of horizons, afforded ontological exploration and understanding of the preceptorship process.

My research philosophy was extensively influenced by the writing of Martin Heidegger and Hans-Georg Gadamer. In the human sciences, researchers and philosophers generally seek to understand the actions of people through dialogue, with their words being understood as the words of self-discovery, motivated by reason (Scruton, 2004). However, for hermeneutic inquiry, two central issues concerning the theory of textual interpretation are considered: the text (its meaning) and the interpretation (the understanding). The hermeneutic approach theoretically fits this current study, since the interpretations must be understood in context (van Manen, 1997). The everyday experiences of participants in this study and the researcher are part of this context (van Manen, 1990). In the search for the lived experiences of participants, the hermeneutic approach requires reflective interpretation of the experiential content to achieve a meaningful understanding (Moustakas, 1994). In this research inquiry, the hidden meanings of the lived experiences of new Saudi nurses and their preceptors are uncovered, so that they can be interpreted to reveal what a new, graduate Saudi nurse needs in preceptorships.

The hermeneutic approach in part, focuses on understanding the meaning of being human. Heidegger (2005) viewed the relationship between human notion and human existence as mainly existing in the world; therefore, the concerns of human beings were historically situated along a range of perceptions involving their worlds (Inwood, 2000). He believed that it is impossible to imagine an existence outside the world because humans' perception emanated from being in the world, thus making it impossible for humans to deal with the outside world objectively (Koch, 1995). Heidegger (2005) aimed to go further than plain description to a theory of interpretation of meaning (Holloway and Wheeler, 2002). He argued that it is impossible to be in a world or to live

in a culture lacking the act of interpretation, which is influenced by the history and background of a person (Heidegger et al., 1962).

Heidegger's (2005) interest was ontological: What is being? The goal of Heidegger's (2005) interpretive phenomenology, termed hermeneutic, is understanding. He argued that one's existence can only be known in relationship with others and other objects (Guignon, 1993; Fleming et al., 2003). 'Being' refers to human existence, which he called 'meaning existence'. Heidegger's notion of human existence is essentially dasein (Heidegger et al., 1962). Human existence is derived from being in the physical world with others in the context of existence itself. For Heidegger, understanding is an essential feature of our being in the world (Holloway and Wheeler, 2002). Heidegger (2005) used the phrase dasein to highlight the ability of human existence to recognise the potential of self-existence in the context of a person's life and his existence in the world.

Dasein, the human way of being, according to Heidegger (1962) arises from our everyday experiences as one with an inseparable world. However, he maintains that what it means to be human is often concealed within our daily lives. Being in the world as a new graduate nurse involves sharing existence with a preceptor, critically ill patient, family, and other staff on the unit. Because such an experience is common to nurses working in acute and critical care units, in its "everydayness" (Guignon, 1993), the meaning of the experience to nurses may be hidden. Examining narratives about day-to-day experiences, one may begin to understand what this experience means to new graduate nurses.

Heideggerian phenomenology is distinct in the notion of pre-understanding. Individuals come to a situation with a background of historical influence, social practices, and cultural beliefs. According to Heidegger (2005), this background should not be suspended but used to understand an individual's experience. Therefore, the researcher is an active participant in the interpretive process and demonstrates convergence of participants' perspectives with the researcher's experiences in the interpretation (Smythe et al., 2008). Understanding is not conceived as a way of knowing, but as a way of being in the world (Heidegger, 1962). Co-constitution represents the blending of participant data and the experience of the researcher. In this way, a new understanding of a phenomenon is revealed (Smythe et al., 2008).

Hermeneutics is concerned generally with the way we come to understand (Schmidt, 2016). It explores and involves all the processes of communication used, including reading, writing and

listening (Thiselton, 2009; van Manen, 1997). It has been argued that data in the social sciences is already partially interpreted and that the role of the researcher is to identify the meaning of an action in terms of the role it plays in the social situation (Valentine, 2013). The emphasis is on structure and explanation of the parts by reference to the whole; explanation is nothing other than a clarification of this structure, as a constituent element (Gadamer, 1975). This empathic understanding leads to a more modern form of research for the social sciences.

The philosophy of Hans-Georg Gadamer (1900-2002) enriches Heideggerian assumptions and informs this study. Gadamer (1976) proposed that understanding is a historical, dialectic, and linguistic event. Consistent with Heidegger (2005), Gadamer (1975) believed individuals come to know through interaction and engagement. Moreover, his philosophy emphasises historical awareness and its value as an essential component of knowledge and understanding (Fleming et al., 2003). Gadamer (1975) used the metaphor, 'fusion of horizons' to describe the process of understanding. Culture, language, history, and the specific situation of an individual affect his/her perception and the meaning it holds for them (Gadamer, 1975). Fusion of an individual's history with his/her present being results in interpretation. According to Gadamer (1976), one's horizon, or range of view, is temporal, dynamic, and all-inclusive.

In Gadamerian hermeneutics, historical awareness is represented as prejudgments; these represent more than judgments but rather the whole of an experience. Therefore, prejudice is a major tenet in Gadamerian hermeneutics without which, interpretation and understanding are not possible. Furthermore, in addition to the subject existing in historical time, the interpreter is also one with the world; this will influence his/her interpretation. In a hermeneutic inquiry, prejudices of the subject and interpreter are positive contributions to an understanding and are not bracketed (Gadamer, 1975).

Gadamer (1975) places a strong emphasis on language that extends Heidegger's (2005) existential ontological exploration of understanding. According to Gadamer, language and history furnish the shared sphere in the hermeneutic circle (Koch, 1996, p. 176). The hermeneutic circle, a metaphor taken from Heidegger (2005), describes the interaction of researchers with participant narratives; interpretation of data occurs through the hermeneutic circle. It is through conversation and language that understanding occurs. In this inquiry, attention to language in participant text may support a deeper understanding of the phenomenon.

Gadamer (1975) argues that the task of hermeneutics is not to offer either a methodology or method of understanding, but rather it is to "clarify the conditions in which understanding takes place" (p. 263). However, since our experience and knowledge are connected to phenomena, such phenomena are certain things that appear in our consciousness. Hermeneutics as an interpretative method that emphasises an approach to health research that focuses on meaning and understanding in context (Gadamer, 1975; van Manen,1997).

4.3 Epistemology

Epistemology concerns the nature of knowledge and how people understand the world (Crotty, 1998). As noted by Crotty (1998) "epistemology is concerned with providing a philosophical grounding for what kinds of knowledge are possible and how we can ensure that they are both adequate and legitimate" (p.8). It refers to the connection between the researcher and factual knowledge (Saunders et al., 2012), including how those facts are acquired. Epistemology involves knowledge and encapsulates how researchers perceive what is entailed in knowing—it embodies how they know what they know (Crotty, 1998). Thus, the epistemological position of researchers is shaped by their beliefs concerning knowledge and how best to acquire it (Phillimore and Goodson, 2004).

For the ethnographic hermeneutic approach taken in this research, the epistemological framework that I align myself with is based on the argument that "there are multiple realities integrated into the form of multiple constructs" (Guba and Lincoln, 1994, p. 110), namely each preceptor and preceptee have their own unique experience. My research is thus situated within a social constructivist epistemology which promotes the idea that humans construct knowledge through their experiences and interactions with the world (Kim, 2001). I disagree with pure positivist approaches, that posit only a single reality which can only be measured through scientific means. Instead, I consider myself more aligned with constructivist ideas, which view reality as subjective, constructed from life experiences and emphasise the importance of culture and context in constructing knowledge and understanding research phenomena (Kukla, 2000). Social constructivists hold the view that reality is constructed via human activity (Kukla, 2000). Knowledge is also conceptualised as a human product that is constructed socially and culturally (Prawat and Floden, 1994). Knowledge is created by individuals through their interactions in the social world within which they live.

As I will discuss further in the following sections of this chapter, my epistemological position significantly impacts upon how I have conducted my research (Denzin and Lincoln 2011; Saunders and Tosey, 2013). Constructivism proposes that there is no single valid methodology but rather a diversity of useful methods. I have therefore adopted an ethnographic hermeneutic approach in alignment with the aims and objectives of my research (Baxter and Jack, 2008; Saunders et al., 2012).

4.4 Research Method: Ethnography

In line with the epistemological framework of this study, a qualitative approach is considered more suitable for this study. Adopting a qualitative exploratory approach enables the researcher to enter the setting with the freedom to use all possible approaches such as observing, listening and recording. This means that the researcher can gain an in-depth understanding of how people perceive and interpret their world. In addition, the researcher is not limited to the testing of explicit hypotheses (Burns and Grove 2007). This allows the researcher to understand and explore the subjective meanings, perspectives and experiences of the participants in this study. The deep involvement of the researcher in the interpretation of qualitative data means that it is important to consider the findings of the study as socially constructed by both the participants and the researcher during the study (Burr, 2003).

Ethnography is defined by Brewer (2000) as the study of people in their natural settings, capturing their daily activities and social meanings through the systematic collection of data. There are various approaches to ethnographic research which may include direct researcher involvement in the setting using a combination of observation, participation and interview (Sim, 1999; Lambert et al., 2011; Van Maanen, 2011). It is considered to be one of the principal research methods used in the social sciences. Van Maanen, for example, (2011 p. 219) states that it is focused on the ‘how’ and ‘why’ rather than the ‘how much’ or ‘how many’. Ethnography is one of the basic qualitative methodologies that go back to early anthropological research. It was used by early researchers to obtain insight into individuals’ experiences of culture. Haviland et al. (2007) assert that ethnography’s objective is to explain the cultural meaning and significance of key practices. It is based on a desire to understand individuals in their cultural context.

The primary objective of an ethnographic approach is gaining a deep and holistic understanding of individuals' opinions and behaviours, in addition to the natural aspects (visual and aural factors) of the communities in which they live, by collecting information via in-depth interviews and observations (Snow et al., 2003). Hammersley and Atkinson (2007) assert that an ethnographic researcher has the task of recording a culture as well as the opinions and behaviours of individuals within it. They add that the approach's objective is to understand individuals' perceptions of the world.

Ethnography is gaining popularity in the study of health related social and cultural processes (Zaman, 2012). It has also become an established method needed in nursing research (Gerrish, 2003; Allen, 2004). Ethnographic principles may be applied to a diverse range of social and organisational situations. Ethnography has previously been used to explore how nursing culture shape the behaviours of newly graduated nurses (Hinds and Harley, 2001), how nurse clinicians learn with and from each other in the workplace (Hunter et al. 2008), how preceptors mediate nursing as a profession to undergraduate nursing students during clinical practice (Carlson et al. 2010) and how nursing students describe, and use, their prior experiences related to practical skills during their clinical practice (Ewertsson et al. 2017).

Ethnography provides a deep understanding of the world around us through involvement and immersion in different social contexts (Richardson, 2000). It has no exact definition as it is used in diverse ways across a wide range of disciplines but it always relates to the investigation of culture (Creswell, 1994). Ethnography has long been used in health contexts and its use has increased rapidly in recent years, as the approach is well suited to providing an understanding of complex issues surrounding patient care.

Observation and in-depth interviews are important aspects of the ethnographic approach as they assist in the identification of meanings and relationships within cultures (Fetterman, 2010). When using questionnaires and interviews, a social desirability approach can impact upon participants' responses, where they say what they think the researcher wants to hear rather than what they actually believe or do. This makes it hard to find out what is really happening in practice. Therefore, observation allows the researcher to obtain a first-hand account of behaviours, events, actions and interactions, and so mitigating these problems (Atkinson and Hammersley, 1998; Gans, 1999). To facilitate the aim of this study which is to provide an in-depth understanding of current

practice within the relationship between new graduate nurses and their preceptors, an observational component has been included.

While conducting my field research, I became completely immersed in the cultural environment by conducting observation of the participants, which ultimately enabled me to gain a deep insight into the participants' experiences and their manifestations in various contexts, as noted in similar research by Polit and Beck (2010) which provides a methodological guide to nursing research and highlights insightful nature of observation. Another key benefit of using an ethnographic method was that I could be effective in identifying and assessing unanticipated issues. Other types of research such as semi-structured interviews that are not based on observation can easily overlook unanticipated issues (Sangasubana, 2011). This omission can occur as a result of relevant questions not being asked or participants choosing not to mention something. I would be better able to recognise these issues should they arise by being immersed in the field site and direct communication with the nurses participating in the study. When carried out well, another advantage of an ethnographic approach is that it provides a detailed and authentic representation of the behaviours and attitudes of participants (Cruz and Higginbottom, 2013). Thus, ethnographic methods can be effective in revealing participants' attitudes and behaviours owing to their highly subjective nature.

4.5 Data Collection Process, Sampling Strategy and Methods

4.5.1 Overview

Selecting an appropriate method to collect study data is considered a challenging task in the research process (Polit et al. 2001). In the literature, there are different types of data collection methods that can be used by naturalistic researchers. These include the semi-structured individual interview, focus group discussions, document analysis, observation, field notes, diaries and reflective journals (Denzin and Lincoln 2008, Burns and Groves 2007, Speziale and Carpenter 2007, Sandelowski 2000). Since the focus of this study is to explore the current practices of preceptorship in Saudi Arabia from the nurse preceptors' perspectives and preceptees' perspectives, observation, field notes and semi-structured interviews were chosen as the methods for data collection. Against this backdrop and following Berger and Luckmann's (1991) assertion that knowledge emanates from social activities, it was crucial to this research to explore the

participants' understanding of their social world. As Wolcott (1999) has noted, the role of a researcher is to acknowledge and detail both the individual and collective meanings of the shared experience and develop an understanding of the experience from the participant's perspective. Thus, it was vital to be immersed in the participants' working environments and communicate with them during their ordinary daily working practices.

Observation and semi-structured interviews were selected to obtain a comprehensive understanding of the phenomenon being researched and investigate subjective meanings (Denzin et al., 2006; Yin, 2013) in alignment with the social constructivist approach (Charmaz, 2008) that underpins this study. This perspective acknowledges the reciprocal creation of knowledge between the researcher and participants so that both parties generate subjective understandings of the world. Moreover, as Rodwell et al., (1998) asserts, a constructivist approach does not investigate the semantics of a phenomenon from an external viewpoint; instead, it relies on the researcher acquiring detailed knowledge as the relevant participants perceive it. Thus, I must understand that multiple realities could exist in the phenomenon being investigated.

Hammersley and Atkinson (2007) describe observation as a data collection method that requires the researcher to engage in people's daily life over a length of time. They explain that this type of method is useful for gaining improved insight into the values and behaviours of participants in a cultural context to throw light on the problem being studied. The researcher can become the participant to describe the experience of whom they are observing. This provides a detailed bank of data to draw from. Ethnographers provide detailed accounts of social life known as "thick descriptions" (Geertz 1974). This is an attempt to reproduce the "lived experience". As Byrne (2004) explains, such insight cannot be gained from observation alone. Indeed, Hammersley (1992) explains that if research relies only on observation, it is possible to misinterpret their actions without considering the participants' verbally expressed views.

The interview process allows for a more in-depth exploration of the participants' subjective interpretations (Guba and Lincoln, 1989). In individual interviews, the researcher and participants exchange dialogue, a process that highlights the complex nature of the research topic and provides detailed data to support the exploration of meanings (Craig and Douglas, 2005). Thus, the interviews become a forum for constructing knowledge and for active dialogue and interactions between individuals, leading to mutually created knowledge (Hand, 2003; Fontana and Frey, 2000; Reinharz, 1992).

In the ensuing section, each data collection method that was employed is discussed comprehensively. This is preceded by a brief discussion of the pilot study that was conducted as a precursor to the research.

4.5.2 Gaining Access to King Abdulaziz Medical City

Data has been collected from a single hospital, King Abdulaziz Medical City. The hospital is one of the largest and most modern health care organisations in Saudi Arabia with a bed capacity of 1,501. The hospital was selected because it is among the largest teaching hospitals in the area and it offers academic and training opportunities for national nursing and medical students. It also encourages research and participation in industry and community service programmes related to health. The hospital is a multi-cultural workplace, combining national and international nurses from around the world including England, America, Canada, Malaysia, Australia, South Africa, Philippines, Finland, India and the Middle East. Contextual information about the research setting is not provided in this thesis in order to preserve the participants' anonymity and confidentiality.

Moreover, the hospital has many specialised ICUs where new graduates spend 6 months with their respective preceptors. Specialised critical care units include General ICU, Neuro Critical Care, Burns ICU, Trauma / Surgical ICU, Medical ICU, ICU Stepdown, Paediatric ICU, Paediatric Cardiac ICU, and Adult cardiac ICU. These units accept between 15 and 20 new graduate nurses each year for six-month placements. These units have been chosen because of the specific nature of the work in an ICU. Intensive care unit work is complex and the environment is one within which the activities of all members of staff are monitored. Staff work closely together and the work and roles are interrelated. Additionally, the transfer of knowledge and multiple tasks occurs in a busy and noisy environment. This correlates well with my clinical and academic background in critical care nursing. I believed that the unit will provide ample opportunities to observe interactions between preceptors and new graduate nurses (preceptees).

Seidman (2013) explains that gaining access to the location of research is a crucial study design step. After completing the ethical approval process, agreement to access the field was obtained. I travelled to Saudi Arabia for the data collection and there is no doubt that being clear about the objectives of the research facilitated my acceptance in the field. It was very important that I gained the trust of my participants and had requisite social skills which facilitated interaction, and

the successful gathering of the required information through listening and effective communication (Wasserman and Jeffrey, 2007). Spending a considerable amount of the time in the field assisted me to gain some confidence in approaching people and to become familiar with the units, preceptors, preceptees and routines. There was also a nurse instructor who introduced me to all the departments, directed me and gave me advice about who to approach and how to communicate with them.

4.5.3 Sample and Sampling Strategy

Sample choice is of fundamental importance in qualitative research, affecting the overall strength and value of the research (Mason, 2010). A purposive sample was identified to be the most appropriate for the objectives of the study. The power of purposive sampling lies in determining and selecting cases that provide information that is suitable for in depth study. This is because such cases enable the researcher to learn a great deal about the central research topic, and this enquiry aims to develop in-depth understanding and insights (Patton, 2002). According to Etikan et al. (2012), purposive sampling is

> *the deliberate choice of a participant due to the qualities the participant possesses. It is a nonrandom technique that does not need underlying theories or a set number of participants. Simply put, the researcher decides what needs to be known and sets out to find people who can and are willing to provide the information by virtue of knowledge or experience. (p.2)*

Bowling (2002) as well as Green and Thorogood (2004) explain that purposive sampling aims to involve participants who are more likely to produce detailed information and generate data. As an insider, the nurse instructor was familiar with her cohorts and advised on the nurses who were the most approachable and appropriate subjects for the study.

The preceptorship or residency programme in the selected hospital involves new graduate nurses working in the clinical setting with preceptors. During this preceptorship experience, the preceptor and new graduate nurse take on patient care assignments (initially one-to-one) and provide care collaboratively. The participants are therefore nurse preceptors working in intensive care units together with their preceptees or new graduate nurses. The four wards included in the study were ICU1, ICU2, ICU3 and ICU4. The four wards were included based on where the preceptees and

preceptors who agreed to participate in the study were allocated during their preceptorship. The restriction of the sample to only those preceptors and preceptees who work in intensive care was intended to provide more specific findings regarding the preceptorship role which could be analysed and discussed in that specific context. While purposive sampling techniques have been criticised for limiting the generalisability of research findings (Etikan et al., 2012), they also produce more specific findings for the intensive care setting and therefore more clinically useful conclusions.

Purposive sampling is a non-randomised approach, which is not concerned with reproducible or generalisable findings but instead aims to produce a sample that is information-rich (Patton, 2002). Since qualitative ethnographic enquiry is concerned with the thorough investigation of a specific situation or culture, and there is no desire to determine incidence, prevalence or statistical significance in the findings, a small sample size is acceptable. Miles and Huberman (1994) argue that a small sample size is optimal in qualitative enquiry to investigate phenomena in sufficient depth and detail, provided that the sample is representative of the population under study (Teddlie and Tashakkori, 2003) and is able to provide sufficiently rich data (Grbich, 1999). The participants are nurse preceptors working in intensive care units together with their preceptees (New graduate nurses). Fourteen participants (5 pairs of preceptors and preceptees) were recruited including one male nurse and thirteen female nurses.

4.5.3.1 Inclusion Criteria for Preceptees and Preceptors

The selection of preceptees and preceptors was governed by inclusion criteria. Participants were selected using criteria informed by Benner's (2001) definition of expert and novice nurses. Expert nurses were considered to be those who have more than 6 years' experience in the ICU, together with a critical care certificate or relevant postgraduate degree; novice nurses were considered to be those with less than 5 years' experience in the ICU, new graduates, nurses that recently commenced working in ICU, or nurses without a speciality certificate. For the purposes of this study, a new graduate nurse or preceptee was defined as a Registered Nurse (RN) working within the first year after completion of a nursing programme, which is consistent with the advanced beginner level of competencies discussed by Benner et al. (1996). Nurse preceptors were defined as senior nurses educated and assigned by the acute care facility to assist the novice nurses during

the first six months of practice. New graduate nurses and their preceptors were approached as dyads. The inclusion criteria covered the following characteristics for preceptees:

(1) New graduate nurses (preceptees) who are currently in their first nursing job and their employment is directly related to critical care units. Respondents to this study were exclusively registered nurses of Saudi nationality and relatively young. The youth and inexperience of nurses in this study may be attributed to the Saudisation program that is now heavily targeting health care professions such as nursing. There has been a move to establish a Bachelor qualification as a prerequisite to entry into professional nursing in Saudi Arabia.

(2) New graduate nurses who are currently undergoing a preceptorship programme and whose preceptors agree to participate in the study.

(3) The preceptees must be Saudi citizens, and graduated from a Saudi university.

(4) Sign a consent form agreeing to participate in the study.

For preceptors, the inclusion criteria were as follows:

(1) Senior nurses (preceptors) who have experience of teaching and supporting a preceptee through the preceptorship programme.

(2) Nurse preceptors are assigned to the participating preceptees for the duration of the preceptorship process.

(3) Sign a consent form agreeing to participate in the study.

The following exclusion criteria were defined in relation to the dyads:

(1) Any new graduate or senior nurses who do not fit the above criteria.

(2) Those preceptees who sign a consent form but whose preceptor does not agree to participate.

4.6. Participant Recruitment

Recruitment for the study commenced following Faculty Ethics Committee (FEC) approval from my university and the Institutional Review Board (IRB) at the hospital (see Appendix 2 and 3). At the hospital, new graduate nurses are recruited and accepted into the programme based on interviews and hospital recruitment policies related to GPA and English score, with no entrance exam. Figure 4 depicts the recruitment process of potential participants for this study. Following the hospital recruitment process, a sample (n=5) was drawn from the hospital list of new graduates, that is, residents or preceptees, to determine the number of new graduate nurses to be hired in ICUs and their preceptors. I acquired the list via the hospital's administration department.

Participants were invited to take part in the study by e-mail invitations (see Appendix 4), containing a description of the study, sent by the nursing coordinator. The existing hierarchy did not pressure the participants to participate in the study, and they were at liberty to accept or decline to participate. Consequently, while 15 NGNs were initially approached for inclusion in the study, only 5 agreed to participate. When they decided to take part, I directly contacted them by phone to set up an initial meeting to explain the study and data collection process and complete a demographic form (see Appendix 5) and schedule the individual interview. The meeting took place during the induction week and I met both the preceptee and preceptor separately. Clear information regarding the study aim, its scope, data sources, data collection and modes of analysis, the type of information needed for the study and where and how the results will be used were explained during the meeting. Prospective participants were informed about the data protection policy of the university to maintain the strictest confidentiality. Informed consent was facilitated by providing the potential participant with detailed written information about the study in the form of a participant information sheet (see Appendix 6). Prospective participants were also provided with the opportunity to ask questions about the research and gain answers directly from me. They were informed of the requirement of consent, for their participation and to have their interview recorded and the data stemming from these held for the duration of the study. The consent forms (see Appendix 7) were distributed, and the prospective participants were given a 1-week period to respond. The signed consent forms were returned to the chief nurse, who collected them and then passed the details of the willing participants on to me. A mutually convenient time was arranged for an interview between me and the participants, during which time, I scheduled a convenient time and location for the research observations with each pair. Before the commencement of observations, further verbal consent was sought. The participants' right to withdraw from the study was fully respected at all times.

Strategies which I used to increase participation and improve response rates included face-to face recruitment, friendliness, and assurances of confidentiality. Additionally, I was present at shift changes to introduce nurses to the study and determine whether there are new graduates and preceptors working on the unit that day and if they might be interested in receiving further information about the study. All research subjects who were willing to participate were given an appreciation gift for their participation, in keeping with cultural expectations. Once the participants were recruited it was essential for anonymity and confidentiality to be maintained. This was achieved by ensuring that participants' responses were not made available to anyone except the researcher. I identified participants by a unique code and pseudonyms, which means that their real names have not been used.

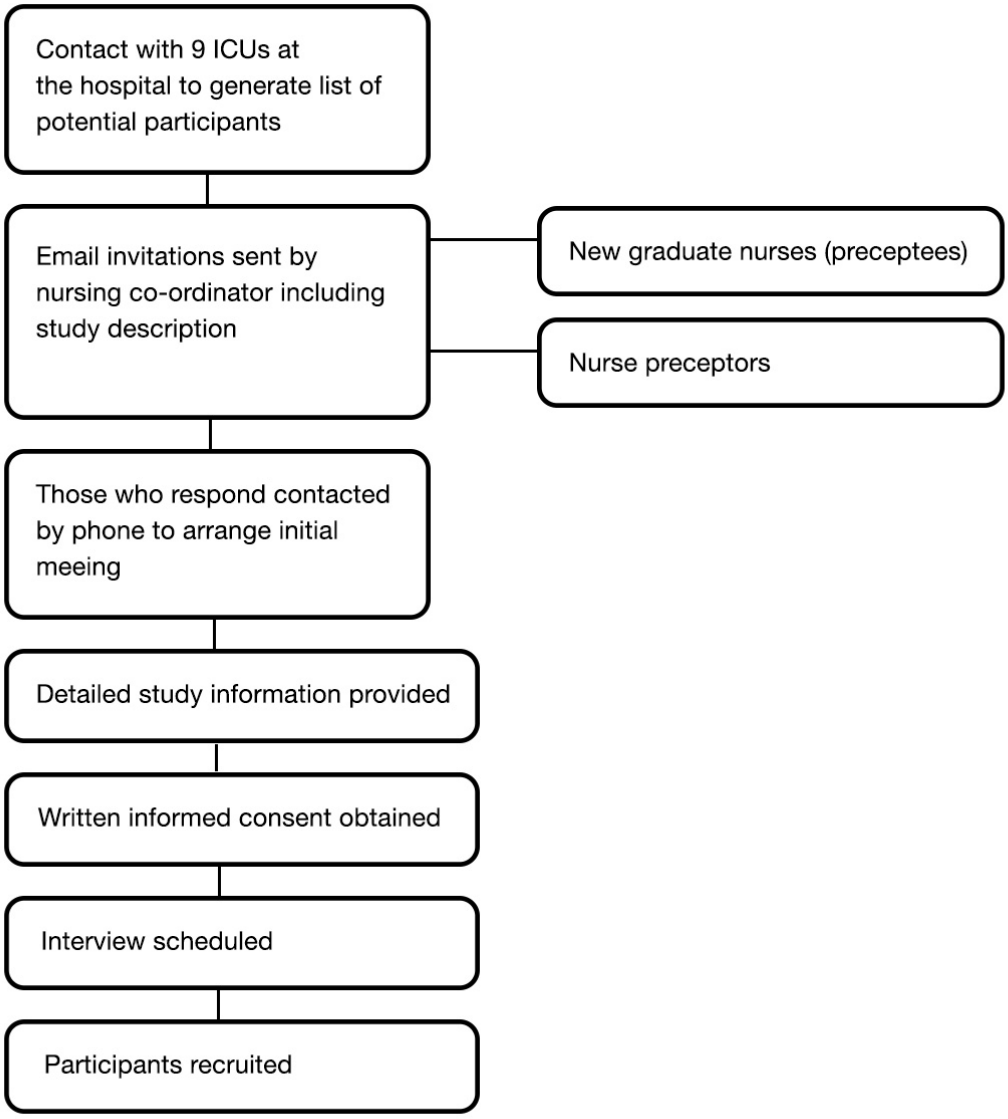

FIGURE 4: FLOWCHART OF THE RECRUITMENT PROCESS OF POTENTIAL PARTICIPANTS

4.7 Pilot Study

A pilot study in qualitative research has been recommended for novice researchers (Kim 2010). The principal benefit of conducting a pilot study is that it provides the researcher with an opportunity to make adjustments and amendments to the design of the main study (Krueger and Casey 2009; Hennink et al. 2011). Furthermore, it helps the researcher to improve their skills and gain more confidence in conducting qualitative research (Hennink 2007). A pilot study was conducted to use and develop semi-structured interview questions intended for the main study. Specifically, a preliminary pilot semi-structured interview was conducted to assess the effectiveness of the semi-structured interview guide and whether responses to the questions would effectively generate data that answer the research questions and thus safeguard the internal validity of the research (Guba, 1981). Additionally, as a novice in the field, I practised observation and interview techniques with my supervisors, focusing on how the data would be collected and documented as well as how the findings would be discussed. Data obtained from this pilot study were not incorporated into the main study, however, the pilot study was crucial for preparing me for the field and for testing techniques and refining the observation procedures.

4.8 Semi-structured Interviews

Gill et al. (2008) describe research interviews as either structured or unstructured verbal communications between the participant and researcher, during which, the participant divulges pertinent information to answer the research questions. Semi-structured interviews allow flexibility, enabling the researcher to adjust, clarify, and explore different avenues as required. Simons (2009) also explains that interviews are effective methods to determine the differing experiences of participants. Furthermore, semi-structured one-to-one interviews are considered appropriate to maintain confidentiality and to encourage the participants to divulge any sensitive information that they may have been reluctant to express in a group situation (Simons, 2009). In this study, semi-structured interviews were used as a tool within a broader ethnographic toolkit. Semi-structured interviews enables additional questioning to produce large quantities of richly-detailed data, which is useful when conducting exploratory research because it allows the researcher to develop findings which may not have been anticipated during the planning of the study (Watson et al., 2008). In addition, semi-structured interviews assist in gaining an ‘emic’ perception of the phenomenon under study and constructing more insight into participants’

interactions (Deitrick et al., 2006). The 'emic' perspective encapsulates participants' perceptions of their experiences (Deitrick, et al. 2006). Ethnographic approaches conceptualise interviews as an imperfect technique (Hammersley, 2006). As Hammersley (2006) explains, they are:

> "*declared illegitimate by the radical critique, on the grounds that they make questionable inferences from what is said in particular interview contexts to events, attitudes and/or behaviour beyond those contexts. Also denied is that interviews display the genuine, individual voices of informants. Instead, it is argued that what informants say in interview contexts is always socio-discursively constructed in a context-sensitive fashion, and indeed that it is only through such local processes of social construction that informants are themselves constituted, or positioned, as having particular identities*". (p.9)

Such viewpoints, however, do not consider the traditional focus of ethnography, which is to understand the perspective of others in a nuanced way and they erroneously assume that such understandings can only be achieved through observed behaviour (Hammersley, 2006). Interviews have nevertheless been considered essential when it is not possible to perform a very large amount of observation and in situations where the participants' perspectives or opinions might not be clear from observation alone (Hammersley 1992).

Each formal interview was conducted at the end of the nurse's shift or during break time and was scheduled to last for an hour. These interviews took place in September 2019. The participants were interviewed in a private room on the ward where they worked. The interviews lasted from forty-five minutes to one hour depending on the time participants required to share their narratives. At the commencement of the interview process, the two parties (the interviewer and interviewee) are normally strangers. This frequently leads the respondent to feel self-conscious, and nervous. Therefore, the interviewer must project him or herself in an encouraging way that will break down any resistance in the respondent. First impressions are important, as the participant will make a rapid decision on whether to become involved during this initial phase. As such, it is prudent to have all the necessary information available for the potential participant, including the study information and the researcher's credentials. This places the participants at ease and makes them feel that they are involving themselves in legitimate research (Rubin and

Rubin, 2011). For this study, my aim was to become acquainted with the participants before each interview by holding several informative meetings on the purpose and design of the study. This allowed for the development of a good rapport before the private interviews were conducted and permitted critical comments to be made by participants.

During the interviews, I made field notes of the gestures and body language of my respondents to complement the narrative data that was sourced. I documented observations and key impressions of the interview process following each interview by maintaining a journal throughout the study. I used the journal for making notes about emerging themes and methodological processes, and to describe beliefs and my personal experiences and how they contribute to the interpretation. The notes helped me to maintain the rigour needed to be in accordance with the actual lived experience. To maintain focus during the interviews, I developed a flexible interview guide (see Appendix 8) which was reviewed by my supervisors before ethical approval. In semi-structured qualitative interviews, researchers are advised to use a list of relatively fixed questions or fairly specific topics to be covered; this is called an 'interview schedule' or 'interview guide'. In this case, the researcher may choose not to use the questions exactly as scheduled in the interview guide, but all questions should be asked, and new questions might be added (Mason 2002). The interview guide was developed based on findings from the observations and field notes from the pilot study. As suggested by Doody and Noonan (2013), during the interviews, the participants were encouraged to ask questions and raise any issues they felt were relevant to the research that may not have been reflected in the questions.

Interviews were undertaken on two occasions: pre-observation and post-observation. During the first occasion, I was guided by my broad research interests – gathering data to explore a variety of possible ideas and lines of enquiry. The purpose of the pre-observation interview was to explore the views of newly-qualified graduate nurses and their preceptors regarding the current practice of preceptorship in nursing in Saudi Arabia and to comment upon any issues which participants feel are significant to the study aims and require further and enhanced recognition. On this occasion, semi-structured individual interviews (separately with both participants) gave me a clear picture of the new graduate nurses' needs or expectations in their preceptorship period and helped me to understand the role of the preceptor from their perspective. This also helped me to understand the perceived role of the nurse preceptors and the values preceptees place on the level of support they receive from preceptors during their clinical placements. The semi-structured individual interview was considered suitable for this occasion as it can be used to explore the

personal philosophy of each participant regarding their relationship in preceptorship without the influence of other participants (Bryman 2008). Moreover, this approach was chosen because it is flexible despite its focus being determined by the researcher. This is because the sequence of questions can be changed during the interview as a response to participants' responses. Furthermore, semi-structured interviews enable the researcher to add new questions in response to the direction in which interviewees take the interview and explore responses to questions to elicit clarity /deeper understanding (Speziale and Carpenter 2007).

On the second occasion, the semi-structured interview was conducted after the observation. The participants who had been observed were asked to participate in them. It should be borne in mind that the structure of the interviews developed over the duration of the data collection, and as I built upon and clarified ideas that arose from previous interviews and observations in the field (Legard et al, 2003).

I adopted different interviewing strategies for preceptors and preceptees. For preceptees, they verbally and emotionally expressed their lived experiences in their own words, in their own language, Arabic. I too entered their world, as Arabic is also my mother tongue and I share their culture. Gadamer (1975) has made an outstanding contribution to interpretation efforts by introducing the hermeneutical method of inquiry. In his philosophy, he focuses on the importance of language as a central concern of hermeneutic understanding and interpretation, not only as an instrument of communication but as a means of transporting feelings, thoughts and traditions. Against this backdrop, allowing preceptees to freely speak about their lived experiences in Arabic and then interpreting the texts in their original form and content enabled me, by living and immersing myself in the texts, to grasp their meaning and interpret the findings from the text. I transcribed and analysed the data in Arabic to retain the meaning of the texts and to ensure that they reflected the views of participants (Twinn, 1997). Translating the interviews into English to analyse them may have affected the intended meaning of the text, as it is difficult to find similar translations for some Arabic terms in English. There is a significant discrepancy between English and Arabic languages, and it is impossible to accurately translate some words into English. In similar studies in Japan and China, differences in the meaning of terms emerged when data were translated into English (Chang et al.1999; Tang and Dixon, 2002). Tang and Dixon (2002) resolved this by conducting a cross-cultural validity test to confirm similarities in meaning. Thus, excerpts were selected to ensure that they captured the intended meaning following translation. The only

parts of the data translated into English were the individual quotes from interviews, cited in the research findings.

For preceptors, I conducted the interviews in the English language since this demographic was primarily non-Saudi in background. The interview transcripts had many grammatical mistakes because many of the interviewees did not speak English fluently. However, despite the errors, the transcripts were not corrected to avoid changing the meaning of the interviewees' responses. Quotations from the interview transcripts are provided in the next chapter in the original format, but punctuation marks have been introduced for better coherence. Furthermore, to avoid altering what the interviewees meant to say, irrelevant parts of the transcripts have been removed, as indicated by the ellipsis points […]. In this manner, it was possible to maintain data consistency and truthfulness while providing a verbatim account of the interviewees' answers.

Verbatim transcription of the digitally recorded interviews was completed to ensure no information was inadvertently lost. The recordings were uploaded onto a password-protected computer as soon as possible after the interview, and always on the same day.

4.9 Observation Fieldwork

In this study, the observation was overt whereby I explicitly made my intention to observe the social behaviours of my participants clear. The observation was conducted over a period of three months beginning in October 2019 and ending in December 2019 (see Appendix 9). This period was considered sufficient to capture a comprehensive picture of the social behaviours of the participants. The participants were 5 pairs of respondents, with each pair including one preceptee (NGN) and more than one preceptor. Each pair was observed for 5 hours per day over 4 days resulting in a total observation of 20 hours per case and 100 hours in total.

Observational methods are considered the gold standard of qualitative methods, because they provide direct access to what people do, as well as what they say they do (Green and Thorogood 2004). Hammersley and Atkinson (2007) describe participant observation as a data collection method that requires the researcher to engage in people's daily life over a length of time. They explain that this type of method is useful for gaining improved insight into the values and behaviours of participants in a cultural context to throw light on the problem being studied. This is particularly the case when an insight into the social nature of the institution is required. In

addition, by examining the notes taken during observation, I was able to ask additional questions and elicit the participants' perspectives on some of the behaviours that were observed. I also gathered additional data from post-observation interviews (Simons, 2009). The main feature of observation as a method of data collection is its ability to view participants' behaviour in the context of the 'real world' (Fetterman, 2010). Vandenberg and Hall (2011) have stated that observation as a data collection method contributes to creating in-depth descriptions of the 'social site'. My observation aimed to gain a better understanding of how the nurse preceptors interact with preceptees in their everyday work practices to closely examine the social and interactive contexts of what constitutes good practice and how learning occurs in an acute clinical setting, where they have opportunities to learn practical skills. They focused on all interactions between preceptors and preceptees so that I could explore a rich variety of precepting activities. I recorded field notes in relation to all activities that the participants undertook in their normal working roles while caring for their patients. During the observations, the sequence of events was described as related to the actions and the behaviour of the participants. The event, how the event occurred, as well as behaviour specific to the act, were all recorded (see section 4.10).

Overt observation occurs when participants know they are being observed and are aware of the purpose of the study (Gerrish and Lathlean 2015). Covert observation means that participants are either unaware of being observed or the observer conceals the real reason for observing them. Covert methods involve deception, with researchers pretending to be someone they are not. This type of observation is now considered unethical because it violates individuals' right to autonomy and their ability to decide whether they want to be observed or not (Gerrish and Lathlean 2015).

Various authors have characterised the range of roles that researchers can play in the field (Adler and Adler, 1994; Spradley, 1980). Gold (1958) presented a typology based on four categories: "the complete participant," "the participant as observer," "the observer as participant," and "the complete observer." In Gold's (1958) taxonomy, the complete participant actively engages with the research setting, although does not disclose her true identity to informants. As with the complete participant, the participant as an observer plays the role of an insider, although in this case, informants are aware of the researcher's purpose in the field. Using this approach, the participant as an observer observes informants informally and/or conducts interviews with them. Contrastingly, the observer as a participant has limited social interaction with informants, typically relying on one-time interviews for information. Finally, the complete observer does not establish any social relationship with informants; instead, observation is covert, occurring through

eavesdropping or behind a two-way mirror, for example. Based on Gold's (1958) classification scheme, the role of participant as an observer was the role adopted for data collection. To establish this role, I first introduced myself as a researcher, and then before the research began. In addition, I gathered data by informally observing behaviour in the hospital wards (and by conducting scheduled interviews). What is more, as time elapsed, I interacted more fully with informants and, on occasion, I socialised with them during breaks.

Gold (1958) stresses several challenges faced by the participant as an observer that may jeopardise the quality of research. He warns that the relationship between the participant as an observer and informant may be compromised if certain boundaries are not maintained, specifically if the fieldworker and/or informant overidentify with one another. To prevent this situation, Gold (1958) suggests that the fieldworker strive to develop trust and intimacy ("intimate content") with informants, although with sufficient emotional detachment that a short-term relationship satisfies both parties (p.221). During the data collection period, I worked to allay informants' fears regarding my presence at the hospital and establish trusting relationships with them. As discussed, I sometimes interacted socially with them to build this trust, but at no time did I lose sight of the need to maintain sufficient emotional distance to keep the relationship confined to the hospital setting.

The knowledge that they are being observed often makes people self-conscious which may affect their behaviour (the Hawthorne effect) (Jones, 1992). However, the results of studies carried out in several areas of nursing suggest that, as participants grow accustomed to the observer's presence, their behaviour will more closely resemble normal, everyday behaviour (Clarke and Bowling 1990; Briggs et al. 2003). A key strategy in minimising the effect of my presence on participants' behaviour was taking time to build a rapport with them before starting data collection. In addition, as the time spent in the setting increased, the perception of me as a stranger transitioned to that of a professional colleague. The degree of trust determined the nature of the data provided by the participant to me in my role as a researcher.

When I first met with the participants to obtain their consent, I explained the research aims and my role clearly and in detail, and I gave them enough time to ask questions. I found that most of them agreed to participate because they wanted someone to hear their voice. I always wore my university identification to show the participants that I was a researcher rather than an investigator. To decrease the participants' stress, I initiated the observation by talking with the

participants in general and not focusing on their work. On some occasions, when participants were struggling to perform some procedures, they appeared anxious, as they looked at me as an expert who would judge their performance. However, I did not comment on their performance, and I followed what Roberts (2009) suggests by being honest and clear with them and explaining to them that I was acting as a researcher rather than an expert evaluating their performance.

With time, the participants invited me many times to eat with them or have coffee; they were very generous to me. I was more than happy to accept their invitation. I was more than happy to bring them some food and coffee and eat together during my visit, which helped to build a good relationship with the participants. With time, I found the participants talked more about their experiences and challenges they faced as Saudi new graduate nurses and immigrant nurses. These conversations helped me understand more about their experience; as Spradley (1979) states, both the researcher and participants may find that this kind of conversation is more than just friendly talk, but instead, it has an aim.

4.10 Field Notes and Reflexivity

In studies that use observation, all data are recorded as field notes. Field notes are a written account of the things that the researcher hears, sees, experiences and thinks in the course of collecting or reflecting on data in a qualitative study (Morse 1995). Spardley (1979) identifies different types of field notes in terms of condensed and extended accounts. Condensed accounts are short descriptions made in the field during observation, while expanded accounts extend the descriptions and fill in the detail. Initially, field notes are only for the eyes of the ethnographer, but ultimately, excerpts are used as data or extended descriptions in ethnographic writing (Gerrish and Lathlean 2015). Detailed, accurate and extensive field notes are necessary for a successful qualitative study.

Field notes have their basis in observations and interviews undertaken in the setting. A tape-recorded interview does not portray the physical setting, the impressions the observer picks up, or the non-verbal communication in an observed interaction. These observations should therefore be recorded in the field notes to supplement the taped interview and to provide a complete picture. In this study, field notes were an important part of the process of recording the observations, and were supported by interviews conducted in the context of the observation itself. Field notes were

recorded by hand in notebooks during the activity or immediately following a period of observation with the assistance of a template (see Appendix 10). These notes were used as the basis for writing an expanded account within 24 hours of completing each period of observation. Each field note was maintained separately from the others and had a set layout with the date and time of the observation, the site or unit in which the observation took place and the code of the participant. My fieldnotes were cross-referenced with my observation and/or interview scheduled because this acts as an aid to keep track of the data and locate related observations or interviews. The field note template (see Appendix 10) consisted of records of salient points that will be developed to provide additional detail later the same day. They took the form of reconstructions of interactions, short conversation excerpts, or descriptions of events. The notes recorded during an interaction are kept brief so that the researcher/observer can concentrate on what is happening to get a feeling for the situation as it unfolds (Emerson et al., 2011). After these were completed, I typed them up using Microsoft Word. These were then saved in an electronic file. The computer used was password protected and field notes were recorded.

Thomson (2011) has stated that field notes consist of local descriptions of events, interactions between groups and further plans. This indicates that field notes may be considered as a technique to structure data collection systematically. Extra notes were kept to one side as a reminder for the researcher to remark on the focus and progress of the observations. This was part of the process of reflexivity (Litchterman, 2017). As part of this, I documented my feelings about how the events unfolded during the observation, and then came back to these notes to assess them. Researchers need to be aware of the ways in which their biases and assumptions shape the outcomes of their research. Reflexivity takes on particular significance for “native researchers” (researchers conducting research in their country of origin) who may be desensitised to cultural norms and thus less likely to notice patterns and dynamics that are a part of the local way of life (Abdulrehman 2017). Therefore, I tried to make it evident how my personality has ultimately been moulded by an Islamic and Arabic cultural background and my values, beliefs, and education have resulted in viewing reality from a certain perspective, including having experience as a preceptor and preceptee nurse. I was both an insider and an outsider in the context of my fieldwork. I considered myself an insider researcher as I share a language, identity and experiences with some of the participants in this study (Asselin, 2003). Being an insider researcher helped me gain a more in-depth understanding of the participants (Kanuha, 2000). Concurrently, I was an

outsider as I had no familiarity with the research setting (hospital) and I had no personal or professional ties with the participants. This played a crucial role in lessening bias.

During this time, I was in regular contact with my supervisor, and we met regularly via Skype and discussed the observations. We also considered how I could improve myself by writing down the observations in more detail and avoiding being biased. In addition, I kept a reflective journal, writing down all the feelings and challenges I experienced and subsequently discussing them my supervisor.

I continued journaling during the analysis phase of the research process. This enabled me to write down my impressions of the data as well to reflect on how my role as a researcher might be influencing my interpretation of the data. I also took measures during data analysis to avoid privileging particular viewpoints over others and compared the viewpoints of each group with one another to determine similarities and differences between them. I also maintained contact with my supervisor, meeting frequently to talk through my (preliminary) findings and continue taking stock of the potential for bias.

4.11 Data Analysis: Finding the Links and Themes in the Research Materials

Thematic analysis was employed in this study as the analytical framework. Thematic analysis is an approach that allows researchers to extract meanings and concepts from qualitative data. This involves “identifying, analysing, and reporting patterns (themes) within data” (Braun and Clarke, 2006, p. 79). Thematic analysis is an analytical technique that can be used to systematically identify, organise and provide information regarding the patterns that are prevalent in a dataset. The focus on identifying themes and patterns throughout the dataset enables the researcher to identify and understand collaborative and implied meanings and experiences. Thus, this method is effectively a means of establishing common factors regarding how a topic is discussed as a precursor to gaining a nuanced understanding of them. Nonetheless, it is important to note that common factors are not always meaningful. In this study, data was simultaneously collected and analysed, as the themes of the study were continuously updated. The large amount of data generated in this study is typical of qualitative research, which is why such projects are considered difficult to manage.

The accessibility and flexibility of Thematic Analysis are the two main reasons why this framework is useful for researchers (Braun and Clarke, 2014). First, Thematic Analysis benefits those who are new to qualitative research by offering a tangible and workable method among a suite of other tools that can appear vague, confusing, theoretically challenging and complicated (Braun and Clarke, 2014). Thematic analysis also offers a qualitative research technique that educates the user as he or she systematically codes and evaluates the data, a skill that can later be used in connection with wider conceptual phenomena (Braun and Clarke, 2014). Finally, while thematic analysis has been criticised for lacking an epistemological underpinning, Braun and Clarke (2006) argue that instead, this is a strong point as it allows the framework to be applied more flexibly and in conjunction with a range of theoretical perspectives.

Braun and Clarke's (2006) qualitative thematic analysis was applied in the analysis stage of this research. This is a flexible and popular means of qualitative data analysis that has been widely used by many researchers. Howitt and Cramer (2008) note that Braun and Clarke's (2006) method of conducting Thematic analysis is methodical and highly effective for helping researchers discern relevant themes. Braun and Clarke's (2006) framework includes six steps to systematically manage data and conduct analysis which are discussed in section 5.3.

4.11.1 The Process of Interpretation

After familiarising myself with each dyad data set, I worked hermeneutically in search of essential meanings that underpin the preceptor-preceptee relationship. I then wrote a description for each of the participants' stories which were typically no more than two paragraphs in length. In Appendix 11, examples of five descriptive statements are provided. After the description was completed, each story was considered interpretively as part of the hermeneutic process of analysis. The analysis process was framed by the following questions: 1) What was the story about? 2) What was the story telling me about the preceptor-preceptee relationship? After reviewing my notes which I had compiled for a story, I would consider the questions above and immerse myself in my responses, thinking about the story while typing out its meanings in a cursory manner. I found it less constructive to make extensive notes that might structure a possible interpretation, nevertheless, it was through the process of writing that meanings emerged.

Invariably, I needed to resist the temptation to categorise, in favour of creatively writing in a way that might help the hidden meanings to be revealed in the text. Interpretations were re-constructed as I became increasingly attuned to other possible interpretations. I found it necessary to dwell on the interpretation of a particular story through several drafts before moving on to the next story. This meant that stories were analysed hermeneutically for an extended period.

The next step in my hermeneutic process was to re-read the entire set of stories and interpretations for a participant and consider what the set of stories contributed to my understanding of the preceptor-preceptee relationship. I approached this phase as a writing activity that involved processes of writing-reading-re-writing and re-reading. It was critically important that I remained open to contemplatively thinking about the meanings within the stories. Heidegger (1996) suggests that interpretive writing allows thoughts to find us. At times, this involved suspending the writing and finding silent spaces to engage contemplatively and imaginatively with the data. For van Manen (1990), hermeneutically interpreting the meaning of a text or a lived experience is "more accurately a process of insightful invention, discovery or disclosure-grasping and formulating a thematic understanding is not a rule-bound process but a free act of 'seeing' meaning" (p. 79). Importantly, suspending my writing for contemplative opportunities lessened my tendency to make simplistic deductions or inferences for ideas that emerge.

When all the stories of the participants had been hermeneutically interpreted to this level, the entire set of stories and their respective interpretations became the basis of dialogue with my supervisors. During this time, the quality of the interpretive writing was discussed, interpretations were challenged, my prejudices became a matter of debate and I was prompted to review my assumptions. An example of this was my tendency to more readily apportion blame to the preceptor if the preceptor-preceptee relationship was a matter of concern. I assumed the preceptor to be responsible for the overall quality of the preceptorship experience and this included the nature of the preceptorship. In dialogue, and as a consequence of re-reading some of the stories, I appreciated more fully the way preceptees actively influence the preceptor-preceptee relationship. In so doing, I was able to develop a deeper understanding of how preceptees influence the preceptor's way of being.

Additionally, some of my interpretations potentially oversimplified the realities of the preceptorship process. Concerned about the preceptor-preceptee relationship, and apportioning greater responsibility on the preceptor, I had overlooked the context of the experience. My challenge was to fully understand the experience being shared by the participant rather than emphasise and idealise certain practices that might demonstrate the potential value of the preceptor-preceptee relationship in these contexts. This process meant that the data analysis process was extensive and the sustained period enabled an immersion experience in and with the text.

As part of this immersive experience, I re-read the entire set of stories, descriptions and interpretations. The purpose was to find themes in a whole sense rather than themes relating to each participant. While re-reading the stories, I made a new set of notes which included aspects of the story that appeared to have something to say. These notes were re-read again, as I identified a set of initial emerging themes across the stories. The themes revealed essential meanings of the preceptor-preceptee relationship.

I continuously worked with my supervisors to further discuss identified themes. I compared written summaries of key phrases within each participant's transcript, re-reading and returning to the text for clarification or to resolve discrepancies in collaboration with my supervisors. This circuitous process was ongoing until the identified themes reflected participants shared practices and common meanings. Common meanings occurred within each interview text and across interviews. It is through hermeneutics that shared experiences and common meanings hidden in the "everydayness" of the lived experience became illuminated.

I maintained a journal throughout the study to document notes about the emergent themes, and methodological processes and to describe beliefs and personal experiences and how they contributed to my interpretations. Drawing upon my lived experience as a researcher was a salient feature of the analysis process to maintain methodological rigour. Demonstrating a convergence of researcher understanding with participant narratives and presenting the findings informed by the writings of Heidegger enriches findings (Draucker, 1999).

4.12 Ethical Considerations

Guillemin and Gillam (2004) explain that ethical approval is significant in research. To gain access to the research setting, I sent an email to the proposed hospital Ethics Committee asking them about the possibility of conducting the study in their hospital. They gave their approval, in principle for the study to take place. Additionally, I was required to gain consent from the nursing director to facilitate the process. Therefore, another letter of support for the research to be conducted in ICUs was sent to the nursing director, informing her of the study. I first obtained ethical approval for this study from the University of Southampton Ethics Committee before applying to the Research Ethics Committee of the hospital in Saudi Arabia.

Furthermore, the King Abdulaziz Medical City authorities and director of Ministry of National Guard Health Affairs reviewed the statement of purpose and study design and granted permission to undertake this study. It was a priority for me to rigorously pursue and maintain ethical standards. The study has been completed in a manner that respects the ethical requirements of research, including respecting the rights of the participants and avoiding dishonesty (Welman et al., 2005). Furthermore, as suggested by Long and Johnson (2007), a robust ethical framework incorporating the benefits versus harm approach has been followed and is further detailed below. As this is a field-based study, observations have been made of individuals not directly involved in the study, including patients. As such, posters explaining the nature of the study and the minimal risk to nurses and patients were displayed in all wards where the observations were conducted. These posters (see Appendix 12) provided details about how patients or their relatives could opt out of the observations.

4.12.1 Autonomy and Informed Consent

Informed consent is central to ethical practice and this means every participant should be fully informed of the research aim and potential benefits and harms of the research to be carried out. Information about the research should be concise and clear to the participant and in a language that the participant can understand. Prior to the commencement of the study, written informed consent was sought from all the participants. The participants were informed of their option to participate, right to decline participation in the study and right to withdraw from participating in the research a week before the data collection procedure without consequence. A participant information sheet for the preceptees and preceptors was designed and distributed throughout the hospital. Following the distribution of the information sheet, a meeting was arranged with the

potential participants and researcher so that details of the study could be provided and the participants' rights could be orally explained. The ways in which the results of the study were to be communicated were also discussed. The participants were provided with a consent form that described the study. The participants were allowed to take the form with them to consider their participation more fully at home or once their shift ended at work. They were asked to return the signed form within a week if they wished to participate in the study. All participants were informed of their right to withdraw from the study at any point in time, with no questions asked. Following this, mutually agreeable times and dates for interviews with the participants were scheduled. Participants and potential participants could raise any questions about the study using the contact information provided by the researcher. The signed consent forms were secured in a locked filing cabinet in the researcher's office.

To safeguard the autonomy of the participants, during interviews, I made a constant effort to avoid introducing my thoughts or opinions about the preceptor and preceptee experience. Semi-structured interview questions allowed each participant to express their opinions in detail and with limited interference. Additionally, I engaged in regular debriefing sessions with my supervisor who offered advice on the difficulties I encountered in the field and coached me on how to avoid bias during my interviews and observations.

4.12.2 Confidentiality and Anonymity

Kaiser (2009) has explained the importance of confidentiality when collecting individualised data, stating that confidentiality and anonymity are vital in meeting ethical principles. Following the advice of Orb et al. (2001), participants' confidentiality was maintained by following a stringent protocol during the recruitment, data collection, analysis and reporting processes. This included the removal of any names of participants from any observational or interview data, and ensuring that the interviews were conducted in private rooms and that all observations were made at the bedside. All the ICU rooms are boxed in glass walls and sliding doors; thus, patients, nurses and preceptees can be seen amidst a tense working environment. Within this environment, nurses and preceptees are under intense pressure, and preceptees undergo intense monitoring and assessments. Thus, it was important to respect their working environment. They must chart significantly more to keep up with the intensive monitoring, assessments and equipment. Though they have fewer patients, this requires two or three times more documentation per patient—and

keeping that information accurate is critical when passing the patient along to the next nurse during the subsequent shift. Nurses were very focused in their working space and, because of the intensity of their work, were not always attentive to other things. Clinical discussions are standard practices in this environment, but it was important to seek a private space outside of the busy working space. This guaranteed confidentiality but also ensured that the interviews proceeded smoothly. To ensure anonymity, pseudonyms and codes for each of the participants were made. Furthermore, any quotes, personal information, or specific traits that could have identified any participant were removed. While these steps were taken, it is impossible to achieve complete anonymity in ethnographic research. The inherent nature of ethnographic research, whereby all participants have knowledge of each other, makes it impossible to ensure complete anonymity (Hoonaard, 2003). Further, during the data gathering stage, the researcher uses consent forms, fieldnotes, interview transcripts audio tapes, all of which contain personal data regarding participants. Even standard consent forms require participants to bestow their signature, constituting a permanent and non-anonymised record of the participant's identity (Hoonaard, 2003).

To protect the data, any digitally recorded interviews and conversations were transferred onto a password-protected computer on the same day as the recording was made. Access to the computer was restricted to me. The transcribed interview data were stored in the same way. Any handwritten, paper-based notes taken during field observations were stored in a locked filing cabinet. All aspects of the study, including the results, remained strictly confidential. The data were only used for the intended explained purposes, in line with current UK, SA and University of Southampton data protection principles. In line with the UK guidance, all data associated with the study will be kept for a maximum of 5 years before being destroyed.

4.12.3 Non-maleficence

By ensuring that the privacy and confidentiality of the participants were maintained at all times, every effort was made to minimize any potential for harm, embarrassment or distress. It was not possible to completely eliminate the potential for harm, however, a private room was utilised for all interviews to maintain privacy and confidentiality. This was located in the participants' departments. The participants could choose the times for their interviews at their convenience.

They could also decide on whether to inform their superiors about their participation. Despite written consent being gathered from all the participants at the start of the study, process consent was also gathered verbally at the commencement of each interview or observation to facilitate the minimal risk of harm.

This is a non-intervention study, meaning there was no direct influence from me on patient care because the observations are around social interaction. However, possible harm might have included physical, emotional, social and financial effects. In the context of this study, there was no risk of physical harm, but it can be more challenging to predict other types of, particularly emotional, harm. One of the possible emotional harms that could have arisen was the possibility that the participants might have been uncomfortable about being observed during their practice. However, it was expected that this will be reduced over time as the participants became used to me as the observer, felt less threatened, and grew more trusting. The participants could contact me at any time following their participation if they wished to talk through anything that perhaps at a later date bothered or upset them. I took every step to reduce any upset that may be experienced. As part of the debriefing component, I advised participants about who to contact, for example, GPs, nurse advisors or other key workers, if they required help.

I was aware that not all participants would feel comfortable answering some questions during the interviews. To reaffirm that participants were happy to continue their involvement in the study, I informed them that if they might feel uncomfortable or suddenly want to withdraw from the interview, they could ask to stop the tape and leave the interview area. I also informed them that if they want to continue but do not want to answer a particular question, I can omit it and move on. Therefore, I anticipated a level of sensitivity towards the possible emotional responses of the participants to the research.

As part of the research protocol, it was mandatory to report any accidents or incidents as a safeguarding measure, however, I did not have to enact this aspect of the protocol at any point. Since I am a preceptor nurse, there was a moral and legal duty to act in the patient's best interest and abide by the professional code of conduct. Thus, patient safety had priority over the research activity. Where occurrences were observed that could have been harmful to the patient or any other person, I intervened immediately. The reasons for intervention were given and the incident was reported using the standard operating procedure. Any poor practice that did not immediately

endanger the patient was discussed with the participant and reported to the appropriate supervisor.

4.13 Quality of the study (Trustworthiness)

Lincoln and Guba (1985) suggest that the criteria for judging the quality of qualitative research are credibility, confirmability, dependability and transferability. In the following sections, each of these criteria is addressed.

4.13.1 Credibility

This study ensured credibility in several ways. According to Shenton (2004), developing an early familiarity with the culture of the study setting before collecting data is one way that researchers can maintain credibility. In the context of this study, the researcher had a priori familiarity with the culture of the study setting and contextual knowledge was reinforced by preliminary visits to the sites to review their policies and guidelines. Preliminary discussions were also held with gatekeepers. Therefore, the researcher had an adequate understanding of and insight into the settings involved, which supported credibility and dependability.

However, the researcher's own experiences, including familiarity with the settings, could have affected her understanding and interpretation of the context of the experiences explored (Finlay, 2002). This explains the adoption of a reflexive approach throughout the study. I kept a reflective commentary throughout the research process, recording her thoughts about the progress of the research, emerging patterns during the data collection, obtaining ethical approval and obstacles encountered while conducting the study. In addition, regular meetings with supervisors throughout the study challenged the researcher's assumptions (Lincoln and Guba, 1985). My supervisors served to improve the rigour of the study by providing oversight that minimized the risk that my bias could interfere with the proper interpretation of the narrative data. Frequent feedback from the supervisory team enabled me to develop stronger justifications for the research design and methods that I used, which increased the credibility of the study (Lincoln and Guba, 1985).

Further, to ensure credibility, adequate time spent with each participant was followed by intense engagement with the raw data. I accomplished this by returning often to the written narratives and by periodically listening to interview audio recordings to recapture participants' emotions through voice tone and inflexion.

4.13.2 Dependability

The dependability of a study is inextricably related to its credibility (Robson, 1993). To address dependability in qualitative research more directly, the processes within the study should be reported in detail, which also allows replication of the research later by other researchers (Shenton, 2004). I carefully examined and discussed with my supervision team, the details of each step of my research, including the analysis procedure to ensure that the process of analysis was compatible with the planned methodology and to safeguard the credibility and dependability of the study. Every emerging theme was examined extensively and discussed in detail with the supervision team before further analysis proceeded. This careful step-by-step discussion through all phases of the study, including the data analysis, became a helpful checklist for ensuring the dependability of this study.

The dependability of the research findings, according to Lincoln and Guba (1985), is enhanced when one can follow the audit trail. Conducting multiple phases of interpretation independently and with my supervisors enhanced the audit trail. Dependability and confirmability were also demonstrated through the presentation of movement from verbatim phrases to themes in an audit trail thus supporting stepwise replication of analysis. This was supported by the inclusion of verbatim quotations described in the audit trail.

4.13.3 Transferability

Transferability refers to how the findings of a study can be applied to other sample groups and contexts (Lincoln and Guba, 1985). In the present study, to help readers make informed decisions about transferability, I provided a detailed description of the research process, including the study situation, the context in which the investigation was undertaken (fieldwork sites) and the methodology that I employed (Lincoln and Guba, 1985). The reader can therefore decide whether

transferability has been achieved and whether the findings apply to other settings (Lincoln and Guba, 1985).

4.13.4 Confirmability

I approached confirmability by giving a detailed description of the methodology used and explaining the beliefs behind the decisions made (Lincoln and Guba, 1985). According to Miles and Huberman (1999), an important criterion for confirmability is that researchers acknowledge their predispositions. As mentioned, I kept a reflective diary to ensure that the study findings were the result of exploring participants' experiences and perceptions as opposed to my preferences. Additionally, all participants were allowed to confirm the accuracy of the transcripts of the individual interviews. The participants' affirmation of the accuracy of transcripts guaranteed that comments were genuine, accurate and objective, increasing the trustworthiness of the study (Roberts et al., 2006). In addition, an audit trail was maintained to examine the research process and data for consistency and to increase dependability (Hoepfl, 1997).

According to Koch (2006), confirmability is usually established with credibility, dependability and transformability and occurs when researchers show how they came to their findings in the inquiry under investigation. In this study, I have taken all possible measures to ensure that steps and processes have been logically carried out, recorded and confirmed with my supervision team. Hoskins and Mariano (2004) argue that to establish confirmability, the researcher must confirm that findings and conclusions are supported by the data and that there is an alignment between the interpretation of the researcher and real evidence.

4.14 Summary

In this chapter, I have provided a comprehensive overview of the methodological framework that underpins this study. I have specifically highlighted the epistemological position of this research, and its roots in ethnography and uncovering the subjective experiences of preceptors and preceptees in relation to the research question. I seek to gain a nuanced understanding of the preceptorship relationship in Saudi Arabia, by focusing on the viewpoints of my research subjects. In the next chapter, the emergent data is presented based on these subjectivities. This data must

however be contextualised within the limitations of the methods employed in this study, which have been extensively discussed in this chapter. In the concluding chapter of this thesis, I delve extensively into the limitations of this study, which can inform the design of future studies.

Chapter 5: Results

5.1 Introduction

To address the research questions of this study, observational data were collected along with pre- and post-interviews.

The following research questions are addressed:

1. What are the individual, organisational and structural factors and processes that shape the relationship between the preceptor and preceptee?

2. What is the range of experiences of preceptors-preceptees relations, and what are factors of preceptorship success?

3. How does the relationship between preceptor and preceptees impact the perceived success of the preceptee?

Fieldwork was conducted to gather information on the day-to-day working practices of new graduate nurses (NGNs) and their preceptors in the hospital wards (ICUs). As part of the fieldwork, both formal and informal conversations with the respondents were captured. Face-to-face semi-structured individual interviews were also conducted with the NGNs and nurse preceptors. A thematic analysis of the resultant data is presented from 5 pairs of respondents through narrative synthesis, with each pair including one preceptee (NGN) and more than one preceptor. Each pair has been observed for a period of 5 hours per day over the course of 4 days resulting in a total observation of 20 hours per case and 100 hours in total. This chapter begins with a discussion of the demographic details of the participants, followed by the findings from the interviews together with those of the observations based on the fieldwork conducted at a hospital in Saudi Arabia.

5.2 Demographic Characteristics of the Study Participants

This study included Saudi and non-Saudi nurse preceptors working in intensive care units and their preceptees (New graduate nurses). Fourteen participants were recruited, including one male nurse and thirteen female nurses from four wards, ICU1, ICU2, ICU3 and ICU4. Ward managers

and clinical resource nurses (CRN), located in the same wards as the preceptees and preceptors, were recruited to obtain multiple perspectives and develop a richer understanding of the preceptorship process. Table 5 shows the demographic characteristics of the preceptees and preceptors.

The preceptees ranged from 24 to 26 years and were predominantly female (n = 5) with a Bachelor of Science in Nursing (BSN) degree as their basic educational qualification. They are currently in their first nursing job, their employment is directly related to critical care units, and they are currently undergoing a preceptorship programme. The preceptees are Saudi citizens and graduated from a Saudi university, and the sample selected reflected the skill mix of the environment and facilitated the acquisition of more diverse data.

Preceptors ranged in age from 32 to 49 years. Eight were female, while only one was male. They were Bachelor of Science in Nursing graduates. The preceptors' clinical experience ranged from 8 to 28 years. The characteristics of preceptors differed in various respects.Regarding nationality, the preceptors were of Filipino, Indian, Jordanian, Malaysian and Saudi origin. In terms of religion, they were predominantly Christian, although a few were Muslim, Sunni and Shia. The diversity in the nationality and experiences of participants enabled me to better understand the range of meanings associated with different roles during preceptorship. The diverse demographic characteristics of study participants allowed me to explore individual and contextual factors when comparing similarities and differences in the accounts and experiences of participants.

No	Participant	Gender	Age	Nationality and Religion	Total years of nursing experience	Total years of experience as preceptor	Unit	Unit manager	Number of Saudi nurses in the unit
Case A	Afnan Preceptee	F	24	Saudi Muslim Sunni	No	-	ICU1	Non-Saudi with Saudi assistant	2 juniors 'Sunni'
	Alice Preceptor	F	49	Filipino Christian	28 years	13 Years			
	Angela Preceptor	F	34	Filipino Christian	13 years	6 years			
Case B	Basma Preceptee	F	26	Saudi Muslim Sunni	No	-	ICU2	Non-Saudi	2 seniors 'Shia'
	Bayan Preceptor	F	34	Saudi Muslim Shia	9 years	No			
	Basel Preceptor	M	45	Jordanian Muslim Sunni	13 years	7 years			
Case C	Carmen Preceptee	F	24	Saudi Muslim Sunni	No	-	ICU3	Saudi	4 seniors 3 juniors 'Sunni'
	Clara Preceptor	F	32	Filipino Christian	8 years	3 years			
Case D	Dalia Preceptee	F	26	Saudi Muslim Sunni	No	-	ICU2	Non-Saudi	2 seniors 'Shia'
	Daisy Preceptor	F	45	Indian -	25 years	18 years			
	Demi Preceptor	F	36	Malaysian Muslim Sunni	15 years	9 years			
	Diana Preceptor	F	32	Filipino Christian	8 years	5 years			
Case E	Elham Preceptee	F	24	Saudi Muslim Sunni	No	-	ICU4	Saudi	1 senior 4 juniors 'Sunni'
	Emma Preceptor	F	32	Filipino Christian	9 years	4 years			

TABLE 5: SUMMARY OF THE DEMOGRAPHIC CHARACTERISTICS OF THE PRECEPTEE AND PRECEPTOR

5.3 Data Analysis

Braun and Clarke's (2006) six-step framework for thematic analysis was used as the primary analytical tool. The first phase of the framework entailed an extensive reading of the data set, to

draw out general patterns in respondents' narratives. Thus, an inductive approach to thematic analysis whereby the themes were drawn out from the dataset as opposed to fitting these within a pre-determined theoretical framework, coding frame, or pre-conceptions of the researcher, was employed. During the second phase, further categories were developed using colour-coding with the assistance of a highlighting pen. This enabled the themes to be clearly labelled and identified during the third phase. As part of the third phase, the transcripts were analysed more comprehensively to establish linkages between the themes and the patterns that emerged. This enabled the themes to be streamlined during the fourth phase, to ensure that they aligned with the research questions and objectives. As part of the fifth phase of the inductive thematic analysis, the highlighted excerpts of the transcripts were cross-checked to ensure that they accurately reflect the identified theme. During the sixth stage, each theme was discussed systematically using a narrative synthesis approach involving the textual analysis/representation of the data, with the support of excerpts from the transcripts.

5.4 Findings

Three themes and associated sub-themes are presented in this section. These themes have been categorized into the following typologies: societal, institutional/organisational and individual/interactional. Under the societal category, the emergent theme was 'Inequalities and Stigma: The impact on the Development and Practice of Professional Values' and the subthemes were: 1) Saudization Policy and Formal and Informal Segregation Practice, 2) Perceptions and Realities of the Saudi Nurse's Professionalism and 3) Discrimination and Ethnocentrism. At the institutional level, the theme was 'Nature of the Work' and the subthemes were: 1) Tensions between Patient Care and Mentoring, 2) The Lack of Institutional Support and Formal Processes and 3) The Division of Responsibility: Preceptorship as non-work. At the interactional level, the theme was 'Communication: Language Politics, Conversations and Locus of Power' and the subthemes were: 1) The Politics of Language (Language and Power), 2) Public and Private Spaces and Interactions and 3) Locus of Power: Trust and Conflict.

Theme 1: Inequalities and Stigma: The impact on the Development and Practice of Professional Values

The practice of professional values is shaped by inequalities, cultural tensions and stigma in the Saudi context. These are rooted in the Saudization Policy and linked with segregation, discrimination and ethnocentrism in the workplace. Non-Saudi nurses feel a sense of inferiority while Saudi nurses feel superior and contravene workplace rules. This, in turn, shapes perceptions about professionalism and shapes workplace relations. In this section, the following sub-themes are discussed: 1) Saudization Policy and Formal and Informal Segregation Practice, 2) Perceptions and Realities of the Saudi Nurse's Professionalism and 3) Discrimination and Ethnocentrism.

1.1 Saudization Policy and Formal and Informal Segregation Practice

In Saudi Arabia, both local nurses and nurses from other countries share the same workplaces, carry out the same nursing duties and care for the same patients, but there is a gap between them. This gap between local and immigrant nurses in Saudi Arabia is the result of the Saudization policy. The Saudization policy is driving both formal and informal patterns of segregation in the workplace, which is experienced by both Saudi and non-Saudi nurses. Immigrant nurses believe that the Saudization policy is causing a lack of professionalism among Saudi nurses so they contravene workplace rules by eating inside the unit and wearing accessories and makeup for example. This is a source of conflict between Saudi and non-Saudi nurses.

Example 1: Elham (preceptee) is aware of this source of conflict and stated:

> *They are afraid of us taking their position and replacing them in the hospital. They always take the issue as a war.*

Basma (preceptee) explains the lack of support from non-Saudi nurses as they are always afraid and feel threatened:

> *No one supports Saudi new graduate nurses at all levels… most of the non-Saudi nurses do not want us to progress because they think that we may take their position in the future.*

The Saudi cultural system and the Saudization Policy are affecting feelings and practices that will consequently impact the collaboration between colleagues. The preceptees (NGNs) in this study frequently voiced concerns about the hospital's lack of collegiality, particularly between the NGNs and other non-Saudi nurses. They shared the fact that they felt side-lined by the other healthcare team members, and that, rather than being part of a greater whole, they often worked alone to provide patient care.

Example 2: During the fieldwork, the nurses were observed congregated in small groups, with the Filipino nurses sitting apart from the Saudi nurses, who also isolated themselves. This divide may have been due, in part, to the Saudization programme, which is intended to introduce more qualified Saudi citizens to replace the foreign workers; an objective that

may have been perceived as threatening by the foreign nurses. The differences in culture, language, and skillset also contributed to the lack of cooperation between preceptors and preceptees in the working environment, as staff of the same nationality separated themselves from those of other nationalities. This self-segregation left the Saudi NGNs feeling marginalized although they nevertheless represent a minority group. Dalia (preceptee) stated:

> *There is racism in the unit. I hate to see that. The majority of nurses here are non-Saudi and they work in groups without cooperation. I always feel isolated because they did not accept us. I have another Saudi resident in my unit (that is Basma), but I barely meet with her.. our schedules are different. They try to separate us as much as they can.*

Example 3: Segregation is also exacerbated by cultural differences. Us versus them dichotomies influence the formation of cliques in the workplace on the basis of common nationality or ethnicity as explained by Basma (preceptee):

> *They always try to group us, but we can smartly avoid that by being neutral. For example, at the beginning of the work in the unit, they told me, "Oh, your name is Basma, as the Malaysian girl in our group but you are with the Saudi group."*

Example 4: Saudi NGN felt discrimination while at work in their own country, where Saudis comprise almost half of the nursing workforce. Dalia (preceptee) complained about the lack of cooperation among her nursing colleagues, noting that it often resulted in feelings of helplessness that affected her general well-being. According to Dalia (preceptee):

> *It affects me mentally. I work 15 shifts a month and spend 12, 13 hours in the hospital. I only meet foreign nationalities who are already sitting together and speaking their language. Two languages are allowed in the hospital, Arabic, and English. However, I speak English most of the time because I meet foreigners. I felt that I was a foreigner living in their country because they treated me as a foreign person even though I was sitting in my country and hospital.*

Example 5: While cultural differences and cliques effectively present as barriers to inclusion, a sub-theme that emerged from the data is the role of fear in presenting a barrier to friendly relations between non-Saudis and nationals whether this relates to the preceptorship relationship or peer-to-peer relationships. This theme was identified through the narratives of the respondents.

Afnan (preceptee) notes:

> *Fear is the barrier between us to building an effective relationship. This is because non-Saudi nurses are always afraid of malicious reports. I remember I talked to the manager about speaking their own language during the shift. She was angry, and they were apprehensive from my side for a long time. Non-Saudis sometimes feel threatened because they believe that we are competing for the same jobs.*

The working relationship between Saudi and immigrant nurses is also influenced by cultural differences. Cultural differences impact the interpretation of verbal and non-verbal cues which in turn, influences perceptions about professionalism. Specifically, understanding and interpreting nonverbal communication such as body language require cultural knowledge, as certain cues are not acceptable in a different culture and can be regarded offensive and unprofessional. There are personal issues that may not be valued and considered by other cultures that can affect the communication between them and contribute to segregation in the workplace:

Example 6: In Basma (preceptee) and Bayan's (preceptor) relationship, for example, the preceptor and preceptee are Saudi but came from different religious and familial backgrounds and cultural differences impeded effective communication because of misunderstandings about behaviours. For example, Bayan (preceptor) tended to laugh all the time, whether this was in response to a genuine concern or confusion of Basma (preceptee), or during the process of solving problems. This behaviour was difficult for Basma (preceptee) to decipher. On one hand, it appeared rude and appeared to dehumanise Basma's experiences as a learner, while also presenting her genuine learning difficulties as insignificant. In some instances, Bayan's (preceptor) tendency to laugh inappropriately was conceptualised by Basma (preceptee) as unprofessional and was a

source of anger for her. On the other hand, it was also difficult for Basma (preceptee) to unpack whether this behaviour had any cultural underpinnings or was a typical reaction of her preceptor with no underlying meanings. In this context, the preceptorship relationship was characterised by divergences in opinions, values, traditions and customs, causing interpersonal conflict between the preceptor and preceptee. Importantly, this resulted in lost productivity and prevented a harmonious relationship.

Basma (preceptee) believed that Bayan's (preceptor) communication style was rigid:

> *In general, she (Bayan) is good, but if she gets nervous, she starts mocking and calling me "Doctor." You know that our relationship is more sensitive because I am Sunni, and she is Shia. I always try to avoid any misunderstanding with her. This creates a barrier in our relationship. She has a different personality and mentality than I have. This difference could be because of the environment in which she was grown. The most important thing is that both of us are Saudi. Therefore, there is a kind of sensitivity and prior expectations. I feel she has to be more flexible and not silent and calm all of the time.*

The balance of power between Bayan (preceptor) and Basma (preceptee) restricted how they communicated and interacted in their professional relationship which deteriorated over time. Interestingly, ethnicity and religion are interwoven with these power dynamics, creating another layer of discomfort and tension in the relationship. According to Basma (preceptee):

> *Bayan takes shortcuts as being an expert and forgot that she has a preceptee in needs to learn…She was silent all the time and made me feel that there was a gap between us. She sometimes feels that I am superior to her as I am Sunni. She was sensitive and cautious to talk to me somehow… there are barriers*."

Cultural differences impact the interpretation of verbal and non-verbal cues which in turn, influences perceptions about professionalism.

Example 7: In case C, Clara (preceptor) noted that body language between Saudi nurses was complex, and always caused conflict because of different ethnicities and different meanings.

She said that Carmen (preceptee) has bad attitudes and communicated with her indirectly, adding:

> *Sometimes I could not understand her behaviours, for example, her body language and her eyes movements, her facial expressions especially as she wears face covering (nigab). So, it is sometimes difficult for me to guess the meaning behind her behavior. She is always moody and impossible to predict.*

The effect of culture and ethnicity in shaping the preceptorship relationship is therefore multi-layered. Culture does not always present a barrier to the preceptorship relationship.

Example 8: In Case B for example, Basma (preceptee) was assigned to a male preceptor for a day and the relationship was effective, characterised by good communication and professional dialogue. This was despite the fact that in Saudi Arabia, most female nurses may not wish to be involved in cross-gender preceptorship relationships because of existing norms and values around gender and gendered power relations. In this case, Basel (preceptor) was an experienced male Jordanian nurse who was also Muslim and an Arab; the same as Basma (preceptee). Although it was their first day together, they worked together smoothly, communicated effectively and engaged in professional dialogue. He permitted her to administer medications and perform suctioning while he watched from a distance from the nursing station. Although she had not been given full autonomy, Basma (preceptee) appeared calm and confident. During the doctor's round, Basel (preceptor) stood behind Basma (preceptee) and gave her private advice about what the doctors might ask about her patient. She was very stressed and anxious, bobbing her hands together as she read through her notes. He encouraged her to talk to the doctors and other disciplinary teams. She responded to their questions sometimes while Basel (preceptor) interjected when needed.

This theme shows that the Saudization policy is exacerbating segregation in the workplace, manifested in discriminatory behaviours and ethnocentrism. The next sub-theme is segregation in the workplace, which is the resultant effect of perceptions about the professionalism of Saudi nurses.

1.2 Perceptions and Realities of the Saudi Nurse's Professionalism

This subtheme discusses the experiences of preceptors and preceptees with different backgrounds, focusing on their perceptions and behaviours within the workplace in relation to professional attitudes. These can act as barriers between them when working together and impact patient care. There is a perception among immigrant workers that the Saudization policy is encouraging different levels of professionalism in the workplace so that Saudi nurses regularly contravene the rules. Although unit managers are responsible for setting rules and regulations, the ability of Saudi nurses to contravene these rules points to gaps in the implementation of workplace rules.

Ward managers impacted the preceptor-preceptee relationship and preceptees' empowerment in this study. Experiences of the preceptorship relationship in this study varied, and many of the participants had different experiences. Conversely, not all preceptees had such empowering experiences, with some describing a more oppressive and hierarchical structure within their units that appeared to impact their learning and empowerment. Some of these experiences were shaped by the managerial approach to the NGNs.

Example 1: During an informal conversation with an Indian Malaysian expert nurse working in ICU3 as a CRN, she noted her cultural view regarding eating and drinking inside the unit and during the shift and believes this is not a professional attitude. She framed the professionalism of Saudi nurses as a function of their nationality and culture. She described them as spoiled and undependable as they grow their nails and wear accessories and makeup. According to the CRN, there is a lack of distinction between their professional and personal identities. They further lack professionalism, conceptualise themselves as superior to other nurses, and have poor time management. Additionally, they tend to break rules because they feel entitled as Saudi nationals, to do as they please. According to the CRN, Saudi nurses are allowed to drink coffee or tea in the corridor of the unit and during the shift, unlike foreign nurses who are not permitted to eat or drink during their shifts.

In ICU3, I found that Saudi nurses are allowed to practice these unprofessional behaviours because of the unit manager. The manager was a Saudi expert nurse, but she did not

enforce any strict rules in the unit unlike the manager of ICU4, also a Saudi expert, who enforced rules to build cohesion in her team. In reality, all nurses wore scrubs and lab coats. No jewellery and make-up were permitted. The staff worked conjointly as a team. Consequently, they were productive. I noticed that in this unit, nurses were open-minded and frequently shared their ideas, analysis, suggestions, and concerns together. They were aware of each other's roles/ responsibilities and are willing to pitch in if one person was unable to complete a certain task. This provided flexibility within the team and created an adaptive team that was able to overcome new challenges. In addition, speaking other languages aside from English in the unit and during shifts was not allowed at all. If there any other language was spoken, the speaker was reported and verbally reprimanded.

Further, preceptors' stereotyping of preceptees on the basis of their culture, nationality and ethnicity impacted their perception of preceptee educational capabilities in a reductionist way.

Example 2: I found that non-Saudi nurses tended to view Saudi nurses as rich, spoiled girls, not capable of undertaking nursing duties and not suitable for the nursing profession. Diana (preceptor) for example noted that:

> *Some Saudi nurses have low levels of clinical competence and are unable to accept challenges, and tend to exhibit high levels of absenteeism and poor punctuality…we are not perfect; we are still learning all the time. However, Saudi nurses do not listen actively to us.*

Additionally, Angela (preceptor) suggests her beliefs about some Saudi nurses being incapable of doing some of the nursing tasks by themselves as they are choosing the easy work:

> *Saudi nurses tend to become lazy; they usually do shortcuts to reach their goals. They also have the right to choose their patient assignment and reject or refuse high acuity patients that require complex procedures.*

Saudi preceptees avoided performing domestic tasks such as cleaning patients, for example, where Carmen (preceptee) refused to clean her patient. Carmen (preceptee) and Clara

(preceptor) prepared some items for cleaning and wore gowns and gloves. The trolley that contained the cleaning tools was on the right side of the patient and once they entered the patient's room, Carmen (preceptee) chose to stand on the left side. Clara (preceptor) pushed the patient toward Carmen (preceptee) and Carmen (preceptee) held him. Clara (preceptor) started taking off the patient's gown and cleaning his back as he had a big wound. The patient passed a stool and Clara (preceptor) cleaned him. Throughout the cleaning procedure, Carmen (preceptee) turned her face to the other side of the patient as if she did not want to look.

Example 3: Elham's (preceptee) experience is one of concern about the image of Saudi girls in the eyes of some immigrant nurses. She noted the different ways in which Saudi nurses are treated. Elham (preceptee) revealed:

> *Culture can also be a barrier. For example, some Saudi nurses say, "I am Saudi. I will not change the patient's diaper or clean their stool". I had seen much unacceptable behaviour from some Saudi nurses when I was a patient and patient attendant. I do not want to make the same mistakes that I have seen. I want to maintain a good reputation for Saudi nurses. I feel angry if someone talks badly about Saudi nurses.*

I also found that they lack punctuality and break the rules by virtue of being a national. They believe that this entitles them to do as they please.

Example 4: In reference to her preceptee Basma (preceptee), Bayan (preceptor) also criticized the workplace practices of nationals:

> *At the beginning of the preceptorship, she was late for break for two hours, and I didn't have her number. I was busy and did not want to complain to the manager. So, I was just waiting for her. Then she came back and I asked her where were you. She said I spent my break time in my car. It had broken down, and I fixed it, so the time passed out. For me, this behaviour is weird and unacceptable.*

Daisy (preceptor) also remarked on Dalia's (preceptee) different approach to punctuality although she did not explicitly comment on her nationality as a factor:

Everybody here usually spends 5 minutes or less on the toilet, but for Dalia it is different she spends over 30 minutes and sometimes more...that's too much.

Dalia (preceptee) however noted that this perception is linked to stereotypes about her nationality:

I try hard all the time to gain her satisfaction. I once tried to come early after the break, I mean, to be on time. Unfortunately, the impression of Saudi nurses is that they are irresponsible and lack time management skills.

Unfavourable comparisons between Saudis and non-Saudis in terms of their capability and experience undermined their confidence and sense of self-efficacy which in turn, impacted their workplace attitudes and ability to work efficiently.

Example 5: Basma (preceptee) stated:

therefore, the main thing that supports us (NGNs) is to be treated well because the foreigners' stereotyped view of Saudis nurses affects our efficiency and makes it difficult to gain their trust.

This theme shows that within a multicultural working environment, perceptions based on stereotypes act as barriers to collaborative work and impacts patient care. In the next section, I will show how perceptions about the professionalism of Saudi nurses as well as discourses of favouritism breed discrimination and ethnocentrism in the workplace, introducing interactional tensions.

1.3 Discrimination and Ethnocentrism

All the participants noted in the semi-structured interviews that discrimination plays a significant role in creating barriers. They noted that this is especially concerning organisational opportunities for Saudi Shia staff, and how the preceptor-preceptee relationship can be affected by discrimination, leading to collaboration barriers among them. Saudi Shia staff also noted organisational discrimination and lack of support. They believe that favouritism is displayed towards Saudi Sunni and other ethnicities (western)

which caused them to be frustrated, upset, and develop emotional feelings that act as barriers during workplace collaborations.

Example 1: Bayan (preceptor) felt she was being discriminated against and not treated equally in the workplace due to her background as a Shia Saudi nurse. Bayan (preceptor) described how the organisational preference for Sunni staff has empowered Sunni nurses while concurrently excluding Shia nurses from organisational roles and functions. The apparent workplace preference for Sunni and foreign nurses and the organisational provision of this group with services and policies that empower them and meet their needs – without the consideration of Shia nurses' needs – could thus be described as the result of institutional racism within this facility. Bayan (preceptor) noted how the organisational discrimination role and barriers toward Saudi Shia staff caused her to feel challenged, unhappy and upset toward Sunni and non-Saudi colleagues. Bayan (preceptor) suggests that Saudi Shia nurses should have opportunities from the hospital as they are more oriented about the patients and culture, unlike other non-Saudi nurses.

In reference to Bayan (preceptor) and the other Saudi expert nurse working in the same unit, Dalia (preceptee) stated:

> *Many Saudi nurses in the ICU retired without appreciation or promotion. We have now in the department two Saudi nurses who have very high experience and have not been promoted to higher positions. This may be because they are Shia.*

While cultural or ethnic differences between preceptors and preceptees complicated relationships, similar experiences were also recorded in the case of Saudi preceptors in their relations with Saudi preceptees. In the preceptorship relationship between Bayan (preceptor) and Basma (preceptee), discrimination between Sunni and Shia nurses was observed, with a Filipino nurse asking Basma (preceptee) if it was okay for her to be trained by Bayan (preceptor) as she was Shiaa. Basma (preceptee) explains below:

> *Yes, there are barriers. I remember a situation where a Filipino nurse said to me "You are originally from Riyadh, and she is from Qatif". He means, you are a Sunni, and she is a Shia. I told him in front of her: We are all Saudis regardless of our beliefs. At that time, she was happy, but I was defeated by him why do you say it*

out loud? The foreigners know that there are social and religious differences between Sunnis and Shiites, and sometimes they seek to cause problems between us, especially, since there is a large group of them who have spent over 20 years in Saudi Arabia.

I also noted discriminatory practices against Saudi nurses, especially in units where non-Saudi administrators dominated management. During an interview with an expert Saudi Shia nurse working in ICU2, she described, in reference to Basma (preceptee) and Dalia (preceptee), feelings of discontent about the discriminative attitudes of individual non-Saudi nurse administrators and clearly labelled Saudi NGNs' experiences as evidence of racism within their workplace:

The main problem of our Portuguese manager is that she treats Saudi NGNs as students whereas they are already RNs. They can handle high acuity patients, but she never gives them a very critically ill patient. She tries in different ways to delay the Saudi new nurses' progress as much as she can in order to protect her position, especially as they are Sunni.

The newly graduated Saudi nurses felt they were discriminated against and marginalised in the workplace and as if they were not trusted. All of these influences combined resulted in many Saudi nurses thinking very seriously about leaving the intensive care units. For example, Basma (preceptee) worked independently as an ICU nurse for a year after the end of the programme and subsequently moved to work in outpatient clinics. She was however unable to remain in the ICU for a long period because she did not receive adequate support as a new nurse. She also struggled because the work environment was highly competitive and the majority of nursing staff were not cooperative. Basma (preceptee) found that the management style caused her to feel voiceless and disconnected from the decision-making process. She argued that supervision by experienced nurses would have made her feel more confident about working with patients and less fearful about making mistakes.

During the interviews, some of the non-Saudi preceptors complained that they were looked at and treated as maids or servants, not only by patients and the community but also by their Saudi preceptees. Saudis typically view foreign nurses as compared to domestic

servants, who are common in middle-class and upper-class homes. These servants perform domestic tasks, such as cleaning, childcare, caring for the elderly and driving, and are recruited into the country in the same way as foreign nurses.

Example 2: Clara (preceptor) was one of the preceptors who said that there was discrimination toward non-Saudis by Saudi nurses. They contended that this perception is not new. Clara (preceptor) noted:

> *Saudi nurses look at us "expatriates" as inferiors, as housemaids*.

With regards to Clara (preceptor) and Carmen's (preceptee) relationship, I had an informal conversation with the CRN during which I questioned the underlying reasons for changing Clara (preceptor) and choosing a new preceptor for Carmen (preceptee). She informed me that Carmen (preceptee) required help as she did not successfully pass her integrated assessment. The purpose of assigning another preceptor was to determine whether she could work alone after the programme or would require more time. This information was surprising because Carmen (preceptee) appeared to be competent. I asked the CRN why Carmen (preceptee) did not pass her evaluation and she said that Clara's (preceptor) evaluation was not favourable as it criticised Carmen (preceptee) for always pretending to know everything. Carmen's (preceptee) 'know it all' attitude was attributed to her nationality. Clara (preceptor) in her report criticised Carmen (preceptee) for assuming that she had superior insight into Saudi patients because of her nationality, thus disregarding her long experience as a professional and preceptor. Carmen (preceptee) also avoided cleaning patients and performing domestic tasks as she perceived herself as superior to foreign nurses. Ultimately, Carmen (preceptee) dominated her teacher and did things on her own terms. Consequently, she became overconfident and did not avail herself to learn new things. Importantly, her overconfidence did not merely emerge as a consequence of her preceptor's teaching style, but from her status as a Saudi national.

This theme illustrates that immigrant nurses believe that the organisational strategy toward Saudi staff and multicultural healthcare professionals, in general, is unequal.

Theme 2: Nature of the Work

There were tensions in the understanding of preceptors clinically and educationally, in terms of what needed to be done and what needed to be learned. In addition, the lack of institutional support and formal processes undermined the value of preceptors' work. This also had implications for commitment and required both preceptors and preceptees to make additional efforts to ensure that the preceptorship is successful. There were no formalised systems for training preceptors to make the preceptorship process more effective. Even preceptors who had been performing their role for more than a decade tended to have chaotic and informal approaches to preceptorship which veered between good practice and being actively unhelpful to preceptees. The best preceptors relied on their interpersonal skills and nursing ability to provide space and time for preceptors to learn, but this depended on the ability of the preceptor rather than any institutional system to produce effective preceptors. As well as the lack of appropriate training for preceptors, there was also minimal support from the administration for the preceptorship process. Nurses in the study struggled to find time to provide feedback and there was often significant pressure to balance patient care with learning opportunities. In this section, the following sub-themes are discussed: 1) Tensions between Patient Care and Mentoring, 2) The Lack of Institutional Support and Formal Processes and 3) The Division of Responsibility: Preceptorship as non-work.

2.1 Tensions between Patient Care and Mentoring

The preceptor-preceptee relationship is characterised by different expectations held by preceptors about the nature of work. Preceptors understand patient care and preceptee mentoring as different types of work. Confusion about distinctions between patient care and mentoring is a source of interactional tensions between preceptors and preceptees. This sub-theme will provide examples of the different expectations held by preceptors about the nature of work and the types of conflict that emerge in response to this.

Example 1: In Alice (preceptor) and Afnan's (preceptee) relationship, for example, Alice (preceptor) did not offer any guidance and when Afnan (preceptee) asked her to participate in providing patient care, she ignored her. Afnan (preceptee) revealed during her interview

that "my preceptor appeared not to enjoy her work with me, which discouraged me. "She added 'If my preceptor "Alice" wants any help, she will not ask me. Instead, she will take help from her friend "Lolo." I can observe, but I have to keep it hands-on'. Alice (preceptor) made distinctions between the work of patient care by referring to the request to Lolo for help, and the work of an educator which she remarked, lacks guidance. The work of educators is understood by Afnan (preceptee) in the excerpt above as mostly the responsibility of preceptees which they do as learning through observation. Alice (preceptor) also understood patient care and preceptee mentoring as different types of work. For example, during break time, she observed a medical team moving in the direction of her patient and running towards them without drawing Afnan's (preceptee) attention. The lead consultant subsequently asked her if she was the presiding nurse or whether she was covering for another, and she responded, "Yes I am," after which she started introducing her patient. The doctors and Alice (preceptor) entered the patient room to discuss the case. Twenty minutes later, Afnan (preceptee) emerged and asked for updates, questioning whether the doctors had had their round with her patient yet. Alice (preceptor) did not update her on new orders. Afnan opened the computer to find some new orders and asked Alice (preceptor):

> *Why you did not tell me about these new orders? Have the doctors already seen the patient and gone?" Alice remarked: "I was in a rush. We will do these orders together. but later, not now." Afnan said to herself in Arabic: "She always says nothing but does everything without me." For Alice, it is the responsibility of the preceptee to be there and observe, if not she must find out on her own. The responsibility of the preceptor is to offer interpretation or guidance when she is 'not in a rush'.*

This theme of patient care being perceived as distinct from preceptee care or mentoring is evident in Alice (preceptor) and Afnan's (preceptee) relationship. When I met Afnan (preceptee) for the first time, she was waiting for her CRN to assist her with some competency areas while looking confused. I sat waiting for approximately 9 minutes for the arrival of the CRN, and I watched as she escorted Afnan (preceptee) to her office and taught her some procedures over the course of an hour. This theme is also apparent when Alice (preceptor) entered a patient's room with equipment, without explaining or informing

Afnan (preceptee). Afnan (preceptee), however, noticed the equipment and began to prepare herself by wearing a gown and a mask. She subsequently joined Alice (preceptor); however, the trolley was placed on her right side, obstructing her view. She was unable to clearly see what Alice (preceptor) was doing, especially as she did not talk her through the procedure. Learning was therefore understood as the responsibility of the preceptee as I have documented in my observation below:

> *The patient was obese, critically ill and had too many back bedsores. Alice asked Afnan to turn the patient to the other side to clean her back and apply some cream. Afnan said: "I am petite and cannot hold him alone". She raised herself over her feet to be able to see what was going on. Alice said: "You can request the charge nurse to change your assignment next time. For me, it is okay but you are still new". Afnan did not speak a word. She seemed to be upset.*

In this preceptor-preceptee relationship, there was a sharp distinction between the work of patient care and the work of mentoring. A lack of formal guidance and the absence of established practice which everyone agrees and follows left the preceptee unsupported at times. For example, Alice (preceptor), Afnan (preceptee), a CRN, and the manager attended their monthly meeting and towards the end of the meeting, Alice (preceptor)rushed out to the medical supplies store in order to collect some equipment. After this, she headed straight to the patient room and did not explain her actions to Afnan (preceptee). She also did not request Afnan (preceptee) to join her as a learning experience. Afnan was in dialogue with the CRN but when she observed Alice's (preceptor) exit, she followed her in order to assist the patient. Alice (preceptor), however, shouted loudly:

> *No, no, no. Get out! You are not sterile." Afnan stepped back and observed the proceedings for 3 minutes, after which she left. After exiting the room, she said to me: "I did not do anything to bother her... she was given bad feedback by the manager and my CRN.*

Alice (preceptor) focused on patient care as a priority and ignored the work of mentoring because she had received negative feedback which impacted her mood and interaction with Afnan.

Following Alice's (preceptor) outburst, Afnan (preceptee) sat idle on a chair located in front of the patient's room. Most of the orders had already been completed by Alice (preceptor) during the course of Afnan's (preceptee) coffee break. The CRN approached her as she sat alone. She asked Afnan if she was okay and enquired about the whereabouts of Alice (preceptor). Afnan (preceptee) explained what had happened and the CRN assured her and invited her to the office to teach her new competencies. The CRN had a different understanding of work and her responsibilities but more broadly, this incident shows how there is a lack of clarity, both institutional and in terms of practice, about the nature of work and responsibilities—specifically, who should do what. Afnan (preceptee), therefore, depended on her Saudi CRN who had 12 years of experience and an MSc to teach her new things and clarify those that she did not understand.

Example 2: Bayan (preceptor) and Basma's (preceptee) relationship also illustrates the key tensions between mentoring work and health work. Here, the medical terminologies used by Bayan (the preceptor) were not always clearly understood by Basma (preceptee). For example, I observed a nurse asking Basma (preceptee) to bring ETT from the equipment store, however, Basma (preceptee) did not understand what ETT meant. She pretended to have understood and went to the store but then came back looking stressed and irritated, asking what ETT was. The other nurse ran and brought it while Bayan (preceptor) stood there without explaining what it was. The lack of clarity about what the preceptor must do and what the preceptee must know meant that Bayan (preceptor) did not provide education in this instance, and Basma did not receive support. During a conversation with Basma (preceptee), she complained that:

> *I have been given very light cases since I started the preceptorship programme. I was not allowed to handle critically ill patients or observe how other nurses received patients from the operating room (OR). I was only allowed to do the documentation. Now I suddenly have to receive an OR patient. and Bayan does not want to help me, she did not even assess my needs before the programme.*

This exemplifies the assigning of non-complex tasks and works to health workers so that preceptors can avoid providing education to their preceptees.

Example 3: The case of Daisy (preceptor) and Dalia (preceptee) offers another approach to the learning process. In contrast to Alice and Afnan where preceptor work was avoided by encouraging simpler tasks so that Alice performed patient care by herself, Daisy (preceptor) remarks that it is the preceptee's responsibility to find ways of learning but similar to Alice and Afnan, the preceptor work remains undone. When I first met Dalia (preceptee) and Daisy (preceptor), Dalia (preceptee) was completing her documentation when a patient's IV pump sounded an alarm. She did not respond and carried on with her documentation as others attended to the alarm. Daisy (preceptor) ran to the patient room and silenced the alarm. She aggressively spoke to Dalia (preceptee) and asked: "how many times did I tell you to be very careful of your patient's care as a whole? Not just focus on one thing and ignore others. You are working in ICU, so you have to be vigilant with electrolytes replacement, numbers, and monitor alarms." Dalia (preceptee) began to cry, and Daisy (preceptor) left her alone, moving to the nursing station. She stayed there and observed Dalia (preceptee) from a distance, illustrating the tensions between health work and mentoring work, as well as tensions concerning who carries the responsibility for failure. These tensions impacted interactions between preceptors and preceptees. For example, in one instance, doctors arrived at Dalia's (preceptee) patient room. Daisy (preceptor) was standing with doctors as she positioned herself in front of Dalia (preceptee), making her feel scared and distressed. She felt as if she was being judged and not being emotionally supported. Dalia (preceptee) started introducing her patient to the doctors by reading her notes. Daisy (preceptor) was giving Dalia (preceptee) some encouragement by nodding her head, and when Dalia (preceptee) missed the doctor's questions, Daisy (preceptor) responded immediately. The consultant wanted to review the surgery site, Daisy (preceptor) was able to help as she had her gown and gloves in hand, while Dalia (preceptee) was stuck in her place without giving any response. The consultant, with three other doctors and Daisy (preceptor), were around the patient leaving Dalia by the door, just watching with her hands on her hips. Dalia (preceptee) said:

> *She (Daisy) can handle many tasks at one time with high focus as she expert, but I cannot as a new fresh nurse. She always insists that I slow and not organised person. I need a preceptor who gives me the time and requirements and lets me*

do my job. If they notice that I am doing something wrong, they have the right to stop me. I am not 100% perfect.

The tensions that exist between mentoring work and health are rooted in sufficient formal processes and poor institutional support which is a sub-theme that is discussed in the next section of this chapter.

2.2 The Lack of Institutional Support and Formal Processes

As previously discussed, there is a lack of common understanding and acceptance concerning the nature of work and responsibility, whereby there are no unwritten rules around this. Also, there are no formal guidelines and written rules concerning the scope of work and the professional responsibility of preceptors. This introduces emotional pressures in the preceptor-preceptee relationship so that some preceptors report feeling undervalued while some preceptees report feeling unsupported.

Example 1: In Bayan (preceptor) and Basma's (preceptee) relationship, years of experience as a preceptor influenced Bayan's (preceptee) understanding of the concept of preceptorship. It also influenced her capability to perform in the preceptorship role. Her clinical experience as a nurse alone was not enough to prepare her to be an effective preceptor, as the ability to teach was also necessary. Basma (preceptee) remarked in her interview that Bayan (preceptor) did not have the necessary teaching skills and knowledge:

Sometimes I cannot understand why we have done this for a specific patient. She does not teach me and sometimes she cannot deliver the information properly.

The lack of formal support and training was mentioned by Bayan (preceptor) who stated,

I would like more training because that is a barrier to my success as well as the solution to the preceptor role success.

Focusing on the inadequate preparation of preceptors, Bayan (preceptor) also reported that they require further preparation to ensure awareness of the expected role and responsibilities of supporting preceptees:

The residency program is recent in the intensive care unit because we do not receive newly graduated nurses. However, due to the shortage and to achieve the Saudization policy, the intensive care unit started receiving large numbers of Saudi graduate nurses. I think we are not ready yet. We need training workshops and clarification on the communication techniques with them and how to teach them the required skills.

This lack of training placed emotional pressure on both the preceptor and preceptees. I observed as Basma (preceptee) attempted to document her notes and asked Bayan (preceptor) whether the patient had peripheral lines. Bayan (preceptor) responded:

I do not know. You should check yourself.

This links back to the theme of the nature of work and the lack of clarity about who should know what but there is also the broader issue of the preceptor lacking the institutional support and training to perform her role diligently, as she noted in the quote above. Later on, Basma (preceptee) asked Bayan (preceptor) about the patient's medications, causing Bayan (preceptor) to adopt a different voice tone:

Were you there during handover? Where is your note? Open it and see what medication he has!.

Basma (preceptee) was trying to calculate a medication dose using a calculator. Bayan (preceptor) watched her and laughed:

the system will do this for you immediately.

Basma's (preceptee) face turned red and there were tears in her eyes. In another instance, a patient was desaturated and needed suctioning thus Basma (preceptee) wore a gown and gloves and began the process. She showed signs of struggling but did not ask for help and Bayan (preceptor) was watching her from a distance. Basma (preceptee) shouted:

Bayan, can you please come to hold the patient for me?

Bayan (preceptor) was holding the patient when she noticed that there was too much blood being suctioned. Bayan (preceptor) asked why there was so much blood, but Basma (preceptee), abruptly and without eye contact, answered:

> *What do you think?*

She reverted the question to Bayan (preceptor) for further explanation. However, Bayan (preceptor) said:

> *You should have done something wrong* and took the suction tube and did the suction by herself.

Bayan (preceptor) got out of the room and told me:

> *It is a headache being a preceptor*

The lack of formal processes and institutional support as can be seen from Bayan's (preceptor) remarks led some preceptors to feel undervalued. Also, there is a need for preceptees to be very actively navigating the system, given the lack of system support for the preceptor role leading to heavy pressure on the level of interactions with significant emotional pressure on both preceptors and preceptees. As with Afnan (preceptee), work was passed down to the preceptee who was required to be able and willing to navigate the system and pick support where she could find it, creating tensions on the interactional level. In Bayan's (preceptor) remarks below, the case conflict is narrated through age difference:

> *I have recognized that an age difference makes the experience different. So you either convince them (NGNs) or get convinced by their point of view. I often avoided being angry and did not react. I was trying to understand her point of view and the reason behind her behaviour. She is hard-headed and strict about her perspective, even if she is wrong, making it difficult to deal with her. This is time-wasting, especially in the ICU, where we do not have sufficient time for these behaviours.*

Bayan(preceptor) showed correct clinical judgment based on her practical experience, however, Basma (preceptee) was also correct on the basis of theory and what she had learned at university.

Example 2: In Alice (preceptor) and Afnan's (preceptee) relationship, the preceptor's view of patient care as distinct from her role as an educator meant that this role was taken up by the CRN, creating a gap in her relationship with Afnan (preceptee). In contrast, Afnan's (preceptee) second preceptor, Angela (preceptor), understood work in a different way which impacted how she approached her work in practice despite the lack of preceptor preparation training. Angela (preceptor) adopted a more preceptee-oriented approach because this is how she understood her role as she noted in her interview:

> *You have to know your preceptee, and their ability to adapt the new things, you also have to assess their critical thinking… how they work, and how they deal with things. You also assess the stability of the emotional state. For Afnan, I am always there for her. If she needs anything, she asks me immediately.*

Angela (preceptor) offers an example of a matter-of-fact attitude, where she does not question the lack of institutional support and acknowledgement of the work her role requires. I found Afnan sitting with her CRN in front of a patient's room, learning how to administer Morphine infusion. Afnan (preceptee) did not see Angela (preceptor); however, she noticed that the doctors would visit her patient during their rounds. She entered the room with her notes waiting for them. As she exited the room, she saw Angela (preceptor) and updated her that the patient should be transferred to the step-down unit. The first question Angela (preceptor) asked Afnan (preceptee) was: "Do you know the referral process and transferring patients to other units?" Afnan (preceptee) answered affirmatively, but she requested that they complete the paperwork together. They started completing the process. Fifteen minutes later, the consultant sent in a new order. Afnan (preceptee) did not know how to administer a specific medication because it did not align with the patient's blood lab results. She loudly asked Angela (preceptor) and the CRN. They discussed the potential reasons and encouraged her to phone the doctor and asked him directly. Afnan (preceptee) paged the doctor and had a discussion with him to ascertain the problem. Angela (preceptor) was proud of her and remarked to me privately:

"*She is an amazing resident. She is different from other residents I have precepted*."

The absence of specific criteria for allocating preceptors to preceptees rendered the allocation process ad hoc and inconsistent. There were no specific criteria identified in the study setting on which to base the selection of appropriate preceptors. As a result, each nurse manager and CRN used their own judgment to assign a suitable preceptor for each prospective preceptee. During an informal conversation with the CRN in Case A concerning the criteria for selecting preceptors, she noted the lack of a formal process and asserted that having 'a strong personality', thus confrontation and discomfort, might be needed for learning:

> *There are no criteria, but personally, I chose Alice as a preceptor for Afnan for some reasons; she is experienced and competent, she has a very strong personality, and she looks serious, and that is what most of the residents need to be with, especially in the first two months of their preceptorship. The other reason is that nurses have different personalities, and as a new nurse, you should be aware of and deal with all these differences. Anyway, I have a new plan for Afnan for the next two months.*

This is an example where the CRN does not have sufficient knowledge or understanding to make the decisions she is making about preceptors – or what the potential consequences are. Afnan (preceptee) was learning more from Angela (preceptor) where there was no confrontational approach. The lack of rules concerning the selection of multiple preceptors to look after one preceptee was another issue that impacted the preceptorship process. Two preceptors (Alice and Angela) were used simultaneously to precept Afnan (preceptee), disrupting her learning as each taught the same procedures using slightly different techniques as Afnan (preceptee) highlighted:

> *The way of dealing differs between them. Jessa has the intention to teach me. She can deliver the information smoothly and conveniently… she is an eager person to convey information. On the other hand, Alice does not have the passion for*

sharing knowledge with high expectations about my knowledge. When I ask her about something, she answers me briefly or sends me to the CRN.

Example 3: Moreover, some preceptees such as Dalia had three preceptors, which confused her. Dalia (preceptee) was signed to a new preceptor (Diana) for only one day because Demi (preceptor) was off work as a result of a prior engagement which had been arranged. Dalia (preceptee) was frustrated and upset. She complained that having multiple preceptors made her confused since each one had a different style of teaching, causing her to start from scratch each time she interacted with one of them. She was also compelled to build relationships which each new preceptor. The lack of formal guidelines and written rules concerning the preceptorship programme was not only limited to how many preceptors can be assigned to preceptees but concerned administrative aspects as well such as the orientation, assessment and training of students. This was noted by Dalia (preceptee):

No one made an assessment for me. They were not ready for us. Basma and I are the first Saudi new graduate nurses to join the unit. They do not have sufficient training to communicate with us as they treat us as students. The program is still new to the intensive care departments... I think they have to be given the proper training and orientation.

The CRNs also have responsibility for their preceptees and preceptors during the preceptorship period. Thus, it is crucial to orient preceptors regarding the preceptee's assignment needs regarding learning goals. In addition, they need to be fully familiar with the preceptor's role and preceptee learning plans. Dalia (preceptee) however reported that:

we have 2 CRNs in our unit, and they are busy, one in the nursing education department giving training and courses, and the other one spends most of the time with the new expatriate nurses. I am considered new staff, but they ignore me because I have a preceptor. They treat me as neither new staff nor a nursing student.

The lack of formal guidelines and written rules means that similar to Alice (preceptor) and Afnan (preceptee), the preceptor work remains undone and preceptees lack emotional and institutional support. Emotional support was identified by preceptees as the most common

form of support they require during the preceptorship period in ICUs. Emotional support for preceptees is provided by letting them feel accommodated, and accepted as a staff member, and showing that somebody was there to help them feel comfortable in their clinical environment. Emotional support is required especially when dealing with their preceptor, however, this was not always provided as demonstrated by the following comment by Basma (preceptee):

> *The responsible for evaluating preceptees must be supportive even if we are wrong. They should discuss and teach us because it is normal to not know at the beginning as a fresher. The best way to support new nurses is to have someone that hears us without bias and partisanship. We also need moral support because the work in intensive care is very stressful.*

Further, there is confusion about role allocation and responsibilities, which is discussed further in the subsequent theme.

2.3 The Division of Responsibility: Preceptorship as non-work

Preceptees who trust their preceptors are more inclined to discover and seek out new experiences, question their own decision-making and actions, and ultimately think critically about their nursing care situations. Preceptees who were autonomous were more successful in developing their professional competencies. In a context where preceptor work is undervalued and lacks clarity in terms of responsibilities, interactions are more authoritative in style. Therefore, preceptees can be successful if they are lucky and the preceptor adopts a heroic or matter-of-fact attitude to the additional work they have to do. Further, preceptees need to be very skillful and proactive in navigating the system by picking support and knowledge where they can find it.

Example 1: In the case of Bayan (preceptor) and Basma (preceptee), unclear responsibilities passed down pressure at the level of interaction. During a conversation I had with Bayan (preceptor) concerning Basma's (preceptee) progress, Bayan (preceptor) remarked:

> *we have spent four months together and she made very super-slow progress. She did not show me how confident she is and I did not trust her. She is dependent and has a very bad attitude. I cannot stand her anymore. I also cannot add more to her. It is time to try someone else. I am giving up. I am done, especially as the CRN is not cooperative. She delegated me all her tasks and then blamed me that Basma did not make any progress. It is very stressful for me.*

Bayan (preceptor) did not adopt a matter-of-fact or heroic attitude towards her work, influencing Basma's (preceptee) lack of progress as noted in the excerpt above. Additionally, lack of clarity regarding responsibilities also introduced tensions concerning who carries the responsibility for failure.

Example 2: In Alice (preceptor) and Afnan's (preceptee) working relationship, Afnan was eager to learn, displayed initiative and was constantly asking thought-provoking questions, however, Alice (preceptor) did not motivate or address these questions, thinking that this was the role of the CRN. Alice's (preceptor) perceptions about the division of responsibilities meant that she understood the preceptorship as a collaboration between the CRN and preceptor to support the preceptee by creating a link between the preceptee and the preceptor's expectations. For example, Alice (preceptor) stated:

> *There is a clinical resource nurse (CRN) in each unit... I cannot teach my preceptee the same as the CRN will do… I cannot explain every single thing.*

Additionally, Alice (preceptor) perceived that the time that was supposed to be spent with her assigned patient was required to be split between patient and preceptee. Therefore, it was challenging to juggle giving care with teaching within the time available. Alice (preceptor) clearly states the tension between the work of the patient and the work of precepting:

> *So, it's an additional load for us because, of course, whatever might happen to the patient, it is our responsibility. I never limit her because I want her to learn but I am throwing between letting her learn and taking care of my patient. we are not practising with a doll. We are exposed to an actual patient.*

Alice (preceptor) was not subservient in terms of performing additional work. She was, therefore, unwilling to precept since the preceptor role was an extra burden for her. Hence, she considered her tasks to be unduly laborious when coupled with the limited time allocated to preceptorship and the requirement to retain a normal clinical workload. She noted that:

> *of course, we know that we are working here in this teaching institution, but it's really exhausting and frustrating because as much as I want to teach her, sometimes, during stressful times, I cannot.*

This is another aspect of responsibility and what Alice (preceptor) implies is that preceptor work is undervalued; it is not sufficiently acknowledged that it takes time and effort. Alice's (preceptor) reaction indicates an important aspect of the provision of support for preceptees, specifically that preceptors must not only rely on their skills and knowledge but require support. It is also about acknowledging the preceptor role as an important one that requires additional time as well as additional support for both the preceptor and preceptee. Currently, this form of support appears to be missing at the organizational level which reflects the broader absence of formal guidance, both written and unwritten. In this context, preceptorship works through self-exploitation and adopting a heroic or submissive attitude, as there seem to be no incentives for the preceptor.

Precepting usually takes place in the stressful and demanding area of a clinical setting where nurses have to be prepared to precept NGNs with different knowledge and skills. Therefore, they need to create a learning environment in which preceptees are given plenty of opportunities to bridge their theoretical and practical knowledge to develop professional competence. Consequently, preceptors face the challenge of meeting the requirements of academic education, balancing teaching and clinical responsibilities, while providing high-quality patient-centred care. Having adequate time is essential to functioning in the role of preceptor effectively.

Example 3: Unfortunately, for Daisy (preceptor), insufficient time to fulfil her preceptor role made her reluctant to assume her role, much like Alice (preceptor). Daisy (preceptor) stated:

time is the issue in ICUs. I think there's actually pressure on us. I don't have time to teach them properly. I'm scared at a point that my preceptee would do something wrong that would harm the patient.

Although Daisy (preceptor) felt undervalued, there were expectations of responsibility placed upon her from the perspective of her preceptee, Dalia (preceptee) who noted:

My preceptor (Daisy) was tough and tried to impose her personality. I need a flexible preceptor to teach me the basics and guide me without imposing her personality. The preceptor's role is to ensure the quality of my work and correct my mistakes, not to impose her way of thinking. For example, we have different ways of writing nursing documentation, and we cannot be similar. However, we both should agree about the content of it. But my preceptor wants me to write in her style and in her words, which I can't do.

This expectation of responsibility links back to the absence of clear rules and norms about what the preceptor's role entails and what their responsibilities are, as this creates unmet expectations and poor support for preceptees. In the next section, the theme of communication and how language politics and other variables impinge on the preceptorship relationship are discussed.

Theme 3: Communication: Language Politics, Conversations and Locus of Power

Power and authority are fundamental and have caused barriers to effective communication in the workplace in the Saudi context and particularly between preceptor and preceptee. Language use is political and language was used to facilitate learning and provide pastoral care and constructive feedback. Within the politics of language, language barriers, on the other hand, played a role in undermining communication and relationships. Conversely, communication was used to exert power, humiliate and reinforce hierarchical roles in ways that hindered the success of the preceptorship relationship via a conflict. Some preceptors developed friendly relations with their preceptees, mediated by trust. In this section, the following sub-themes are discussed; 1) The Politics of Language (Language and Power) 2) Public and Private Spaces and Interactions and 3) Locus of Power: Trust and Conflict.

3.1 The Politics of Language (Language and Power)

It was evident from the fieldwork how communication is a two-way occurrence between a preceptor and preceptee or patients. Language barriers have a considerable impact on communication effectiveness on both sides. Notably, there are many languages mixed in one single unit; the preceptors' Arabic language skills were poor and, in some instances, non-existent.

Communication was used to exert power in some instances for humiliating preceptees or reinforcing hierarchical roles in ways that hindered the success of the preceptorship relationship. Within the politics of language, language barriers played a role in undermining communication and relationships. In this study "language barriers to effective communication" includes the poor Arabic language skills of staff as a barrier between nurses and patients. Additionally, staff using different languages within a single unit is problematic.

Example 1: Alice (preceptor) used language to exert power over Afnan (preceptee). In one instance, for example, Alice (preceptor) and Afnan (preceptee) entered a patient's room to insert an IV cannula after which Alice (preceptor) requested a nurse to assist her although Afnan (preceptee) was next to her, and it could have been leveraged as a learning opportunity. Alice (preceptor) asked Afnan (preceptee) to explain the procedure to the patient. Afnan (preceptee) spoke Arabic with the patient to explain the procedure while Alice (preceptor) and her friend administered the cannula, speaking their language Tagalog throughout the whole procedure. Afnan (preceptee) kept reminding them: "Please speak English!" and sometimes, she used her eyes to caution them. By communicating with the Filipino nurse in Tagalog, she introduced a barrier in her working relationship with Afnan and behaved in an unprofessional way by failing to respect her inability to understand the language. Language capacity influences interactions between preceptor and preceptee, interactions with patients, and interactions between colleagues. Here, Alice (preceptor) and Afnan (preceptee) had different levels of language competence. Despite these varying levels of language competence, Alice (preceptor) maintained the ability to do as she pleases by speaking Tagalog, as an expression of power.

Afnan (preceptee) noticed how the different ethnic groups and languages in one unit could cause huge communication barriers and lead to collaboration barriers and frustration between preceptor and preceptee:

> *One time, we had an admission from a different department to our unit. Both nurses were talking in their language (Tagalog) during the handover, and I was standing beside them, understanding nothing. I was waiting for her to speak English, but she did not. I asked her in a loud voice with a sharp attitude to speak English, telling "Excuse me, speak in English,". One of them stopped talking for a while, and then she continued on a different subject. She told me we are talking about something else, not the patient.*

Alice (preceptor) explains that the different ways of expression between different ethnic backgrounds can cause misunderstandings because of interpretation issues. She noted how the different values could cause limitations in relationships and lead to collaboration barriers between staff:

> *I cannot freely talk to Saudis. In the Philippines, we are free to talk about personal issues but here in the Saudi family's culture, they might be prohibited.*

This is a good example of how power is normalized. Expressing such personal concerns in other cultures may be acceptable, however, there is quite a 'normal' expectation that non-Saudi nurses should not conform to the cultures that they are familiar with.

Varying levels of language competence mean that practice networks have developed in the workplace and these networks are organized in part, according to language commonalities but also ethnicity. Saudi patients and nurses share the same beliefs and cultural values that skilfull overseas experts lack. In addition to being only a few in the profession, preceptees spoke of not only the shortage of local nurses but the recognition that they provide something unique to patients, being both Saudis and nurses. They felt strongly about the value of cultural understanding and being able to provide culturally sensitive care and form closer relationships with patients than other nurses because of cultural and language similarities. Very few immigrant nurses speak Arabic and many lack a deep knowledge of Saudi culture. Preceptees felt that the cultural, religious and language differences between

overseas nurses and Saudi patients may result in a lack of understanding between them and their patients. The negotiation of different language competencies, public and private conversations as well as patient and mentoring care at the workplace work meant that the ability of preceptors to do as they please by speaking another language constituted an expression of power. This also relates to privacy and friendship so that in some instances such as in Alice (preceptor) and Afnan (preceptee), friends share private jokes that are expressed in the same language, that no one else can understand. Ultimately, using or not using different languages is not only about communication about patients or learning, but is also an expression of friendship, privacy, power and how there is a struggle in terms of how these are defined and enforced as 'the right thing to do.'

Example 2: This point is also apparent in the case of Clara (preceptor) and Carmen (preceptee). Carmen (preceptee) was preoccupied with impressing doctors as opposed to working collaboratively with her preceptor and took advantage of her preceptor's pregnancy to exert her authority. Clara (preceptor) and Carmen (preceptee) were required to change a patient's position using a Hoyer patient lift assisted by two other nurses or the physiotherapist (because of the patient's size) on the first day of observation. The patient wanted to sit on the chair. Clara (preceptor) instructed Carmen (preceptee):

> *Please, call two other nurses or the physiotherapist*" but Carmen remarked: "*No, we do not need to move her from the bed to the chair. Let's change the bed to the fowler's position. So, she can sit. I know this lady; she will ask us again in a few minutes to take her back to bed.*

She did not take instructions from her preceptor but rather challenged her based on her knowledge of the patient's preferences. The patient insisted so Clara (preceptor) called her neighbours for help and the patient was transferred successfully to the chair. Clara (preceptor) and Carmen (preceptee) went out and sat in front of the patient room, watching her through a window. Approximately twelve minutes later, the patient shouted:

> *I want my bed, I cannot sit here any longer*

Carmen (preceptee) looked at Clara (preceptor) and said:

I told you, I know her more than you. She gets tired and bored very quickly.

Carmen (preceptee) did not engage with Clara (preceptor) as if she were in a position of authority. She adopted a dominant position and did not engage with her preceptor professionally even when Clara (preceptor) was patient. Carmen (preceptee) responded emotionally. Clara (preceptor) was smiling but Carmen (preceptee) was very angry. Before returning the patient to her bed, Clara (preceptor) asked Carmen (preceptee) to talk to the patient in Arabic and tell her how important it is to change her position. Clara (preceptor) recognised Carmen's (preceptee) position as a registered nurse, and in contrast to the case of Afnan (preceptee) and Alice (preceptor), she was tasked to provide medical advice to the patient as opposed to merely translating instructions. Carmen remarked,

No, it is her decision, not ours. The lift side is the same as the right one. All we need to do is just keep her blood flowing and her skin staying dry and healthy

She attempted to advocate for herself and her patient, however, she was not flexible and professional when communicating with her preceptor. The language similarities between Carmen (preceptee) and the patient meant that the preceptor was unable to establish the same level of rapport. Clara (preceptor) took a deep breath and said:

I can talk to her but not convince her as much as you can because both of you speak the same language, so she can understand very well.

The patient was transferred again to the bed. According to Clara (preceptor) in her interview:

"for me, communication is challenging in this country, of course, I do not speak Arabic but sometimes I understand."

Preceptors tried to find several strategies to overcome communication barriers. These were at an individual level, such as learning Arabic to communicate better with patients, and self-awareness of different cultural communication skills.

Example 3: In case E, the patient asked Elham (preceptee) for a cup of water. Emma (preceptor) instructed Elham (preceptee) to remain with the patient while she sourced the

water. Emma (preceptor) was able to discern what a patient said in Arabic. She highlighted a passion for learning the Arabic language for better communication with the patient:

> *I always try to learn Arabic words during my break time, I am very interested in Arab culture and language.*

Some problems arose from personal and cultural communication patterns. For example, Diana (preceptor) reported that Saudi staff challenge the policy and advocated for patients' safety while the disempowerment and lack of advocacy may have been a result of culture. During the fieldwork, I found that non-Saudi nurses are usually disempowered and feel insecure to speak up. Saudi nurses refused the risky order by doctors and challenged them, and they stood up for patient care and challenged the physician. Diana (preceptor) suggests that Saudi nurses have different communication styles whereby they are straightforward:

> *Saudi nurses have very strong personalities. They state their feelings clearly without indirectly demeaning others. They express assertiveness with non-verbal communication. In contrast, Filipino or Indian nurses, for example, do not challenge authority and avoid interpersonal conflicts if possible. They are softly spoken, agreeable and less direct. They do not question doctors' orders as well.*

Example 4: Dalia (preceptee) illustrated the high-risk communication barriers which exist when there is a dominant ethnic group in the unit speaking in their language and not speaking to team members. She is not able to understand anything since the official language for healthcare in Saudi Arabia in English:

> *My preceptor (Daisy) interacts with other Indian nurses in the unit most of the time and speaks their language, it is really difficult for me to understand them.*

Where there are cultural similarities between the preceptor and preceptee, communication is easier as seen below where Afnan (preceptee) remarks:

> *Saudi nurses are more flexible than foreigners. For example, Saudi nurses have no issue if I am late during my purchase from a snack shop. However, foreign nurses are more strict and have a sharp attitude toward delay.*

Aside from language use, the spaces within which preceptors communicate with preceptees, and how messages and teachings are conveyed have important implications for learning as discussed in the next section.

3.2 Public and Private Spaces and Interactions

This subtheme discusses how preceptors communicate publicly and privately with their preceptees and how this influences the preceptees' learning.

Example 1: Afnan's (preceptee) learning process during a suctioning procedure was frustrating because of how Alice (preceptor) publicly communicated with her. The patient was intubated and heavily sedated, thus requiring deep suctioning. Alice (preceptor) instructed Afnan (preceptee) to begin the procedure as she watched over her shoulders. As Afnan (preceptee) began to conduct a head-to-toe assessment, Alice (preceptor) suddenly snatched the suction tube from her hand while concurrently raising her voice and performing the suction herself. In response, Afnan (preceptee) froze and remained silent throughout the procedure, evidently stressed and frustrated. In my field notes, I observed that:

> *Alice behaved aggressively because the procedure was not done quickly. Her face flushed red as she was struggling to control her mood. The patient's mom got closer to see what was wrong. Afnan reassured her in Arabic, and Alice said: "Sorry, my mind got slow again". Afnan took a deep breath and stared at Alice, angry. Alice did not stand Afnan to be around anymore. She asked her to take off the gown and bring some fluids from the medication room. Afnan said: "Not now, let me reconnect the patient tubes and then I will grab them." Alice said, "no, no, go now". Afnan brought the fluids and wanted to set the pump, but Alice took the fluids from her hand and did the set-up herself. Afnan seemed angry and left the room. Alice did everything herself and left the room…*

Alice (preceptor) spoke to Afnan (preceptee) in an abrasive way and by providing improper feedback and criticism which I recorded in my field notes:

Towards the end of the medication administration task, a sound came from outside of someone calling Afnan. The door opened with a Filipino nurse kindly asking Afnan to translate a memo that was written in Arabic. Afnan was on the other side of the patient's bed. As she started turning around, Alice said: "Not now! this is your patient, not mine. you have to get everything done with him and make sure he is safely positioned before helping others". Afnan's face turned red, and she looked embarrassed as this happened in front of the patient, his mom and the nurse.

Alice (preceptor) humiliated Afnan (preceptee) publicly in front of patients when she made mistakes. On the contrary, Angela (preceptor) supported Afnan (preceptee) throughout her clinical procedures without publicly informing patients that she was a novice. During patient care, Afnan (preceptee) was provided with the opportunity to talk to the patient about the surgical dressing and the medicines. In this conversation, the patient was actively engaged, telling Afnan (preceptee) about his pain. It was a good discussion between a patient and preceptee with the preceptor close by, listening attentively and just adding the odd word occasionally. Angela(preceptor) advocated for her preceptee and appeared genuinely interested in her professional development.

Angela(preceptor) would offer feedback privately while maintaining a relaxed body posture. She would also refrain from raising her voice or using gestures that might appear harsh, aggressive or offensive. Angela (preceptor) intervened quietly without much fanfare, creating a safe space to be approached by her preceptee. Her practice of criticising her preceptee quietly as opposed to publicly encouraged a healthy rapport between them and established their relationship as one that exists between co-workers in a clinical environment. Angela (preceptor) stated:

There are some issues that you need to remind your preceptee to do in a not open area. Do it as private as possible.

Example 2: In Basma (preceptee) and Bayan's (preceptor) relationship, the lack of communication from Bayan (preceptor) inhibited learning and negatively impacted the transition experience. On one occasion, Basma (preceptee) remarked to her preceptor,

I am done with the documentation,

To which Bayan replied:

Not yet! you should check the IV fluid. I will go for 5 min.

Basma (preceptee) looked scared and went looking for someone else to help her. She called a male nurse for help, and he taught her in detail, everything she needed to know. Following this, he accompanied her to the computer and helped her get her documentation done. When Bayan (preceptor) came back and saw them together, she laughed and said: "She is new, it is her first time receiving OR patients. Thank you for helping her". The nurse told Basma (preceptee): "Do not worry! I will come back in a bit" as he realised Basma needed more clarification and help. Bayan was standing behind Basma (preceptee), saying nothing. Basma (preceptee) turned her face around and asked Bayan (preceptor) if she could explain a word she was unfamiliar with, but Bayan (preceptor) said:

I do not know. Ask him or try to find the meaning yourself.

Basma made a frustrated smile. According to Basma (preceptee):

> *Bayan makes me stressed with a lack of focus on my work. She also affects me in different ways. For example, if someone comes to help me, she will stop them from assisting me.*

Preceptors facilitate the transitioning of new graduate nurses to professional nurses. Preceptees such as Basma expect their preceptors to involve them in the learning process, identify if learning objectives have been met, and ensure that feedback is given on time to help them become professionals. Preceptees who are exposed to collaborative relations are better prepared and confident individuals who adapt to the realities of the clinical practice.

Example 3: Demi (preceptor) was able to facilitate learning by using a variety of coaching, mentoring and facilitation techniques to identify Dalia's learning needs. Demi (preceptor) provided a platform for Dalia (preceptee) to develop a sense of self-awareness and confidence by making her feel that she was competent enough to handle patient care independently. In my field notes, I observed,

Dalia looked different today. She was interested with a high level of energy. She used her pocket notes that she did not use when she worked with Daisy. She involved herself in doctors' discussions and confidently asked critical-thinking questions. Demi was able to build a high-energy environment for Dalia to engage in.

Dalia (preceptee) appeared much happier after discussing the issues of concern. The advice and support Demi (preceptor) had given had provided much-needed reassurance. I had a short conversation with Dalia (preceptee) and discussed her relationship with Demi (preceptor). She was happy and on the first day of working with her, she remarked:

Look at me, I am like a new person. I am feeling energetic and excited. I feel like I have a voice, and somebody listens to me and appreciates my knowledge. I know what I am doing now and what I will do the next minute. We have a clear plan for today.

Demi (preceptor) gave Dalia (preceptee) the complete responsibility of caring for a patient under her care. Whenever she wanted to assist Dalia (preceptee), for example, by sending blood samples to the lab, she said "I will do it for you." This communicated the idea that it was Dalia's responsibility, and she was merely assisting. Demi (preceptor) treated Dalia (preceptee) as a staff nurse, and that made Dalia (preceptee) feel confident and responsible. Dalia (preceptee) provided her patient with afternoon care while Demi (preceptor) sat outside the room observing the care being given.

Treating Dalia (preceptee) as a colleague publicly and privately created a harmonious relationship of mutual respect, open communication, and trust.

Demi (preceptor) demonstrated care for Dalia (preceptee) by refusing to push her hard publicly during an emergency case, choosing rather, to adopt a supportive approach. The patient in question had been sent to the OR in the early morning and both Demi (preceptor) and Dalia (preceptee) were waiting for him. When the patient arrived at the unit, Dalia (preceptee) was very excited and focused on multiple tasks at the same time. She took charge of the handover and answered doctors' questions about the vital signs of the patient. She also followed directives given by Demi (preceptor) and they worked as a team. Suddenly, however, Dalia (preceptee) lost her concentration, possibly because the room

was packed with doctors and nurses. She stood frozen and watched without doing anything. Demi (preceptor), realising that Dalia (preceptee) was stuck, attempted to keep her focused for as much as she could. She asked her to bring some equipment, extract blood samples, send these to the lab, and set up IV fluid. Dalia (preceptee) followed Demi's (preceptor) commands but quite slowly. Demi (preceptor) decided not to try to push Dalia (preceptee) harder, treating her with care.

I once observed doctors arriving to see a patient as Dalia (preceptee) and Demi (preceptor) stood next to each other. The doctors began to ask about the general condition of the patient, and Demi (preceptor) gave Dalia (preceptee) enough time to answer. When Dalia (preceptee) did not respond, Demi (preceptor) stepped in. Demi (preceptor) occasionally approved her statements non-verbally by simply nodding or giving an approving look in the presence of doctors. Doctors ordered new medications and X-rays, and as they left, Dalia (preceptee) went to the medication room, brought the new medications and asked Demi for their indications and side effects. They had an educational discussion for about eight minutes. Demi (preceptor) helped Dalia (preceptee) get to know herself better, she infused her with confidence making her feel that she can handle patient care. Dalia (preceptee) was working independently, doing suction and changing patient position. Demi (preceptor) still kept a close eye on Dalia's (preceptee) work even when Dalia (preceptee) was seemingly alone. Demi (preceptor) started preparing the equipment needed for CVC while teaching Dalia (preceptee) how to care for the central venous catheter. Dalia (preceptee) was encouraged to do the procedure herself, and she did it with Demi's (preceptor) instructions, step by step.

Once they finished cleaning the CVC, Dalia (preceptee) asked Demi (preceptor) about the difference between urine analysis and urine culture, so Demi (preceptor) taught her in a very detailed manner. Through her instructions, constructive feedback, guidance and testing of theoretical as well as practical knowledge, Demi (preceptor) supported Dalia's (preceptee) competency development which in turn, boosted her confidence. I recorded in my fieldnotes as follows:

> *Dalia noticed that the magnesium dose was too high, so she informed Demi, who suggested: "Call doctor Ahmad and ask him to change the dose, thank you, love."*

> *She appreciated how Dalia recognised and responded appropriately. Dalia felt confident and acted as a staff nurse, quickly walking to the nursing station and calling the doctor. When she returned to her patient room, she could be heard saying "when will I be working alone?". She was glad to have identified the issue, raised and got the results she wanted. She gave the revised dose of magnesium and then sat in front of the computer doing the documentation. Demi was still in the next room. Dalia started the patient feeding and afternoon care while Demi was standing watching by the door. The next shift nurses arrived at the unit, but Dalia was not ready to give the handover. Her documentation was not yet complete. Demi took a chair and sat next to Dalia, telling her what she should write. She pushed her a bit. Dalia apologised to the night shift nurse and admitted that "I am a super slow person. Please have a seat". He took a chair and assured her: "Take your time." She then was able to give the handover, but she was not confident enough. During the handover, she noticed that she missed giving a vital medication, but Demi asked her to continue the handover, and she will give that medication.*

Demi (preceptor) provided additional support and helped Dalia (preceptee) overcome the challenges faced during the transition period. I had a short conversation with Demi (preceptor) concerning Dalia's (preceptee) progress. She informed me that Dalia (preceptee) is a very slow person and has family issues that potentially impact her cognitive skills. She is suffering from confusion and experiences difficulties in concentrating. Demi (preceptor) noted that she needs to be reminded at all times, but she is doing this gently, just step by step. She noted:

> *This is how the learning process is performed. I do not want her to leave the unit. I believe she is going to improve slowly. It is my responsibility to encourage her and let her work independently by stepping back a little bit. I try to not display any behaviour that could be misconstrued as aggressive. I avoid imposing additional stress on her. I try my best to spend quality time with her talking about her concerns.*

Example 4: The preceptorship relationship between Clara (preceptor) and Carmen (preceptee) was similar to that between Angela (preceptor) and Afnan (preceptee). During lunchtime, Clara (preceptor) treated Carmen (preceptee) as a staff nurse thus they did not spend their break time together, but rather, covered each other. Praising progress publicly and privately, encouraging effort, distanced guidance, listening to answers, and asking for opinions boosted the confidence of preceptees. On the first day of observation, Carmen (preceptee) worked independently like a staff nurse, observing the cardiac monitor, writing documentation, and giving medications. She looked competent doing advanced practice and most staff members acknowledged that. She was alert and responsible as I recorded in the observation below:

> *The doctor's round started. Once they arrived at the room, Carmen stood in front of Clara, introduced her patient, and answered the doctors' questions without any interruption. Clara was very proud of her as she was very responsible, confident and very trustworthy.*

Clara (preceptor) protected the preceptee and the patient when she forfeited a pre-natal appointment to attend to Carmen (preceptee) who was caring for a deteriorating patient. Clara (preceptor) was aware of the patient's condition and could not leave Carmen (preceptee) to work alone. Clara (preceptor) had attempted to attend the appointment, however, the queue was too long, and she returned. Upon return, she looked happy and proud of Carmen (preceptee) as she had executed everything perfectly in her absence. Clara (preceptor) only left for her appointment upon receiving a call from the ultrasound appointment. Before leaving the unit, she sat next to Carmen and revised her endorsement notes to ensure that she was ready. Clara (preceptor) asked Carmen

> *"are you okay*?" and Carmen confirmed: "*Yes, I am ready... go, go*."

Clara (preceptor) left to attend her ultrasound appointment.

Clara (preceptor) said:

> *she is very willing to learn. That's why I love her. She helps me as well, especially with my condition.*

Regardless of the role adopted by the preceptor, where there is a difference in personality between the preceptor and preceptee, preceptorships are less likely to be successful as these shape both public and private interactions. While preceptorship is about a harmonious relationship, personality mismatches make the development of such relations impossible.

During the fieldwork, Carmen (preceptee) invited me to join her lunch break and we had a very nice conversation about the importance of having a junior preceptor for their up-to-date knowledge and age differences. Junior preceptors were conceptualized as more flexible than seniors as they accept NGNs and can teach them using modern strategies. She considered herself lucky as she had Clara (preceptor):

> *she is open-minded and shows genuine interests. She always encouraged me to work hard and self-learn to take a higher position very soon. She believes in me. I really love her*.

Also:

> *I like the relationship to be comfortable without any stress. My preceptor and I are not too close, but I feel comfortable with her. I used to jest with her during her pregnancy by telling her to rest and do the work instead of her. This helps me to be independent because I do the work alone under her supervisor. In this way, I find a larger space to deal with the patient and the clinical decision-making ability.*

The quality of interactions depended on nurses' personalities, but some preceptors were not helpful and thus, did not co-operate with preceptees effectively as evident in the case of Daisy.

Example 5: Dalia(preceptee) described her relationship with Daisy (preceptor) as an unfriendly preceptor-preceptee relationship owing to personality clashes. Personality differences influence their public and private interactions as they were not able to determine how to relate to each other:

> *My preceptor is a little sharp and does not prefer to communicate with me. This could be due to the huge age difference and no common interests.*

During her interview, Dalia (preceptee), amidst tears, informed me that she was experiencing family issues as her father was in prison. She explained that this was a source of significant pressure for her. She blamed herself for things going wrong, but her preceptor also played a role in shaping her negative self-image and confidence concerning her competencies as a nurse. Consequently, Dalia (preceptee) experienced challenges in becoming cognisant of ICU systems and dealing with critical emergencies. Dalia's (preceptee) biggest challenges were getting up to speed with the ICU systems and processes that demand quick actions and focused attention to the frequently arising critical situations. Personality clashes were also informed by age gaps so that the harmonious relationship required for preceptorship was not achieved where the age differentials between preceptors and preceptees were not well matched. Dalia (preceptee) about Daisy (preceptor) remarked that:

> *She has sufficient experience in the unit, and she can handle many things at one time with high focus. However, I am not. She always insists that I am a slow and not organized person.*

The next section illustrates how power relations and personality interplay between preceptors and their preceptees.

3.3 Locus of Power: Trust and Conflict

Power and authority are fundamental and have caused barriers to effective communication in the workplace in the Saudi context and particularly between preceptor and preceptee. A trustful relationship is crucial to enhancing preceptee learning. On the other hand, the preceptor needs to trust the student's knowledge and abilities to be able to allow students to care for patients in an increasingly independent way. This is a process evolving from the preceptor being in total control to a more peripheral role where the preceptor finally invites the preceptee to perform professional nursing work more independently. In instances where the preceptor is in total control, this appears to suggest that there is a lack of trust and this can be a source of conflict in the preceptor-preceptee relationship.

Example 1: Alice (preceptor) played the role of an assessor who observes and evaluates the developing preceptee. Concerning this relationship, Alice (preceptor) explained that:

> *I cannot ask her personal questions or talk to her on a personal level. In ICU we don't have much time to talk personally…we are monitored all the time.... we have actual patients. That is why sometimes I'm running alone, and Afnan gets frustrated .. even during break time, I don't like to eat with my preceptee.*

The preceptor's role as an assessor can be a source of interactional conflict as this overshadows her role as a mentor. Although Alice (preceptor) adopted the role of the detached assessor which created an interactional barrier between her and Afnan (preceptee) based on professional superiority, Afnan (preceptee) still recognized that she was capable of making practice-related mistakes and did not entirely trust her competence. Consequently, Afnan (preceptee) did not always accept the idea of Alice (preceptor) being more knowledgeable than her and this was a source of interactional tension. For example, there was an instance where Afnan (preceptee) was in the process of completing her documentation and realized that Alice (preceptor) had erroneously entered the frequency rate (FR). She informed her that it should be 12 and not 13. Alice (preceptor) responded by saying "no, no, no. I am sure it is 13." Afnan (preceptee) attempted to explain why it should be 12 and not 13, however, she remained unconvinced. Afnan (preceptee) subsequently made enquiries from the patient's non-Saudi doctor, who confirmed that it was 12. Alice's (preceptor) face turned flush and she looked anxious. She disappeared for a while before returning, saying nothing. On the same day, following the release of the patient's lab test results, Alice (preceptor) remarked to Afnan (preceptee):

> *Do not forget to inform the doctor that the result is normal.*

Afnan (preceptee) said:

> *No. I will not do it. It is not logical to tell doctors that the patient's result is normal. I would inform them only if it was not.*

Afnan (preceptee) ignored Alice (preceptor) and left her alone. The teacher-student dynamic was interrupted in this case because of a lack of trust since Alice (preceptor) lacked some skills.

Whenever Alice (preceptor) required assistance from Afnan (preceptee), she asked her impolitely without saying please. She exerted her power by affording Afnan (preceptee) any courtesy or respect. Alice (preceptor) followed Afnan (preceptee) each time she performed a task and watched her closely. If things were not done according to her specifications, she would out rightly object. According to Afnan (preceptee)*:*

> *She (Alice) feels worried about work pressures. She works nervously, and she may raise her voice to me without being conscious of doing so."*

Afnan pointed out that her preceptor (Alice) treated her as though she did not exist. She also expressed how hard it was for her to be ignored: Afnan (preceptee) also revealed during her interview that students need affirmation:

> *my preceptor does not even offer good encouragement such as 'you are doing a good job' to support me. She appeared not to enjoy her work with me, which discouraged me.*

Angela (preceptor) approached Afnan (preceptee) as a co-equal as opposed to a subordinate. During the fieldwork, aware that their break time was supposed to be 1.00 pm, Angela (preceptor) asked Afnan (preceptee): "are you hungry?" to which Afnan responded: "Ohh, not yet. I am going to get this done before I join you." Angela (preceptor) helped Afnan (preceptee) administer the medication and set the IV fluid before they left and spent their break time together. They shared personal details about family and friends and talked about the experiences and challenges they faced as new nurses. This helped to build a good preceptorship relationship. Angela (preceptor) was very interested in learning Arabic and Afnan (preceptee) was teaching her all the time. They were also very kind to me and generously invited me to join their meals on several occasions, which I happily accepted. Afnan (preceptee) described her relationship with Angela (preceptor):

> *It was formal at the beginning. After that, it became more friendly, we are not close friends. We are not in a strict relationship like teacher and student. We are together for 12 hours, and I see her more than my family. Therefore, we should have some common conversations to share our updates.*

Angela (preceptor) showed respect for Afnan's (preceptee) educational background when she accepted her comments about her clinical performance when she made mistakes and encouraged her to discuss the gap between the preceptee's knowledge and the preceptor's clinical performance to fully link theory with practice. On another occasion, Afnan (preceptee) noticed that the Total Parenteral Nutrition (TPN) bag was missing and made enquiries from Angela (preceptor). Angela (preceptor) informed her, "I discarded it" to which Afnan responded, "why? It is still valid for another 24 hrs." Angela (preceptor) readily admitted: "Sorry! I did not know." She moved on to hold other discussions with Afnan (preceptee), asking her about what she had learnt at the university and subsequently read the national guidelines conjointly to add to their discussion. Angela (preceptor) and Afnan (preceptee), as part of their discussions, shared their knowledge and Angela (preceptor) valued Afnan's (preceptee) knowledge which she was willing to incorporate while caring for the patient.

Preceptors are responsible for giving constructive feedback, modelling capability and clinical judgment by assigning the most appropriate patient to the preceptee for effective learning. Angela (preceptor) used practical and theoretical knowledge, professional dialogue and constructive criticism as opposed to public humiliation with Afnan (preceptee) to assess and improve her level of competence. Afnan (preceptee), with Alice (preceptor), resorted to performing simple and basic tasks such as bed making and feeding. While Afnan (preceptee) performed mundane tasks, Angela (preceptor) prepared her for complex scenarios that could potentially arise during the procedures. She focused on the complex procedures to increase Afnan's (preceptee) confidence level and motivate her to take her role seriously, which helped build a healthy preceptor-preceptee relationship. Afnan (preceptee) described these dynamics in her post-interview:

> *We look for trust. If it is increased, you will feel more supported. However, if you are a lazy resident, then you will never get the support. My preceptor (Angela) has*

realized that I deserve the support. She told me that if anyone asked about you, I would praise you because you deserve that.

On one occasion, Angela (preceptor) stressed the needs of the patient and encouraged Afnan (preceptee) to reflect on what nursing interventions she can decide upon and implement independently as a nurse. Angela (preceptor) supported Afnan (preceptee) to care for the patient while providing less guidance under supervision, observing her ensured that she demonstrated clinical competency in performing the tasks. Angela (preceptor) assured Afnan (preceptee) that she would subtly check on her work, just to help her and make her aware that she looked after her, but from a distance. She approached Afnan (preceptee) as a co-equal as opposed to a subordinate. The preceptor-preceptee relationship thus became defined by mutual respect, trust and open communication. According to Angela (preceptor)*:*

Compared to other preceptees, the trust I'm giving Afnan is much more, I completely trust her.

Example 2: When Bayan (preceptor) and Basma (preceptee) attended to a patient who was extubated but still very sick, Basma (preceptee) sat on a chair in front of the patient's room crying. Bayan (preceptor) was next to her but said nothing and provided no emotional support. Basma (preceptee) went to the toilet, and I took this opportunity to ask Bayan (preceptor) what was happening. She informed me that there had been a misunderstanding between Basma (preceptee) and the night shift nurse during the handover. Basma (preceptee) felt that the nurse underestimated her, however, Bayan (preceptor) heard what the night shift nurse said but she did not respond. Basma (preceptee) came back and entered the patient room alone, doing nothing. She just stayed there, avoiding other interactions. She looked pensive and as if she was waiting for something. Basma got out of the room, asking Bayan (preceptor): “when are you going to take your lunch break?” Bayan was not sure so Basma said: "I want to bring some food", but Bayan said: “not now, get your documentation done first.” Basma (preceptee) sat in front of the computer, pulled the computer screen and started the documentation. She did not look well at all, but Bayan did not allow her to leave the unit. Basma (preceptee) was thinking of a way to go outside to be alone, so 30 minutes later, she told Bayan (preceptor) she was going to pray so Bayan could

not refuse or avoid it. She took 25 minutes for praying when this normally takes 10 mins or even less. Basma (preceptee) described these dynamics in her interview:

> *My relationship with Bayan is not a friendship. I share with her only the work-related issues without telling her about my problems. I tend to keep a distance and avoid deep relations with her to avoid problems with high expectations.*

And Bayan (preceptor):

> *I don't know. It is good, fine. Our relationship is a student and teacher, or it can be a colleagueship. I can ensure that we are not friends and that there are no common things between us.*

When preceptors exert their power as assessors, this can lead to interactional conflict since the mentoring aspect of the relationship is subdued. Preceptors who balance this role of power, mediated by trust, have more constructive relationships with preceptees which can result in better learning outcomes.

Example 3: Emma (preceptor) and Elham (preceptee) had a long-standing relationship that dates to her internship year before the start of the preceptorship. They were familiar with each other based on a resilient relationship based on trust. Despite Elham (preceptee) wearing a face covering (nigab), Emma (preceptor) did not find difficulties in communicating with Elham (preceptee). Emma (preceptor) expressed that she understood Elham (preceptee) through her eyes and could discern her feelings:

> *We have been together for a long time. In the beginning, we spent time to get know each other's personalities, weaknesses, and strengths both on sides. As time went by, we became friends but in a professional way. like colleagues. Sometimes I treat her like a baby she can tell me whatever she doesn't like, something bothering her. And now we are working like a team, even though we will not talk about it, we know already our roles, just seeing each other's eyes.*

Elham(preceptee) stated:

Having previous experience in the unit was a meaningful variable. She (Emma) knows me very well on a personal level and professional as well. She is doing her best to help me by regularly assessing my weakness and strengths.

Sharing food is a common expression of friendship and plays a key role in developing bonds, trust and solidarity. During their break time, they invited me to join them and I accepted their invitation. I witnessed them joke and laugh together, alluding to their close and warm relationship. In addition, they greeted each other with hugs and kisses when they met at the beginning of the shift. Elham (preceptee) noted during her interview that:

In fact, she is a friend. I mean, we do not consider a formal relationship between a resident and preceptor. The formal preceptor keeps an eye on the preceptee until finishing the work. However, I reached a point where she trusted me, and allowed me to perform nursing care independently.

There were instances of a balance of power in the context of the preceptorship relationship. This is evident in the relationship between Emma (preceptor) and Elham (preceptee). The relationship was more balanced as the preceptor was not only the preceptee's superior but also an equal as a result of having to pay attention to what the preceptee is saying. During an observation which followed a doctor's round, Emma (preceptor) asked Elham(preceptee) what new orders they added and what she was trying to tell them. There was constant professional dialogue. Moreover, there was a good atmosphere. It was the time of the doctor's round and Elham (preceptee) stood in front of her patient room, waiting for the doctors. Emma (preceptor) stood at a distance but within earshot. She seemed to completely trust Elham in interacting with the doctors. Elham (preceptee) introduced her patient case and answered the doctor's questions professionally. She advocated for her patient and questioned the doctor's orders. She voiced her opinion and tried to persuade the doctors where necessary and was confident in telling them why they could not follow orders. She was very alert and observant, noticing small but important details that others might have overlooked. The doctors listened to her and respected her views.

Elham (preceptee) stated:

> *In order to increase my knowledge and rely on myself, I approach my preceptor to discuss a specific topic when all the patients are stable. I always carry a notebook that could be a reference for the previous cases and write the important information that she gives me. I always think that because some nurses and doctors may make mistakes or pass on wrong information; therefore, I have to be aware and not only a receiver. Sometimes I will not be convinced by an answer, so I keep asking to get self-satisfaction.*

Emma (preceptor) served as a resource person by modelling the technical skills needed to function as a competent nurse. Emma(preceptor) and Elham (preceptee) entered the room of an elderly comatose woman. Even though the patient did not react to their presence, Emma (preceptor) started talking softly to her explaining who they are and what they will be doing. Elham (preceptee) approached the bed and spoke in a soft voice too. Emma (preceptor) was confident and competent. Emma (preceptor) understood the requirements of competence, specifically, what skills are needed to be considered competent.

I noticed that feedback between Emma (preceptor) and Elham (preceptee) included empathetic statements, supportive comments, and suggestions for further reflection through challenging statements. Emma (preceptor) assisted Elham (preceptee) to develop effective and concise oral and written communication skills, setting priorities by explaining the daily routine and demonstrating how to redirect performance to higher priority tasks. Emma (preceptor) and Elham (preceptee) sat in front of the computer doing their documentation together. Elham (preceptee) asked many questions regarding her documentation accuracy. Emma gave her some tips for improving her documentation. Once Elham (preceptee) finished, she allowed Emma to double-check her documentation by turning the computer screen to Emma's (preceptor) side. Elham (preceptee) reported that Emma's (preceptor) positive personality enabled her to gain a sense of feeling respected and trusted. Elham (preceptee) described her relationship with Emma (preceptor) which has supported her to grow academically and encouraged her to develop the skills of critical thinking. Effective communication, openness and frequent interaction made their relationship robust, leading to favourable learning outcomes.

Elham (preceptee) stated:

> *I need her as reference support to refer and ask about my concerns. I do not feel shy about it. I am pretty sure that she will not make me feel limited and mock me for asking questions. She always helps me on both personal and professional levels.*

Preceptors help with the development of knowledge of clinical skills and professional attributes in nursing and encourage the improvement of critical thinking and problem-solving skills. It takes six months or more to develop critical thinking competencies, however, Elham (preceptee) had different experiences from other NGNs working in ICUs. Elham (preceptee) passed her integrated assessment successfully on the last day of observation after just four months under her preceptor (Emma). The support received from Emma was crucial for her success. She moved from being the observer to performing the ICU nursing tasks independently. Her performance developed dramatically, and she developed professional judgments before completing the program. I had an informal conversation with Emma (preceptor) and asked her about the decision to pass Elham (preceptee) early in her assessment. She stated that Elham (preceptee) is good at providing culturally appropriate and high-quality care and communicating with doctors and other disciplinary teams. She noted that Elham (preceptee) had unique qualities which enabled her to perform nursing care independently. She demonstrated commitment, she was punctual and responsible for her patient. Elham (preceptee) was able to develop her nursing identity in a manner that stood apart from other NGNs. Thus, Elham (preceptee) noted in her interview that:

> *I feel like Emma is my backup. She helped me learn how to perform nursing practice and shape my nursing identity. She trusts me and gives me time to examine my insight to solve my patients' problems, and she always asks my opinion. She allows me to make safe mistakes and gives me enough time to correct my actions. Emma was appreciative of my knowledge and willing to respond and include my knowledge in our patient care.*

Balancing power and establishing critical friendship which is built upon trust, engagement and commitment in a non-hierarchal setting creates an environment within which preceptees can thrive through supported learning, feedback and mentorship.

5.5 Summary

This chapter has presented the research findings of this study, which illustrate the societal, institutional/organisational and individual/interactional factors that impinge upon the preceptorship relationship. Inequalities and stigma are shaped in the clinical setting, as a result of the Saudization policy and the practices of segregation that underpin them. Further, this has influenced perceptions about the professionalism of Saudi nurses in ways that reflect broader practices of ethnocentrism and discrimination that ultimately permeate preceptorships. At the institutional level, a lack of clarity about the nature of work was found to introduce tensions into the interactions between preceptors and their preceptors. It was found that preceptors must grapple with the pressures of performing both patient care and mentoring, while also battling a lack of institutional support and formal processes. The lack of these formal processes also means that a significant amount of work performed by preceptors is unrecognised. At the interactional level, the role of language, spaces of interactions, and variables such as trust in shaping preceptorships was highlighted. In the next chapter, the implications of these findings are unpacked.

Chapter 6: Discussion

This chapter is developed into two parts. The first part of this chapter focuses on the interactional level of the preceptor-preceptee relationship and then explores different aspects of its dynamics. It focuses explicitly on relational work in the preceptor-preceptee relationship, inequality and equality in the preceptor-preceptee relationship, and defining factors that constitute success in the preceptor-preceptee relationship. The second part of the chapter will explore recommendations, in relation to the key contextual processes that have been identified from the empirical findings, literature review and background of this study. These include workforce development and workforce sustainability, organisational processes and the Saudization policy. A Heideggerian perspective will be used to guide the discussion. In particular, the Heideggerian concepts of being-there (Dasein) and being-with (Mitsein) provide a structure for understanding the results of the research in terms of the structural aspects of preceptorship (Dasein) and the interpersonal relationships which form its basis (Mistein).

FIGURE 5: VISUAL SUMMARY OF FINDINGS

6.1 Relational Work in the Preceptor-Preceptee Relationship

It was clear from the findings of this research that a significant amount of relational work is conducted in the creation of the preceptor-preceptee relationship. Relational work for a nurse is the work involved in creating, sustaining and managing relationships with patients, families, other nurses, interdisciplinary healthcare professionals and administrative staff (Cathcart, 2014). This study illustrates that the amount of relational work and the nature of the relational work involved in each of the preceptor-preceptee relationships varies.

The most significant difference between preceptor-preceptee pairings in the study was the extent to which work was put into developing an interpersonal and social relationship between both parties. Pastoral care and social interaction were found to be important parts of the relationships. In some preceptor-preceptee relationships, there was mutual personal interest beyond simply being colleagues and this was referred to in the findings as a professional friendship. This included sharing meals, making jokes and finding common ground beyond patient care. The foundation of trust on which such relationships were based allowed preceptors to perform an important pastoral role in addition to friendship while maintaining professional boundaries.

The pastoral element of the preceptor-preceptee relationship can therefore be seen as creating a safe and trusting space for preceptees to share their emotions and concerns as well as the ability of the preceptor to respond to those concerns. In some cases, the pastoral element was still present in the absence of a close professional friendship, demonstrating that this is not an essential element of effective pastoral care.

The Heideggerian concepts of being-with (mitsein) and concern or care (sorge) help to understand and characterise this relational work (Stolorow, 2014; Elley-Brown and Pringle, 2021). The preceptor-preceptee relationship is primarily conceived of as a social relationship and not simply a process which could be carried out by a computer given the correct inputs. The preceptor and preceptee represent being-with each other in a mutual relationship of growth and development. The preceptor must give of themselves to the preceptee in terms of time, energy and emotional sensitivity in a way that adapts to the particular personality of the preceptee. Similarly, the preceptee must engage in being-with the preceptor by

responding to their feedback, following instructions where appropriate and considering whether their actions are appropriate to their role. It was found that the greater the extent to which both parties engaged in being-with as social beings, the stronger the preceptor-preceptee relationship and the more quickly the preceptee was able to develop. The concept of care (sorge) was expressed in two important ways. Firstly, care in the preceptorship was a mutual act from both parties depending on the circumstances and the patients available. Secondly, there was the care shown to each other as human beings similarly in the process of development and for the patients in their care.

The findings of this study align with previous research which shows that the successful preceptor-preceptee relationship is more like a friendship than it is like a teacher-student or other professional relationship due to the semi-formal, voluntary nature of the relationship and the participation of both parties in building a strong relationship (Nielsen et al., 2017). As with an intimate friendship, the relationship can be unstable due to this dependence on voluntary relational work that is required in maintaining friendships. When preceptor-preceptee relationships worked particularly well or when they were dysfunctional, participants often pointed to the interplay between the personalities of the preceptor and preceptee to explain the success, or not, of the relationship. A "strong personality" could both promote and inhibit relational work in the preceptor-preceptee relationship as preceptors described as having such personalities tended to impose their own views on preceptees.

The effective 'matching' of personalities to promote relational work has been studied by a number of researchers, including the factors which can influence how well-matched a preceptor-preceptee pair is. These include education level, experience, generation or age, cultural identification including religion and learning style (Robbins, 2017). In the present research, all of these factors could be included under the heading of personality when considering the sources of conflict or commonality in the preceptor-preceptee relationships. Research into the particular personality features which lead to success has shown that 'extraverted' preceptors with objective attitudes to assessment were found to have greater self-efficacy and therefore interact more effectively with preceptees (Li and Su, 2014). Research by Lalonde and McGillis Hall (2017) has additionally shown that when preceptors are less open, conscientiousness and emotionally stable this was related to higher

preceptee job turnover and dissatisfaction. This suggests that poorly-matched preceptor-preceptee relationships could cause long-term recruitment issues within nursing.

Although it was clear from this research that participants viewed well-matched personalities as important to a successful preceptor-preceptee relationship, it was not always clear what made a successful personality match. It was noted that preceptors having a 'helpful' personality tended to lead to preceptees feeling more valued and being given greater opportunities to learn independently, while preceptors who were resistant or domineering tended to hinder these learning opportunities. It is not clear from the research whether the 'personalities' being discussed are sets of values which cannot be changed or are in fact malleable attitudes and skills which could be taught to improve interaction between preceptors and preceptees. If personality mismatches are dependent on aspects of a person which cannot be changed then ensuring good matches prior to placing preceptees with preceptors becomes a much more important task in ensuring preceptor-preceptee relationship success. Crucially, there is no strong evidence which supports the methods used to find and develop relationship matches by preceptors and administrative staff.

Relational work is also devoted, within the preceptor-preceptee relationship, to the establishment of effective communication (DeFrino, 2009). Effective communication both in the direction of preceptor to preceptee and preceptee to preceptor was seen as important to a successful preceptor-preceptee relationship by the participants included in the study. Thematic analysis of the data revealed that communication, both verbal and non-verbal, could be used by both members of the preceptor-preceptee relationship to aid the progress of the learner, communicate concerns and provide pastoral care. Conversely, communication was used to exert power, to humiliate and to reinforce hierarchical roles in ways that hindered the success of the preceptor-preceptee relationship. Another important finding of the research was that the direction of communication was also important to the preceptor-preceptee relationship's success. If the preceptors or preceptees chose to direct their communication at other members of staff including doctors and the CRN instead of towards each other, there tended to be a breakdown in communication to the detriment of the preceptor-preceptee relationship.

Communication is a well-studied aspect of preceptorship and nursing more generally. Content analysis of communication within nursing preceptorships by Jeoung et al. (2014) found that there was a wide variety of types of content in communication including kindness, criticism and reproach, stigmatisation, talking behind one's back, impolite words, and emotional expression. This reflects the findings of the present study, which included all of these types of communication in-context as observed by the researcher. Studies have investigated whether interventions can be used to improve communication content in preceptorships to make it more effective and improve attitudes and there is evidence that this is possible (Anwar et al., 2020). In particular, the teaching of assertive communication skills can be a boon to preceptees both during preceptorship and in their later careers, but this may involve a motivated preceptor who is able to teach these skills before or during the programme (Mansour and Mattukoyya, 2019). It is not clear how unassertive preceptees with unhelpful preceptors can learn to assert themselves more effectively.

A particular feature of the participants in the present research was the complex interplay between different languages including Arabic, Tagalog and English. Requests were made by Saudi preceptees to Filipino nurses to speak in English so that preceptors could understand them during patient care. In addition to nurses' first languages being used out of convenience, they were also used as private spaces in which to share jokes without being understood by others, which could be used to exclude other nurses and appeared to lead to the formation of linguistic and cultural cliques. There were no institutional systems in place to enforce interaction in any particular language or to help overcome linguistic barriers between groups. Some preceptors and preceptees did additional relational work to overcome this barrier by learning a second language. Thus, overemphasis on cultural difference and communication difficulties in the Saudi context may be unjustified as there is evidence of similar experiences in other contexts. Instead, a careful exploration and understanding of cultural differences as important aspect of other contextual factors is important for developing an understanding of the concrete relationships and tensions and the development of interventions that are appropriate for the Saudi context.

Further relational work was devoted to creating a system of teaching and learning. Previous research has acknowledged the significant work which goes into providing education leadership and into being a receptive and adaptive student (Cathcart, 2014). Supporting the

education of newly qualified nurses as they develop competencies is acknowledged as a core component of preceptorship (Quek and Shorey, 2018) and the present research found a variety of ways in which the preceptor-preceptee relationship was structured around learning. Perhaps the most striking finding was that within a single hospital setting there were no formalised structures in place to ensure that the preceptor-preceptee relationship delivered effective learning opportunities for preceptees. Indeed, the opportunities available to the five preceptees included in the research were varied significantly and depended to a large degree on the relationship between preceptors and preceptees working out on the interpersonal level, and that expectations and commitments of both parties would be compatible and clearly set out.

Although none of the preceptors included in study used a formalised system of teaching, several approaches have been developed in the literature to improve the education component of preceptorship. The One-Minute Preceptor (OMP) model (Gatewood and Gagne, 2019) is well-supported in the evidence base as a way of using five micro skills to organise learning experiences for students. In the OMP model, the clinical educator begins by asking what the nurse thought during the patient encounter, collects more evidence regarding the nurse's decision-making, teaches a general rule for patient care based on the experience and then provides timely feedback in the final two steps (Gatewood and De Gagne, 2019; Teherani et al., 2007; Farrell et al., 2016). This method has been shown in randomised controlled trials to be popular and effective with learners but has not been widely integrated into preceptorship programmes (Furney et al., 2001; Pascoe et al., 2015). In the present study, several preceptors already implemented parts of the OMP model, although not consciously, as part of their preceptorship practice so it is likely that it could be easily integrated.

6.2 Inequality and Equality in the Preceptor-preceptee Relationship

The preceptor-preceptee relationship was frequently characterised by inequality. Relationships were asymmetrical in terms of different types of power: the power of professional status, the power of social status within Saudi society, the power of taking,

carrying, and assigning professional roles and responsibilities at the workplace, and the power of knowledge, skills, and experience in caring for patients and navigating the hospital environment of the preceptor and preceptee. The negotiations of these different power positions and the experiences of trustworthiness shaped the development of trust and respect on both sides. Inequality was additionally created by negative attitudes towards other nurses based on their ethnicity, religion and first language, with some participants tending to essentialise these differences to the detriment of the preceptor-preceptee relationship. For example, non-Saudi nurses tended to form unfavourable views of the professionalism of Saudi nurses. These views appeared to be linked to resentment about the Saudization policy and the idea that Saudi nurses would come to 'replace' non-Saudi immigrant nurses over time despite the perceived inferiority of attitude in Saudi nurses.

These tensions were seen to exist in a self-fulfilling circle in which the assumption of preceptors that Saudi nurses would underperform led to them providing fewer opportunities to learn and succeed. Saudi nurses had to work harder to learn the same competencies. Similar tensions existed between Saudi Sunni and Saudi Shia staff, with the participants reporting that Shia staff were excluded from organisational roles and functions and their needs not appropriately accounted for. These tensions caused a significant amount of unnecessary work-related stress which erected barriers to preceptee success. Again, this demonstrated that perceived inability due to cultural factors led to actual impediment of the preceptee's progress rather than the opportunity to fulfil their potential.

There is currently no research which has specifically investigated stigma, racism, and ethnocentrism in preceptorship, although the broader concept of "fitting in" has been studied. Leong and Crossman (2015) found that fitting in was closely related to the rate of attrition of newly qualified nurses, with those who feel excluded more likely to leave the profession early in their career. This research, however, focused on the need for the graduate nurse to fit into the organisational context they find themselves in. In the present study, it is clear that it is the organisational context and culture itself that need to change. Rules and guidelines are required to remove negative attitudes towards Saudi nurses based purely on their nationality and professional practice, tensions between Sunni and Shia nurses based on religion, and tensions between Saudi and non-Saudi nurses based on unequal treatment and opportunities. Other research has noted that the preceptorship

process itself may need to adapt to meet the cultural needs of the local population rather than being considered a "one size fits all" approach internationally (Ke and Hsu, 2015). For example, social attitudes concerning gender can be considered when assigning male preceptors to female preceptees. Attitudes to professionalism of Saudi nurses in particular seemed to be an area where cultural value systems were more important than objective considerations.

Inequality was also found in the structure of the preceptor-preceptee relationship through the creation of hierarchies with the preceptor at the top at all times. In some cases there was an explicit decision to establish this asymmetrical preceptor-preceptee relationship, but it was conceptualised as supporting the preceptee in their learning alongside the CRN on the same ward, with both of them existing at the top of a hierarchy above the preceptee. This unequal, hierarchical preceptor-preceptee relationship was in contrast with other professional roles observed in the research in which responsibility and power was passed to the preceptee or passed back to the preceptor depending on the circumstances.

A further finding from this study was that the professional roles adopted in the preceptor-preceptee relationship are a negotiation between both parties, rather than something which pre-exists the relationship. This was influenced in particular by the desire of the preceptee to have independence in patient care balanced against the desire of the preceptor to protect patients from potential poor care by inexperienced preceptees. The power dynamic could also swing in favour of the preceptee if they have a strong personality. A final finding was that some preceptor-preceptee relationships showed that there is potential for the professional roles to shift gradually over time from a more formal and hierarchical model to one of collegiality.

In the wider evidence base, there is similar confusion regarding the roles and responsibilities of preceptors and preceptees in balancing education, facilitation and patient care (Omer et al. 2013, 2016; Omer and Moola, 2019). Although preceptorship programmes are widespread, there is no commonly-agreed standard model of preceptorship and this is reflected in studies which have assessed perceptions of preceptorship programmes using quantitative methods. Marks-Maran et al. (2013) found that preceptorship was well-received by preceptees as a way of developing skills, with more than 85% of participants

viewing the process positively, but there were also difficulties in adopting and maintaining the roles of preceptor and preceptee due to the pressure of providing patient care. Qualitative investigation of preceptors has revealed that preceptors feel similarly and see their role as encompassing both the position of an educator and an emotional support for preceptees (Tracey and McGowan, 2015).

Asymmetrical, unequal relationships were often characterised by a lack of trust and respect, usually on the part of the preceptor towards the preceptee. Trust and respect were discussed repeatedly by all the participants as an integral part of a successful preceptor-preceptee relationship. Those relationships which lacked respect and trust were more likely to fail both as interprofessional relationships and structures to aid the learning process of preceptees. A feeling of trust on the part of the preceptor towards the preceptee was likely to result in the preceptee being given more freedom to explore their own skills when dealing with patients without being monitored closely by preceptors.

It is a common theme in the literature investigating preceptorship models that trust on the part of both the preceptor and the preceptee is an important part of a successful preceptor-preceptee relationship (Quek et al., 2019; Paton, 2010). The building of trust and mutual respect is conceived of as a crucial step in the establishment of a good preceptorship relationship (Hilli et al., 2014). However, this study found that this can be difficult, especially if the desire for respect by the preceptor actually results in the preceptee fearing them rather than respecting them. Research has suggested that one of the places where this process fails is the disparity in intergenerational understanding of what constitutes respect and trust, with older nurses viewing respect through a hierarchical lens while younger nurses see collegiality as a sign of trust and respect (Foley et al., 2012; Earle et al., 2011; Clipper, 2013). The findings also demonstrated that age disparities could also have a negative impact on preceptor-preceptee relationships and this may be an area where future research could establish mechanisms for better cooperation between nurses of different generations.

Respect was also important to both preceptors and preceptees within the research. Preceptors wanted to be respected as more senior nurses with greater experience in a position of authority, while preceptees wanted to be respected as dedicated nurses who

were trying to learn. Respect was demonstrated in a variety of verbal and non-verbal ways. Respect, or lack of respect, was developed in the context of cultural differences. In the Saudi context, personal respect and cultural respect go hand in hand and this is reflected in the healthcare setting where personal respect involves cultural competence (Alsadaan et al., 2021). Thus, some preceptor-preceptee relationships embodied respect for cultural differences while others showed a distinct lack of respect for other cultures which impacted negatively on the preceptorship. Those preceptor-preceptee relationships which were most successful included holistic respect for the individual.

Equality was also expressed in preceptor-preceptee relationships through collegiality. That is, relationships in which nursing responsibilities were shared between the preceptor and the preceptee effectively rather than performed solely by the preceptor due to a lack of trust in the preceptee's abilities. Without conceptualising it in these terms, the most effective preceptors naturally pushed their preceptees into what Vygotsky termed the Zone of Proximal Development (ZPD) (Vygotsky, 1978). The ZPD is that area of nursing competence which the nurse is able to perform with support, as opposed to those competencies which they are able to perform without support present.

The sharing of responsibility and power within the preceptorship relationship has an important role in the development of learning experiences that are successful, whereby success is mostly understood in terms of ensuring patient safety, even if this causes additional stress for preceptors (Omansky, 2010). A number of researchers have attempted to characterise the effect of sharing of power, authority and responsibility in the preceptor-preceptee relationship while maintaining patient safety (Sorrentino, 2013). An important concept is that of empowerment, both through passing of responsibility to preceptees and improving their self-efficacy through guided development. The effectiveness of the preceptor is directly related to the level of psychological empowerment and professional autonomy (Watkins et al., 2016). This finding was confirmed using a qualitative ethnographic investigation in the present study, where those preceptors who were most effective also created empowerment in their preceptees.

The Heideggerian concepts of the One (das Man) and being-in-the-world (in-der-Welt-sein) were particularly prominent in the findings related to the third research question: how does

the relationship between preceptor and preceptees impact the perceived success of the preceptee? (Richardson, 2012; Paley, 2014; Mulhall, 2014; Ekeh, 2016). The concept of das Man or the One/the They is the set of socially constituted norms which we belong to when we are in the world. When we grow up, Dasein is necessarily informed by the understanding of others which is used to form social norms, sometimes deliberately and sometimes unconsciously. The set of assumptions about the competence of Saudi nurses versus those of immigrant nurses is a result of what 'one thinks' within the culture of immigrant nurses, with views regarding their lack of professionalism constituting the One of this group. Similarly, the concept of das Man is important in understanding the socially constituted views of Sunni nurses regarding Shia nurses. These views pre-exist the meeting of these nurses as individuals and are imposed onto them regardless of their truth, such that 'all' Saudi nurses are considered to be unprofessional (Dreyfus, 1995; McKinney, 2018). This presents a difficulty for institutional change because das Man represents a sort of social normative idea which is difficult to change, such as the idea that 'one gets married' or 'one has children' (Knowles, 2013).

6.3 Defining Factors that Constitute Success in the Preceptor-preceptee Relationship

This research found that there were no consistent factors of success in the preceptor-preceptee relationships analysed in the study although determining these factors is essential to determining whether a preceptor-preceptee relationship is functioning poorly or well (Shinners and Franqueiro, 2015). One factor which appeared frequently in this study was the ability for the preceptor and preceptee to ensure patient safety, even if this was to the detriment of the learning experience of the preceptee. The preceptor-preceptee relationship is primarily a working relationship which must takes place in the course of normal nursing duties, even though preceptors were able to create private moments away from patients where learning opportunities could take place. As such, all of the preceptor-preceptee relationships featured in this study were characterised by the way in which the relationship was structured around patient care.

This study found that the prioritisation of the patient's health and autonomy as part of patient-centred care placed pressure on the preceptor-preceptee relationship if the preceptor was not able to find a way for patient care to form a natural part of preceptorship. In some cases, the preceptor continued their work as a nurse without making relatively simple accommodations to include the preceptee in that work and to allow learning to occur. This meant that the preceptee often felt uninformed or 'out of the loop'. Preceptors were also found to be critical of preceptees who prioritised learning over patient care.

It has been noted in previous research that the preceptorship model can present ethical problems for nurses due to the need to allow preceptees to perform skills which are currently beyond their ability to perform independently while maintaining patient safety (Luhanga et al., 2010; Lim et al., 2016). Depending on the ward on which preceptorship is taking place, such as neonatal ICU, the risks to patients of poor or unsupervised care by preceptees may be greater (Edwards and Connett, 2018; Welborn, 2017). In Chapter 5, some preceptors were uncomfortable to hand over too much responsibility to preceptees, but it must be acknowledged that these graduate nurses will eventually transition to unsupervised care and perhaps become preceptors themselves, so this is a crucial step in their training. Myers et al. (2010) have noted that this transition is not just the acquisition of patient care skills but also critical thinking to allow newly qualified nurses to seek help when they are in a situation in which they feel unsure if they can provide quality care.

Another factor which was seen to be a marker of a successful preceptor-preceptee relationship in this study, was the presence of dedication to the role of preceptor or preceptee. Although the words dedication and heroic, where heroism in this context refers to getting on with one’s work despite feeling unappreciated and despite a lack of organisational support, were not mentioned by any of the participants, there were a number of instances where both preceptors and preceptees were dedicated to their roles and made additional effort to ensure the preceptorship was successful. In some cases, the preceptor was seen to take a great deal of care to be patient with the preceptee and to provide them with time and space to grow and learn during patient care in situations where it would have been easier for them to take over patient care duties as the more skilled nurse. In other cases, the preceptor ignored the preceptee and specifically stated that

preceptorships hindered their own patient care and were therefore something of a nuisance.

As well as preceptor dedication, preceptee dedication was also an important finding of the research. Dedicated preceptees were well-prepared with a notebook which indicated a preparedness to learn and were constantly looking for opportunities to engage in learning activities. They were keen to learn but also cognisant of the fact that there were better and worse moments to learn from their preceptor. They seamlessly moved between urgent patient care and learning in quieter moments. Research has shown that preceptors who have a combination of professional qualities including dedication and the enjoyment of their work are likely to make better nurse preceptors (Chen et al., 2012). The concept of 'commitment' may be thought of as synonymous with dedication. Hyrkas and Shoemaker (2007), revisiting an earlier piece of research, found, using the Commitment to the Preceptor Role Scale, that commitment to preceptorship measured using this scale was high, as it had been in previous studies. They also found that preceptors who worked with nursing students as well as newly qualified nurses tended to have higher commitment to the role. Macey et al. (2021), using the same scale with a sample of ICU nurse preceptors, found that commitment to the role was significantly increased when there were organisational benefits to the role and that preceptors who felt undervalued were less committed. In the present study organisational benefits were absent, leaving preceptors to draw commitment from their own self-efficacy.

Linked to dedication was a more general trend in the data for preceptees to thrive when their preceptors perceived them as capable of success. In some cases, the preceptor-preceptee relationship began prior to the beginning of the study without the trust that was evident at the time of data collection. This trust was built gradually over time and during the study it was evident that the preceptor had a perception that the preceptee would succeed in their learning which led to them being given greater opportunities to succeed through learning. This was in spite of other barriers which had affected other preceptor-preceptee relationships. In cases with more than one preceptor there were examples of different expectations of success leading to the preceptee thriving or struggling depending on the attitudes of the preceptor. This demonstrated the importance of the expectations of the

preceptor, as the same preceptee performs very differently if the preceptor expects them to succeed rather than expecting them to fail.

Preceptees were also seen to assess their own ability to succeed according to their own factors. The concept of being-in-the-world (in-der-Welt-sein) was prominent in the self-perception of success among preceptees. These graduate nurses are attempting to be-in-the-world by following a path of growth towards being more experienced nurses. Those preceptees who self-perceived as successful could be said to be more in-the-world through their orientation towards growth (Dreyfus, 1990; Svenaeus, 2011). The preceptor-preceptee relationship impacted significantly on the preceptee's self-perception of their own factors of success. Feedback from effective preceptors included empathetic statements and supportive comments mixed in with challenging statements. Feedback was always intended to motivate as well as highlight areas for improvement. Preceptees responded well to this and in turn became more open to preceptors checking their work. Preceptees described preceptors as a core part of their success and it was clear that they felt more successful as a result of the preceptor's positive comments. In some cases, preceptees who were less confident in her own abilities and required more support from their preceptors to complete duties, such as handover and patient care, felt success was possible if they worked hard due to the support of their preceptor.

Preparation was found to be a factor of success. Preceptors prepared preceptees for situations which they knew would be unfamiliar or complex in advance, so that if these arose during procedures the preceptee would be able to cope with them without panicking. This in turn increased the preceptee's confidence in assisting in these procedures and the sense of success gained from them. In other cases, it was the preceptee who was able to prepare themselves to succeed supported by their preceptor. A contrast was also seen with relationships in which the preceptor felt the preceptee's progress had been slow and overly dependent. In one relationship, the preceptee was reduced to tears and clearly felt she had failed because her preceptor failed to provide encouragement. This shows that both the preceptor and the preceptee's attitudes can contribute significantly to the preceptee's self-perception of their success.

Strategies used by preceptors and preceptees in the present study to improve the chance of success and to reinforce the self-perception of success have been noted in previous research (Ferrara, 2012; Matua et al., 2014; Horton et al., 2012; Rebholz and Baumgartner, 2015). These include proper orientation, preparation for complex situations as seen with Angela and Afnan, appreciation, acknowledgement, assurance, positive feedback, time spent together, personal understanding, taking breaks and encouraging commitment. It is clear from the present study that when these factors are present, there is a greater likelihood that the preceptees will perceive themselves as successful both due to positive communication from the preceptor and the additional progress they are able to make when properly supported. There appears to be a circular, positive feedback between support from the preceptor and the ability of the preceptee to self-support.

6.4 Recommendations for Practice

The importance of the interactional level is discussed in the wider literature, but the analysis of the Saudi context in this study identified a highly complex context. This is due to diverse and deep social, economic, and professional inequalities, and cultural, linguistic, and religious differences within the workplace and in wider society. This study has illustrated the complexity of negotiating interpersonal relations in the context of Saudi preceptorships and the substantial and complex relational work that needs to be done. If organisational processes, specifically processes related to the development and retention of the workforce, and wider societal processes are not addressed, this study has shown that tensions become articulated on the level of interactions. This study has also shown that these tensions undermine workplace relations which require significant relational work. The next section will examine how the findings of this study can inform possible changes and interventions, focusing on workforce development and workforce sustainability, organisational processes and the Saudization policy.

6.4.1 Workforce Development and Workforce Sustainability

Preceptor training, standardised preceptor preparation, clearly established guidelines for preceptorships and clearly defined evaluation and assessment methods are crucial for workforce development and workforce sustainability. This study found that there were no formalised systems for training preceptors to make the preceptorship process more effective. Even preceptors who had been performing their role for more than a decade tended to have chaotic and informal approaches to preceptorship which veered between good practice and actively unhelpful to preceptees. The best preceptors relied on their interpersonal skills and nursing ability to provide space and time for preceptors to learn, but this depended almost exclusively on the ability of the preceptor with limited or no institutional support. As such, it is recommended that hospitals put in place preceptor training schemes which use evidence-based teaching to develop preceptors who are focused on creating moments of learning and providing targeted feedback to preceptees, which can be augmented by the preceptor's own skills, rather than leaving preceptors to develop their own systems. This places unnecessary and avoidable stress on preceptors and preceptees.

There are several findings from the present study which suggest what might be undervalued or underdeveloped skills in many preceptors which could potentially be improved through training. Several of the preceptors were overly critical or provided negative feedback without balancing this feedback using positives or constructive feedback. This tended to result in preceptees becoming disheartened rather than motivated to improve. It would also be an improvement to preceptor practice if preceptors were trained in the safe but detached monitoring of preceptee patient care. The ability to allow preceptees to learn independently while maintaining patient safety was crucial to progress in the most successful preceptor-preceptee relationships. Finally, the ability to be receptive to feedback from preceptees without taking it personally could increase the resilience of some preceptors (Wilkinson et al., 2013; Allen and Molloy, 2017; McClure and Black, 2013).

A more frequent, standardised preceptor preparation workshop should also be offered. This workshop should be mandatory for all programme stakeholders. Its contents should cover the roles and responsibilities of preceptorship, preceptees' needs, adopting the principles of adult learning, effective teaching, performance assessment and strategies for effective precepting and support. Preceptees sometimes felt that time was wasted learning skills and

carrying out clinical procedures not commonly practised in ICUs, therefore it is recommended that the generic competencies addressed as part of the preceptorship process should be based on each unit's requirements. Preceptors also need to consider individual preceptees' learning needs in the practice setting and plan activities to meet these needs. They must be acutely aware of the challenges that their preceptees face during the interpersonal clinical relationship, such as fear, lack of time and continuity with the preceptor and language barriers. If these findings are appropriately disseminated, they will help preceptors examine and improve their efforts.

The findings of this study show that there is no clear understanding of preceptorship among preceptors or administrative staff, and no standardised model for the preceptor or preceptee role. This has the potential to cause long-lasting effects within the Saudi health care system if the quality of preceptorships is completely dependent on the individual abilities of preceptors. This lack of a reproducible model could reduce the effectiveness of the mentoring process and, therefore, is an area that needs to be improved. A national mentoring policy for Saudi Arabia could help decrease the ambiguity about the roles of preceptors, preceptees and those administering the programme, as well as acknowledge the value of preceptorship and the work that preceptors do. Preceptors and preceptees need greater awareness of their own and the other's role and expectations. Whether preceptors are responsible for mentoring, assessing and evaluating preceptees in their clinical placements needs to be carefully considered as part of the process of standardisation of the role.

Clear written guidelines to help make the preceptorship programme a positive experience and help preceptees, preceptors, clinical resource nurses and nurse managers understand their roles in the preceptorship process should also be constructed. These guidelines should outline how the preceptorship programme should be implemented and enacted by each party involved in the process to generate a consistent approach to the execution of the programme.

As well as the lack of appropriate training for preceptors, there is also minimal support from the administration for the preceptorship process. It is expected to take place as a necessary part of developing effective nurses but without impacting on daily care. Nurses in

this study struggled to find time to provide feedback and there was often significant pressure to balance patient care with learning opportunities. For those preceptors who routinely prioritised taking control of patient care due to lack of trust in preceptees, there were fewer opportunities for preceptees to learn. Support could potentially be provided to reduce this pressure by increasing staffing numbers during certain periods to allow more flexibility for learning and feedback (Odelius et al., 2017; Vernon, 2017). Ultimately, teaching, reviewing, guiding, directing, and supporting preceptees takes time. The provision of support will assist in the management of workloads and thus constitutes a key time management approach if they are well prepared to accept responsibility for learning. Further, collaborating with CRNs allows preceptors to feel supported in meeting preceptees' learning needs.

Preceptors should be provided with protected time by their managers, to enable them to spend sufficient time with their preceptees, in addition to having time for reviewing practice documentation and ascertaining the success of preceptees' progress in relation to practice based competencies. As staffing levels are a significant barrier to undertaking this work while ensuring patient safety, it would make sense for some of this paid, protected time to follow or precede handover.

In order to ensure sustainable, high-quality mentoring and teaching in practice, additional measures should be taken by organisations to recognise and reward preceptors for their work. This should involve suitable remuneration, for instance in the form of an increase in pay, paid training days, or a decreased workload for the duration of mentorship. In addition, recognition could also include certificates or thank you letters from senior management. Development of a reward system not only for preceptors but one that includes all those programme stakeholders who demonstrate best practice in order for them to feel more integrated and valued within the organisation. In this way, commitment to the programme can be enhanced and the importance of the preceptorship programme for improving the organisation should be stressed as a way of raising the profile of the preceptorship programme to effect greater engagement with the process. In order to retain existing staff, there must be greater investment of resources into mechanisms to support the orientation and integration of new Saudi nurses into healthcare environments.

6.4.2 Organisational Processes

Organisational processes must consider factors such as personality mismatches, learning styles, preceptors' professional qualities and age disparities, to encourage better cooperation between preceptors and preceptees. Personality mismatches were found to be a significant barrier to preceptee success within the preceptor-preceptee relationship in this study. It is recommended that systems are introduced to effectively match preceptors with preceptees. Assessments of learning styles is one of the methods which has been trialled in order to perform this matching (Pena et al., 2021), although the process tends to rely on the judgement of clinical staff in general rather than systems (Doherty et al., 2020). It would be an easy change to introduce the opportunity for preceptees to switch preceptors in the case of a significant personality mismatch, such as that between Afnan and Alice in the present study.

Critical or professional qualities of preceptors that facilitated preceptees' ability to care for patients were revealed in this study's findings. These included the ability to safely hand responsibility to preceptees and making time for considered feedback. Careful consideration of preceptors is essential to ensure that they are nurses who are recognised as a clinical expert, who want to take on the role, and are committed to providing supervision that balances "patience for doing" with patient safety. These qualities were essential in making preceptees feels safe and facilitated the development of their competence and confidence in caring for critical patients.

The findings of this study revealed that preceptors who provided ongoing coaching by promoting dialogue and reflection with preceptees, was essential to the latter's growth. This finding also has implications for nursing administration. Developing and maintaining such "clinical coaches" requires ongoing training and support. Administrators must continue to dedicate resources to this aspect of preceptor development so that expert nurses may develop into expert teachers. Expecting preceptors to mature into the role without training produces very mixed results.

Age disparities were also found to cause issues for preceptor-preceptee relationships in the present study and this may be an area to be considered during the matching of preceptors and preceptees, and where future research could establish mechanisms for better cooperation between nurses of different generations.

6.4.3 Saudisation Policy

The Saudisation policy must be adapted to the realities of the nursing workplace in Saudi Arabia so that it delivers what is intended in a manner that is appropriate to the organisational set-up. This requires dealing with racism and ethnocentric attitudes, especially embedded hostile attitudes to Saudi nurses which this study revealed. Within the context of the Saudisation policy, it is essential to deal with the fact that there will be a set quota of Saudi staff coming into the hospital as graduate nurses. The situation at present, where these nurses are judged as incompetent, is not sustainable. Equally, unsustainable is the disrespect against non-Saudi nurses and Saudi Shia nurses that builds on existing social and economic inequalities in wider Saudi society. This racism in the workplace has also been noted in previous research (Alsayed and West, 2019; Inocian, 2015) and this presents a significant threat to good preceptor-preceptee relations. This is likely to be a process which happens at all levels of governance within the hospital which would benefit from openness about attitudes which are widespread and openly acknowledged by stakeholders.

There are several aspects of the workplace which contribute to justice and empowerment of staff. The organisational culture of the hospital would benefit from being less hierarchical and the power possessed by individuals flattened within nursing management. If done effectively, this would mean that both Saudi and non-Saudi members of the workplace feel valued both implicitly and explicitly. Those with power currently should recognise that subcultures, ethnic groups or ethnocultural populations exist and that these groups have different experiences from those of the dominant culture with which they identify. This cultural group may be defined by nationality, language, religion, socioeconomic status, education, or other factors that functionally unify the group and cause each member to have a conscious awareness of these differences.

Rules of professionalism that apply to everyone can also be imposed to address social inequality and the stigmatised perceptions held by some nurses, influenced by societal norms. This would promote a more tolerant and inclusive environment and open up spaces for prevailing issues to be addressed in a structured and comprehensive way. This would go a long way to dismantle preconceptions and promote equality. As well as this, a more cooperative relationship should be fostered between immigrant nurses and Saudi nurses (NGNs). At the moment the Saudization policy creates tension by making the immigrant nurses feel that they are gradually being replaced, that their position is therefore unstable and that Saudi nurses represent a challenge to them in the long term. Collaborative efforts across the boundaries of healthcare, between all policymakers, nurses, patients, doctors and hospital stakeholders are needed for the development of effective multicultural nursing collaboration protocols within the Saudi context.

Respect and dignity policies should be adopted in all wards through a charter of communication to create an empowering and inclusive environment in which to collaborate and to encourage nurses to embrace differences. This is essential not just for fostering good relations between staff members but also between patients and staff. Unit managers should put into place practices aimed at preventing the mistreatment of all workplace staff. They should establish a formal system for Saudi nurses (NGNs) to prevent unprofessional practices and unacceptable behaviours, such as wearing accessories and makeup, eating inappropriately in the workplace and deliberately speaking other languages to exclude members of staff who do not speak to them. These efforts would help promote an environment of excellence and equality within the healthcare organisation. A zero-tolerance policy should be introduced across the health system to tackle endemic rudeness. The combination of these policies could create radical and lasting change within the hospital to promote justice and equity for all groups without privileging or disadvantaging any particular group.

The preceptor-preceptee relationship was least successful when there was a greater personal distance between the preceptor and preceptee and when there was a greater power imbalance between the two roles. Collegiality should be encouraged while maintaining patient safety to allow preceptees to settle into the responsibilities and competencies which they will need to perform independently in their career. Collegiality will

play a crucial role in transcending the differences between nurses that give way to stigmatisation. The development of a closer interpersonal bond appears to aid in developing trust and collegiality, so activities such as communal eating should be encouraged early in the receptor-preceptee relationship. This is likely to improve communication, especially non-verbal understanding, which forms an important part of the preceptor-preceptee relationship but can often be a source of confusion and tension, as this study found, due to cultural differences.

Despite the complex context of inequality and stigma, it is possible to encourage collegiality by supporting or enhancing the contextual factors that reduce obstacles to having such relations. The study highlighted the important aspects that contribute to a successful preceptor-preceptee relationship. These included communication and openness between preceptor and preceptee, mutual respect, preceptor's involvement in the preceptee's professional development, and easing of preceptees' fear during new procedures and situations. With these important aspects confirmed in a Saudi Arabian setting, an assessment of preceptorship relationships can be implemented to ensure that both parties work together as well as possible but in a manner that acknowledges the multicultural nature of the workplace. A culture of helpfulness that encourages cross-cultural interactions in the workplace can encourage nurses to become familiar with themselves and thus, break down cultural barriers.

6.4.3.1 Recommendations for Workplace Practice

Business leader Margret Heffernan is challenging the roles of the workplace pecking order and suggests replacing superstars with fleeting achievements with a more community success model to help achieve the highest levels of success in business and the world. In her TED talk, Heffernan speaks about the "pecking order" and how it has progressed and advanced over the past years. She used a story about the Super Chicken mentality and approximately stated this:

> This idea is based on research conducted by Purdue University, where scientists set out to build a flock of successful chickens by selectively breeding the best of the

> flock. A study was conducted on two groups of chickens. One group were average layers which were average-sized and "regular". The other group were excellent egg layers that went above and beyond in the quality and quantity of eggs they provided. The two groups were separated for a long time, and observations were conducted regularly to see how they adapted within their "groups". It was discovered that the average chickens in their "regular" environment flourished! They became healthy and plump and laid a bounty of eggs. They thrived in their environment. The Super Chickens, in the end, killed each other off and failed in their environment, unable to produce half the amount of eggs they once did. It turned out that the success of the "super chickens" was only found by eliminating the competition and not by working together—that was the flock's downfall.

This study proved that the "Pecking Order" is unsuccessful. In groups of super chickens, they competed, fought and damaged each other in their drive for success and power. Regular chickens thrived off of each other and were content to co-exist in an environment where they could improve together. They worked as a team to progress and build. The Super Chicken Theory is not only applicable in agriculture; it can also be applied to mentoring. It has been proven in workplaces that the same applies to the dynamics of employees. The theory examines how star employees only shine by suppressing the productivity of others. This behaviour is detrimental to not only the team but also to the organization as a whole.

Mentoring is a reciprocal relationship where the preceptor and preceptee collaborate towards a common goal that will build the preceptees' skills, knowledge, and abilities. Preceptors and preceptees do not just feel more connected to each other, they feel more connected to their organisations. When organisations invest in mentoring training, they are creating a cohort of preceptors and preceptees which further enhances a sense of belonging. Future economic and social plans for Saudi Arabia are set out in the "Saudi Vision 2030". This plan focuses on economic diversification, private sector investment, trade expansion, and employment opportunities for Saudi citizens. It also outlines several goals for the healthcare sector. To meet these objectives, the Saudi government needs to implement strategies to advance the nursing profession and improve healthcare delivery in Saudi Arabia.

The government sets targets for successful Saudization and reduces the need for immigrant nurses. This would then also enable the delivery of culturally relevant care to native Saudi citizens. Despite continued efforts to increase the number of Saudi nurses, immigrant nurses still constitute 74% of the total nursing workforce in Saudi Arabia. By its nature, the hospital environment is complex, combining many different professional groups within an intricate administrative structure. In Saudi Arabian hospitals, relying as they do on a nursing workforce composed primarily of immigrants, these complexities often lead to conflict (Zakari et al., 2010). A better understanding of the NGN transition period, as well as the needs of experienced nurses, is crucial to ensuring safe and high-quality patient care. These insights could help lay the foundation for a nursing infrastructure that supports nurses at all stages of professional development and acts as a safeguard against high attrition rates. In their discussion of the nursing crisis, the Joint Commission (2008) stressed that teamwork is at the heart of good nursing relationships and patient care.

This study's participants reported that their workplace was largely unsupportive, and at times, even hostile. A large body of evidence suggests a significant link between negative work environments and high staff turnover (Almalki, FitzGerald, & Clark, 2011). To retain existing staff, there must be a greater investment of resources into mechanisms to support the orientation and integration of new nurses into healthcare environments. The negative experiences, leading to conflicts between Saudis and immigrant nurses, and Saudi nurses' feeling of being humiliated, pose a problem for the work environment. Conflicts linked to race and ethnicity can escalate to cases of incivilities, and as these give implications for safety, integrity, and dignity, they are not only contributing to an unhealthy work environment for the individual but also amplify the consequences in terms of questioning the legitimacy of the organization itself (Roscigno et al., 2009).

Saudization as a strategy to educate and train Saudi nurses to replace immigrant nurses might be understood by immigrant nurses as they are not wanted and that they will be made redundant as soon as a Saudi nurse is ready to take the position. Fear of being made redundant is taken personally and can affect the quality of care (Sprinks and Snow, 2011). Newly hired immigrant nurses might lack the cultural insight that might contribute to misunderstanding and create a foundation for conflict. The same might happen to Saudi student nurses who might not have interacted much with immigrants before being assigned

to clinical training in a hospital and may also perceive non-Saudi nurses as socially inferior. Although there might be an understanding of Saudization only concerning Saudi nationals and perhaps leadership, it implicates managers and clinical nurses in terms of aspects on a day-to-day basis. It is therefore essential that immigrant nurses get involved in the process. Recognition of contributions and achievements has a positive influence on nurses. This is often used in transformational leadership and influences job satisfaction positively (Alghamdi et al., 2011).

We need to redefine leadership as an activity in which conditions are created so everyone can do their best thinking together. We will not solve the world's most difficult problems alone, as individuals, we will only solve them when we accept everyone has value. Only then will we solve our most difficult problems. Margaret Heffernan suggests that management needs to stop creating rivalry, and pitting employees against each other. That entails creating an environment where employees can get to know and trust each other. Talent and creativity are compounded when we work collaboratively in trusted teams. We bring out the best in each other, and in doing that we bring out the best in ourselves.

Changing the work culture to collaborative teamwork has been proven to show success beyond measure. Based on cooperation, social working environments grow and compound over time, leading to further productivity. Collaboration is the key to a successful work unit. If one chicken tries to be the Star, it causes problems for the rest of the team. What Margaret Hefferman is pointing out, is that everyone should be a team player. Super-chickens in the workplace impact the entire team's morale. The super-chicken puts down others' work by disregarding its importance and the impact that their work makes on the organisation as a whole. We all need to collaborate and share, without stepping on each other to have all the eggs, or none of us will see success.

Chapter 7: Conclusion

7.1 Summary of Findings

The main aim of this research was to provide an in-depth understanding of current practice within the relationship between newly-qualified Saudi Arabian graduate nurses and their preceptor during their period of preceptorship in an intensive care setting in Saudi Arabia, through the use of exploratory ethnographic research. The broader aims and purpose of undertaking the research was to expand the evidence base available, exploring the preceptor-preceptee relationship in the unique Saudi context, as well as the broader non-Western context, to help meet the demands of a changing healthcare landscape. By understanding this relationship in greater detail, it was hoped that strategic goals and specific recommendations could be developed for healthcare systems planning and the improvement of preceptorship programmes.

In order to meet this research aim, three research questions were identified to guide the design of the study and the collection of data:

- "What, are the individual, organisational and structural factors and processes that shape the relationship between the preceptor and preceptee?",
- "What, are the experiences of preceptors-preceptees relations, and what are the factors that determine preceptorship success?" and
- "How does the relationship between preceptor and preceptees impact the perceived success of the preceptee?".

This research found that the practice of professional values is shaped by processes that operate on the interpersonal, organizational and wider social level. The Saudisation Policy is a key reference point that makes visible a range of tensions, inequalities, cultural tensions and stigma in the Saudi context. These are deepened by and made more visible by the Saudization Policy but are not reducible to it, as these reflect already existing processes in the Saudi social structure. On the individual and interactional level, non-Saudi nurses feel a sense of inferiority while

> Saudi nurses feel superior and contravene workplace rules. This, in turn, shapes perceptions about professionalism and shapes workplace relations. There were also tensions in the understanding of preceptors clinically and educationally, in terms of what needed to be done and what needed to be learned. In addition, the lack of institutional support and formal processes undermined the value of preceptors' work. This also had implications for commitment and required both preceptors and preceptees to make additional efforts to ensure that the preceptorship is successful. There were no formalised systems for training preceptors to make the preceptorship process more effective. Even preceptors who had been performing their role for more than a decade tended to have chaotic and informal approaches to preceptorship which veered between good practice and being actively unhelpful to preceptees.

The most effective receptors relied on their interpersonal skills and nursing ability to provide space and time for preceptors to learn, but this depended on the ability of the preceptor rather than any institutional system to produce effective preceptors. As well as the lack of appropriate training for preceptors, there was also minimal support from the administration for the preceptorship process. This study also revealed that power and authority are fundamental and have caused barriers to effective communication in the workplace in the Saudi context and particularly between preceptor and preceptee. Language use is political and language was used to facilitate learning and provide pastoral care and constructive feedback. Within the politics of language, language barriers, on the other hand, played a role in undermining communication and relationships. Conversely, communication was used to exert power, humiliate and reinforce hierarchical roles in ways that hindered the success of the preceptorship relationship via a conflict. Some preceptors developed friendly relations with their preceptees, mediated by trust.

The original contribution of this thesis is a new understanding of preceptorship from a non-western context and key themes related to preceptorship from both the preceptors' and preceptees' perspectives.

Although there is considerable research on preceptorship in nursing in the UK and other western countries, a thorough search of the literature on the nursing preceptorship in the

specific context of Saudi Arabia found only one previous study which investigated this topic from a qualitative perspective (Aboshaiqah & Qasim, 2018). Since 2019, there has been an increase in the number of studies that investigate preceptorships in Saudi Arabia however, all of these have adopted quantitative approaches. Nursing in Saudi Arabia presents some different issues that might not be found in the western world. Firstly, there is the Saudization policy, which since 1992 has aimed to gradually replace the foreign-born nursing workforce with Saudi nationals to increase workforce security in the Kingdom. Secondly, there is the continued high proportion of immigrant workers within the Saudi health service, with around 60% of nurses being born abroad in spite of Saudization (Alsadaan et al., 2021).

The thesis presents key themes related to preceptorship from different perspectives, including both of the preceptors and preceptees. A major gap in the literature which was identified by the literature review was that previous research which provided evidence regarding the preceptor-preceptee relationship only explored this incidentally within broader aims. In contrast, it was the main aim of this thesis to explore this relationship fully using qualitative methods to arrive at the richest dataset and the most complete conclusions possible. As such, this research contributes a fuller picture of the preceptor-preceptee relationship than has been possible in previous research. It is unique in its qualitative examination of barriers and facilitators of the preceptor-preceptee relationship within a culturally unique, complex Saudi context.

This research will therefore influence and enhance nursing preceptorship practices in Saudi Arabia. The results and recommendations will be shared with the participating institutions and the Saudi Ministry of Health in order to gain their support in increasing the quality and status of nursing preceptorship in the Kingdom. It was a key finding that cultural diversity in a multicultural nursing workforce, within a context of huge social, economic, and opportunities inequalities can adversely affect the collaboration between Saudi and non-Saudi nurses and quality of care delivered to the patient. The recommendations include suggestions for improved integration of Saudi and non-Saudi nurses and protection of preceptees from adverse cultural perceptions of preceptors and other nurses which may impact on their training and retention within the workforce.

This study will inform future research on preceptorship in non-Western countries, multicultural workplaces and the wider population that has roles to play in this process. As the first study to use ethnographic methods to specifically and exclusively explore the preceptor-preceptee relationship in a non-Western setting, this study provides a model for future qualitative research and a point of comparison for the conclusions of such research particularly it was conducted during a time of pronounced economic, social and political change. Where there are differences found between the findings in the present study and future studies conducted outside Saudi Arabia, this will be able to improve the generalisability of the research and also strengthen any findings in the present study which appear to be uniquely related to the Saudi setting, thereby providing further evidence for quality improvements within the Kingdom.

7.2 Strengths and Limitations

The present study had a number of strengths, but also several limitations. In this section, these strengths and limitations will be discussed critically in order to explore the internal and external validity of the results and conclusions. Internal validity refers to the ability of the research to reach valid conclusions based on the methods used. A study with poor internal validity reaches conclusions which we cannot be confident about based on the methodology. External validity refers to the generalisability of the results based on the methods used. A study with poor external validity is unlikely to be applicable to situations beyond the context of the study.

Strengths

This study has several strengths which improve the internal and external validity of the findings and conclusions. Firstly, the study utilised an ethnographic methodological approach with recording of field notes, casual interactions and interviews with participants (Wolf, 2012; Katz, 2015). The use of an ethnographic approach, as opposed to more formal qualitative methods such as semi-structured interviews, allowed the researcher to be embedded in the setting and to record data which was relevant to answering the research questions when and where it was available. Valuable data was collected during interactions at the bedside, through observation of preceptor-preceptee interactions and in private

interviews, representing a variety of data collection settings (Pinsky, 2015; Rashid et al., 2015; Robinson, 2013).

The ethnographic approach used in this research, combining semi-structured interviews with fieldwork observations, allowed for continual clarification of concepts and an ongoing analysis of data. Applying different data collection methods strengthened the findings of the study. The ethnographic approach in this study enabled the researcher to observe and communicate with participants in real time. During this period, it was apparent that the researcher's presence might interfere with data collection. Every effort was thus made to be personable and respectful to encourage participation and to reduce wariness or anxiety concerning the researcher's presence. The field-based approach also generated new data as participants raised new issues each day and allowed the researcher to follow up on interviews. Moreover, it provided time to establish a rapport with participants before their interviews. Finally, the use of ethnography facilitated an in depth understanding of the preceptors' and preceptees' views, as the accounts that they provided were both vivid and highly perceptive, leading to much richer data than could be obtained from interviews alone.

The collection of data in-context in different settings improves the internal validity of the study by allowing the findings to more fully respond to the research questions (Draper, 2015). It was a further strength of the study that the perspectives of both preceptors and preceptees were explored in the data collection so that the findings did not represent a single-sided viewpoint. Combined with the use of different ward settings within the hospital and the selection of participants of a range of nationalities, these factors improve the external validity of the study and make it more likely that the conclusions and recommendations for practice will be generalisable beyond the setting chosen for the study itself (Deggs and Hernandez, 2018).

During the analysis of the data, the six-step method developed by Braun and Clarke (2006) was used to code and develop themes from the data. The use of a validated, systematic thematic analysis method (Alhojailan, 2012) improves the internal validity of the study and reduces the chance of researcher bias being introduced through the selection of themes based only on researcher perceptions. The inductive method developed by Braun and Clarke

(2006) encourages the researcher to let codes and themes emerge from the data before reaching any conclusions. This allows for unexpected results to emerge based on frequency rather than prejudgement of the results by the researcher. Although there is still the potential for the researcher's own understanding of the data to shape the results significantly, this can be seen as a strength of thematic analysis and ethnographic data collection as it leads to the production of rich, in-context findings (Higginbottom et al., 2013; Lopez-Dicastillo and Belintxon, 2014).

Limitations

This study has several limitations which may affect its internal and external validity. Some of these are applicable to qualitative methods more broadly and some are specific to the methods used in this study in particular. Firstly, the study used a very limited sample size of fourteen participants, including only five preceptees and nine preceptors. Small sample sizes present problems for both the internal and external validity of a piece of research. In a quantitative study, a small sample size can distort statistical effects so that outliers lead to statistically significant results which are not truly present in the underlying population (Button et al., 2013; McNeish and Stapleton, 2016). A qualitative study such as the present research obviously does not include statistical results, but that does not mean that small sample sizes have no effect on internal validity (Marshall et al., 2013; Boddy, 2016; Dworkin, 2012). In the present study, the recruitment of only five preceptees for the research could introduce bias by making the unusual viewpoints of a single participant appear overrepresented in the results. For example, the finding that the preceptor-preceptee relationship can be strongly influenced by a preceptor choosing to ignore the needs of a preceptee and to offload responsibility onto other members of staff was based on a single preceptor-preceptee relationship. If a different preceptee had been recruited, this finding may not have appeared in the final results.

As well as presenting problems for internal validity, a small sample size can present issues for external validity of the results (Barratt et al., 2015). In order for the results of the study to be useful for practice, it is essential that they can be generalised to other settings. That is,

preceptorship in other Saudi Arabian settings and preceptorship internationally. The sample selected should be representative of the underlying population in order to allow this, but the selection of a small sample reduces the likelihood of this being true. In addition, the sample selection for the study was purposive, rather than random, with participants selected to represent a range of nationalities. This was justified in the present study as it had the benefit of exploring a wider range of issues than would have been possible with Saudi-only participants, but it also reduces the likelihood that this sample truly represents the wider population of preceptees and preceptors (Faber and Fonseca, 2014).

The researcher intentionally chose a research design with a smaller sample because it offered several advantages, including increased validity and the opportunity for thick description of participants' experiences. This approach also facilitated the conducting of interviews in person, and personally transcribing them, requiring full engagement with all aspects of data collection, and helping to ensure the quality of the data. In addition, Liamputtong and Serry (2013) argue that this method is beneficial, because it reassures the participants that the sensitive information they share is valued and will be treated respectfully.

Ethnographic methods have disadvantages despite their strengths; this pertains to validity (Boddy, 2011). As mentioned above, this has the benefit of a holistic approach to the participants in their cultural setting, but it may also be argued that ethnographic methods introduce unacceptable observer bias. A single researcher building close ties with participants in their setting may produce data points and reach conclusions which cannot truly be considered detached or impartial (Boddy, 2011). This observer bias could be introduced during the creation of field notes, the questions asked to participants during interviews and in the analysis of interview data. To counter this argument, theorists have argued that observer bias may actually be a benefit in ethnographic research, rather than something to be discounted or corrected.

In the ethnographic approach, the researcher acts as the primary data collection instrument (Creswell, 2014; Miles et al., 2014). Throughout all the stages of this study, the author made a concerted effort to remain as open-minded and objective as possible. This involved setting aside personal preconceptions and bias when interviewing the participants or observing

activities or behaviours at the hospital. The author also made field notes after each interview as a reflexive mechanism when considering thoughts and feelings about what had transpired. Throughout the data collection process, the author brought professional credibility and authority to each interview. This was based on an in-depth knowledge of the literature, as well as personal experience as an NGN (preceptee) and hospital nurse (preceptor). The fact that some interviews lasted for the agreed time limit while others lasted longer, reflects the author's interviewing skills and ability to make participants feel sufficiently comfortable and secure to express their views honestly, without feeling the need to 'perform' for the researcher (Monahan and Fisher, 2010).

Finally, the use of qualitative methods in a single setting may be seen as a limitation of the study in terms of its external validity. Qualitative ethnographic methods allow the collection of a large quantity of fine-grained data from the participants. However, this comes at the expense of taking a broader view of the population in order to answer the research question (Quieros et al., 2017). This study was conducted by one person, making it limited in scope, due to time and budgetary constraints. The study was also restricted geographically, since the data was collected from a small pool of participants at one hospital in Saudi Arabia, rather than across hospitals, another limitation on the generalisability of the findings. On the other hand, several scholars, including Freeman, DeMarrais, Preissle, Roulston, and St. Pierre (2007), Creswell (2009, 2014) and Merriam (2009), have pointed out that focusing on a single hospital provides an in-depth study, which may produce data that is valuable in its specificity.

Lincoln and Guba (1985) suggested that quantitative and qualitative studies cannot be judged by the same criteria and that qualitative studies should be judged by their credibility, confirmability, dependability and transferability. The researcher paid careful attention to these criteria to increase the trustworthiness of the case study. Credibility was ensured as the researcher had experience in Saudi culture as both preceptor and preceptee. The researcher also made preliminary visits to the study’s settings, so she had adequate knowledge about the environment. However, to ensure that her experiences did not influence the results, the researcher took a reflexive approach throughout the study. In particular, she kept a reflective commentary and met regularly with her PhD supervisors in

order to challenge her assumptions. Therefore, the findings of this study could be transferable to other settings with similar characteristics as those studied.

The researcher independently collected and analysed the data and reported the findings. Not all interpretations of the data were checked by another party, such as a peer or expert, which could have negatively affected the study's findings. However, two supervisors acted as experts during the research process and helped to confirm, interpret and verify the findings. This collaborative process was extremely useful when reaching conclusions regarding the consensus. Moreover, during the data analysis process, the researcher again consulted the supervisors to ensure that they agreed with the approach to thematic coding, which provided reassurance about the credibility, dependability and confirmability of the research findings. The researcher was aware that some participants, specifically, foreign nurses, might have feared that providing honest answers would give their clinical setting a bad reputation. To avoid this problem, the researcher assured participants that their data would be kept confidential and used only for research purposes only and no one except the researcher would have access to it. The researcher also stressed the importance of honest and genuine responses.

The experience and related knowledge I had accumulated enabled me to better grasp the complex issues associated with the preceptorship process. I am an insider researcher as I share a language, identity and experiences with some of the participants in this study. Being an insider researcher helped me gain a more in-depth understanding of the participants that might not be accessible to an outsider researcher. Although shared connections between the researcher and participants were very useful and facilitated the research initiative, it presented the opportunity for bias in the research as it progressed. For instance, participants may have provided elusive responses about their experiences on the assumption that the researcher was already familiar with similar ones as per the Hawthorne Effect (Landsberger, 1958). Alternatively, they could have provided responses perceived as socially desirable, such as responses that made them appear more professional or knowledgeable than they actually were. Hence, in this study, I ensured during the interviews and discussions not to use leading questions associated with personal assumptions. I adopted this technique to minimise the researcher's impact on participants' responses and, in turn, to minimise any negative impact on the study's trustworthiness.

My personal experiences and association with the participants can affect my perceptions, making it difficult to separate my perceptions from theirs. One outcome of this could be that the researcher's experience, rather than that of the participants, ends up steering the direction of the interviews, impacting data analysis, with the researcher highlighting the shared aspects to the detriment of existing differences or vice versa. Therefore, during the research process, I kept a reflective diary to examine and diminish the implications of the above issues and to evaluate the extent to which my experiences and assumptions may have influenced how I interpreted the data. Being challenged during the supervision process was also helpful in this respect.

During different stages of the research, my positionality caused me feelings of both power and powerlessness to different degrees. Therefore, it was important for me to be aware of the power differential between myself and the research participants. For example, in the data collection stage, it appeared that the participants were in control, as they possessed the information required and could decide whether or not to share that information and participate in the study. Even though I tried to behave as someone who is open and who was trying to understand people's experiences, I had the impression that some of the participants perceived me as an expert who shared their experiences and concerns and who may have solutions to related issues.. This introduced the possibility of the Hawthorne effect (Landsberger, 1958) whereby participants may have responded in a manner based on what they thought I wanted to hear, i.e they may have responded in a socially desirable way (Nederhoft, 1985) particularly during the early stages of the research and less so as the study progressed.

When I collected the data, I strove to create a welcoming environment in which the participants would be comfortable and relaxed to encourage them to be as open as possible about their experiences and views. Furthermore, I interacted with the participants in an informal and non-hierarchical environment to afford them a sense of intimacy and balance of power. In addition, I paid close attention to what the participants said to show them that their opinions were important. At the same time, I refrained from passing judgement on participants' views when I did not agree with them. I defined my task as a researcher at this

stage of the study as collecting data and not making personal judgements about it. Another strategy that I employed to reduce the power differential between myself and the participants was the provision of clear information concerning the rationale behind the research, the aim and the questions that guided the research, as well as anticipated ethical considerations.

During the data collection, I acted as if I were unfamiliar with the topic being studied. Furthermore, despite sharing cultural ties with the research participants, I may lack an understanding of the various subcultures. In this study, the approach applied by me, underpinned by self-consciousness, allowed the exploration of a range of issues related to ethnicity, power and social status, as well as how they affected the relationships developed during the interviews. In this way, I was able to understand various aspects, such as how the participants perceived themselves and their interactions with other people.

However, I again had a position of power and control during the stage of data analysis. This is because once participants have shared their views and experiences, they no longer have control over them. The researcher can process those views and experiences according to specific historical, political and cultural settings. Once the researcher had the data, her primary role was to give voice to the participants' expressed views and experiences by carefully analysing the data and identifying emerging patterns and themes. To minimise or eliminate any overt influences caused by the researcher's interpretation of the participants' perceptions and experiences, the data were constantly assessed and re-examined concerning the research questions and detection of any inconsistencies in the findings. In addition, to ensure transparency of data interpretation, direct quotes from the interviews were used by the researcher. In addition, a detailed audit trail was recorded to increase transparency and support examining potential bias. Nevertheless, the interpretation may not have been completely free of bias as the meaning of participants' experiences and views were processed through the researcher's interpretation.

An ongoing discussion of related issues with the supervisors complimented the analysis and interpretation. Cross-checking of the data by the supervisors also facilitated the assessment of the accuracy of the researcher's data analysis. The significant and conflicting roles fulfilled by the researcher and participants contribute considerably to the complexity that

characterises the relationship between the two sides. In this study, I had to deal with the delicate task of building trusting relationships with the participants whilst making sure that she did not get so close to them as to affect her professional judgement. Against this backdrop, it is important to note that the self-consciousness process fostered by reflexive practices was beneficial in increasing awareness and identifying the power dynamics in the relationship between the researcher and participants.

The COVID-19 pandemic also adversely impacted the research. Up until March 2020 I had been progressing on my doctoral journey as originally planned. I completed my data collection in Saudi Arabia and following this returned to the UK to complete my analysis and write up my thesis for submission to meet my submission date in March 2021. Following my return to the UK, the developing global COVID pandemic has had a significant impact on my studies. Once the UK went into lockdown, I was awaiting repatriation to Saudi Arabia, which led to a significant period of uncertainty and anxiety. I did eventually get a flight and spent 3 months in Saudi. During this time, I began to struggle with low mood and my study progress was slow. Once lockdown restrictions in the UK were eased, I returned once more. I have persevered with my studies throughout, but my progress has been hampered by the stresses of social restrictions. I could not go back to visit the sitting and see my participants for clarification and follow up discussion. The isolation caused by Lockdown Measures in the UK made me feel less supported as I could not meet my supervisors face to face.

My supervisors have noticed the impact that this has had on my personality. My supervisors recommended that I accessed medical help with my mental wellbeing and I have successfully completed a course of remotely accessed Cognitive Behavioural Therapy. My supervisors were completely supportive of me towards completing my thesis. They have encouraged me to apply for an extension to my candidature as in their judgement, the disruptive impact of COVID on my studies has put me significantly behind where I would have been if the pandemic had not happened. This entire period, with the uncertainty and unpredictability of events, meant that progress on data analysis was further delayed.

7.3 Recommendations for Future Research

This is the first study of a sample of Saudi nurse preceptees and preceptors from different national origins. This resulted in important findings regarding the tensions produced in the preceptor-preceptee relationship by differences of language and culture, and social and economic inequalities, as well as the tendency for the Saudization policy to lead to divisions between Saudi and non-Saudi nurses. In order to explore these findings further, future research should use the findings of the present research to analyse these phenomena in a broader sample. The present research developed in-depth engagement with, and embeddedness into an organisational context, using a relatively small sample (n = 14) with the intention of producing a rich dataset and producing an in-depth examination of the preceptor-preceptee relationship in the Saudi context. Future research should explore whether the findings of this research are applicable across Saudi healthcare settings and internationally through the use of larger-sample qualitative and quantitative methods. Such research would help inform policy by demonstrating common issues with the preceptor-preceptee relationship which could be resolved by institutional change.

The present research also suggested avenues for future ethnographic research into the preceptor-preceptee relationship which it was not possible to explore within the limitations of the aim and research questions. Administrative support was found to be a significant barrier to the effective operation of the preceptor-preceptee relationship, but it was not possible to investigate this in detail as participants only included preceptors and preceptees. In order to explore this fully, a piece of research is recommended which includes the CRN and administrative staff as part of the recruitment to gain a fuller picture of resource allocation to preceptorship when it is recognised as a crucial stage in the development of nurses. Other potential avenues for ethnographic research could include patients as participants to explore the role which patients play as learning resources for newly qualified nurses and their feelings about being part of this process. This could potentially lead to new structures and processes being developed in which patient care and preceptee learning are balanced more effectively.

7.4 Reflection

My PhD is beyond doubt one of the hardest, most rewarding, confidence-sapping, confidence-boosting, brutal and uplifting academic challenges I have ever faced. The progression from neatly defined, taught modules of an undergraduate or Master's degree to the student-led study required for a PhD is vast. Vast, but absolutely achievable. It was not devoid of stress, worry, trials and tribulations, however, it was a highly educative process of learning. Through this experience, I have become an independent researcher and improved all of my key skills while meeting and collaborating with great people and researchers along the way. It is my genuine belief that there is no other role which I could have taken on in the past five years, that would have challenged me as much or given me as much satisfaction.

I learned how to learn. I obtained the ability to teach myself any topic to a high level regardless of its difficulty. Via my PhD program, I have developed the skill of acquiring new knowledge. The ability to teach oneself challenging topics is an amazingly useful life skill.

The experience of working on big and challenging projects over five years has taught me dedication and perseverance. I believe that these skills will beneficial when I have to confront challenging projects and problems which undoubtedly, will arise throughout my life. I believe that my good teamwork which I learned during my PhD program will come in handy.

A PhD is an exceptional experience, especially as an international student crossing the pond to start this journey, leaving behind family and friends. Despite this, I have learned so much about cultural differences, diversity, and inclusion. The University of Southampton has been a wonderful place to start this journey, as it provides all students with the tools and network to thrive and survive a PhD.

I have developed myself as a person more than or as much as I have developed my academic knowledge in the subject. I have learned how to think, act, read, write, communicate, present, question and answer as effectively as possible. I have learned how to pose a research question and a clear method for proving or disproving a hypothesis. As I have delved deeper into my research, I have realised that having well-defined questions is the basis of intellectual enquiry. Having well-defined questions is the starting point for the generation of new knowledge.

I have also developed my reading skills and ability to read purposively to collect key information. When I first started my PhD, it used to take me approximately 30 minutes to read journal articles of between 10-15 pages, Now, I only require 10 minutes to read these articles. Thus far, I think the biggest skill I have acquired throughout this process, is how to critically assess research claims and information via a critical analysis of variables such as reliability and validity. I have developed the ability to critically evaluate research methods and the resultant data acquired from these, by thinking in a nuanced way about methodological robustness.

Ultimately, the overarching aim of a PhD is to sharpen one's research skills and flourish as a rewarding researcher. It is no easy task and one certainly needs persistence, enthusiasm, and diligence to accomplish the end goals. I will keep continuing to learn and engage with my research area of interest, making a concerted effort to step out of my comfort zone. The words of W.B Yeats that "education is not the filling of a pail, but the lighting of a fire," is particularly instructive in this regard.

Appendixes

Appendix 1: Critical appraisal of included studies using the CASP tool (n=16)

Study	Reference Year	Methodological Quality	Finding Presentation Quality	Discussion Quality	Overall Quality of Evidence
Aboshaiqah and Qasim	2018	Moderate-The use of two open-ended questions in a questionnaire is unlikely to elicit the same depth and quality of responses as semi-structured interview data	Moderate: Qualitative findings lacked depth but based on direct responses of the participants	High-Findings supported by the secondary literature	Moderate
Bengtsson	2015	Moderate: Use of a single written question to elicit data does not produce in-depth insights	High: Clearly situated in Burnard's method of analysis	High-Findings supported by the secondary literature	Moderate
Chen et al.	2011	High: In-depth interviews and clear overview of thematic analysis	High: Findings based on the verbatim experiences of participants	High-Findings supported by the secondary literature	Moderate
Della Ratta et al.	2016	High: In-depth interviews and clear overview of thematic analysis	High: Findings based on the verbatim experiences of participants	High-Findings supported by the secondary literature	Moderate
Della Ratta et al.	2018	High: In-depth interviews and clear overview of thematic analysis	High: Findings based on the verbatim experiences of participants	High-Findings supported by the secondary literature	Moderate

Duffy	2009	High: In-depth interviews and data derived verbatim from participants	High: Clearly situated in Burnard's method of analysis	High-Findings supported by the secondary literature	Moderate
Ebu-Enyan et al.	2021	High: In-depth interviews and clear overview of thematic analysis	High: Clearly situated in Braun and Clarke's method of analysis	High-Findings supported by the secondary literature	Moderate
Ewertsson et al.	2017	High- Collection of large quantities of ethnographic data over an extended period of time using multiple data collection methods	Moderate-The interpretation of the data often appears to reflect the opinions of the authors, especially when body language of students is recorded in field notes and used as evidence	High-Findings supported by the secondary literature	Moderate

Hunter et al.	2015	High- Collection of large quantities of ethnographic data over an extended period of time using multiple data collection methods	Moderate- The authors are unclear how the four main themes were arrived at using software and it appears that the final decisions about the themes were made through discussion between researchers, which could potentially introduce bias through the imposition of the authors' own prejudices on the choice of themes	High-Findings supported by the secondary literature	Moderate
Jonsson et al.	2021	High: Detailed account of methodological approach based on qualitative interviews	High: Clearly situated in Graneheim and Lundman's method of content analysis	High-Findings supported by the secondary literature	Moderate
Lewis and McGowan	2015	Low: Little information provided about methodological approach	High: Clearly situated in Newell and Burnard's (2011) Pragmatic Approach to Qualitative Data Analysis	High-Findings supported by the secondary literature	Moderate

Marks-Maran	2013	Moderate: mixed methods approach limited the depth of qualitative data	High: Clearly situated in the Framework Method of analysis	High-Findings supported by the secondary literature	Moderate
Myrick et al.	2010	High: Clear overview of methodology with multiple data collection approaches	High: Cleary situated in grounded theory approach	High-Findings supported by the secondary literature	Moderate
Quek et al.	2019	Moderate: Little information provided about research design but there is significant detail concerning the data collection method	High: Clearly situated in thematic analysis framework	High-Findings supported by the secondary literature	Moderate
Valizadeh et al.	2016	Moderate: Relatively little detail given in the study about the phenomenological methods used so it is difficult to critically appraise the theoretical approach adopted	Moderate: theoretical underpinnings of findings are unclear	High-Findings supported by the secondary literature	Moderate
Yonge	2012	Low: Little information provided about methodology	Low: Little information given in the study about how the data from these interviews was analysed and themes produced	High-Findings supported by the secondary literature	Moderate

N- No
Y- Yes
N/A-Not Applicable

	Aboshaiqah and Qasim (2018)	Bengtsson (2015)	Chen et al. (2011)	Della Ratta et al. (2016)	Della Ratta et al. (2018)	Duffy (2009)	Ebu-Enyan et al. (2021)	Ewertsson et al (2017)
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
4. Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
5. Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher and participants been adequately considered?	N	N	N	N	N	N	N	Y
7. Have ethical issues been taken into consideration?	N	N	N	N	N	N	N	Y
8. Was the data analysis sufficiently rigorous?	Y	Y	Y	Y	Y	Y	Y	Y

9. Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y

	Hunter et al. (2015)	Jonsson et al. (2021)	Lewis and McGowan (2015)	Marks-Maran (2013)	Myrick et al. (2010)	Quek et al. (2019)	Valizadeh et al. (2016)	Yonge (2012)
1. Was there a clear statement of the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
2. Is a qualitative methodology appropriate?	Y	Y	Y	Y	Y	Y	Y	Y
3. Was the research design appropriate to address the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
4. Was the recruitment strategy appropriate to the aims of the research?	Y	Y	Y	Y	Y	Y	Y	Y
5. Was the data collected in a way that addressed the research issue?	Y	Y	Y	Y	Y	Y	Y	Y
6. Has the relationship between researcher and participants been adequately considered?	Y	N	N	N	N	N	N	N

7. Have ethical issues been taken into consideration?	Y	N	N	N	N	N	Y	Y
8. Was the data analysis sufficiently rigorous?	Y	Y	Y	Y	Y	Y	Y	Y
9. Is there a clear statement of findings?	Y	Y	Y	Y	Y	Y	Y	Y

Appendix 2: Approval Letter from University of Southampton

Approved by Faculty Ethics Committee - ERGO II 45537

ERGO II – Ethics and Research Governance Online https://www.ergo2.soton.ac.uk

Submission ID: 45537
Submission Title: AMAL ALASMARI - ID 24463728
Submitter Name: Amal Alasmari

Your submission has now been approved by the Faculty Ethics Committee. You can begin your research unless you are still awaiting any other reviews or conditions of your approval.

Appendix 3 A: Approval Letter Ministry of National Guard – Health Affairs King Abdulaziz Medical City (KAMC)

Kingdom of Saudi Arabia
Ministry of National Guard - Health Affairs

المملكة العربية السعودية
وزارة الحرس الوطني - الشؤون الصحية

NURSING SERVICES
Center of Nursing Education (NS-CNE)
Ref. No. RM/2019/05/23

Date: 23 May 2019 (G)

Permission to conduct nursing research at KAMC-R, Nursing Services

Applicant Details:	AMAL ALI ALASMARI , PHD STUDENT RESEARCHER- University of Southampton - Faculty of Environmental and Life Sciences - Health Sciences School
Title of proposed research study:	An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabian intensive care units.

Subsequent to screening review by the Nursing Services Research Committee (NSRC), permission in principle is granted for you to conduct your nursing research study at KAMC-R Nursing Services.

Best wishes for successful completion.

Permission recommended by:

Dr. Rana Mulla
Chairman, Nursing Services Research Committee
Director, Nursing Education & Clinical Practice
Date: 23 May 19

Permission granted by:

Ms. Nabeeha Tashkandi
Associate Executive Director
Nursing Services, KAMC-R
Date: 23 MAY 2019

cc. Dr. Majed Al Jeraisy, Chairman, Research Office KAIMRC (Memo only)

MMB/SL/31 Mat 2016 /Permission to conduct nursing research at KAMC-R, Nursing Services – Template B (without feedback)

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تلفون ٨٠١١١١١
تلكس ٤٠٣٤٥٠

Appendix 3 B: Institutional Review Board (IRB)

Kingdom of Saudi Arabia
Ministry of National Guard - Health Affairs

المملكة العربية السعودية
وزارة الحرس الوطني - الشؤون الصحية

King Abdullah International Medical Research Center (KAIMRC)

IRB NCBE Registration No.: H-01-R-005

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IRB Office **Memo Ref.No. IRBC/0509/19** **E-CTS Ref. No.** **RYD-19-419812-56981**

Study Number: **SP19/074/R**
Study Title: **An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabian intensive care units**
Study Sponsor: **Saudi Cultural Bureau in London**
IRB Approval Date: **09 April 2019**
IRB Review Type: ■ **Expedited Review** ☐ **Full Board**
Study site(s): **Central Region**

Dear **Dr. Adel Faza Almutairi**
Research Scientist, KAIMRC
Ministry of National Guard – Health Affairs

Sub-investigator: Amal Ali Al Asmari

After reviewing your submitted research proposal/protocol and related documents, the IRB has APPROVED the submission.

The approval includes the following related documents:

Document/Title	Version	Date
Research Proposal	01	09 April 2019
Data Collection Form	01	09 April 2019
Informed Consent Form	01	09 April 2019

The approval of the research study is valid for **one year** from the above approval to expiration date.

Terms of Approval:

- **Annual Reports:** An Annual report must be submitted for approval to avoid termination/suspension of your research.
- **Financial report:** If your study is funded project, details financial report should be submitted with the scientific report.
- **Final Report:** After completion of the study, a final report must be forwarded to the IRB.
- **Retention of original data:** The PI is responsible for the storage and retention of original data pertaining to the project for a minimum of five years.
- **Reporting of adverse events or unanticipated problems:** The PI is responsible to report any serious or unexpected adverse events or unanticipated problems, which could involve a risk to participants or others.
- **Biological samples:** No biological samples to be shipped out of the Kingdom of Saudi Arabia without prior IRB approval.
- **Participant incentives:** No financial compensation or gifts to be given to participants without prior IRB approval.
- **Storage of biological samples:** All biological samples collected for the purpose of this research must be stored in the KAIMRC related repository.

Dr. Abdallah Adlan
Chairman, Institutional Review Board (IRB)
Head, Biomedical Ethics Section - KAIMRC
Ministry of National Guard - Health Affairs

AA/GA/mda

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Appendix 4: Email Invitation

Date:

Title of the Study: An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabia intensive care units

My name is Amal Alasmari, I am a PhD student in the Faculty of Environmental and Life Sciences at University of Southampton. I am conducting a research study as part of my PhD thesis as a requirement of my degree, and I would like to invite you to take part in this study. The main aim of the study is to explore the support provided for new graduate nurses (preceptees) during their preceptorship. The focus is to examine the lived experiences of recently graduated registered nurses' interactions with preceptors during their preceptorship. Since the topic of discussion is important for the development of Nursing and Nursing Education in the Kingdom of Saudi Arabia, I hope you will want to participate in this study.

If you agree to take part in this study, you will be asked to participate in an individual interview lasting about one hour, we will discuss any issues you feel are significant to the study aims. I will be undertaking short periods of observation of the daily precepting activities and interactions between preceptor and preceptee in everyday work practice in the unit. When an observed situation needed clarification, informal interviews will be performed. The interviews will take place at a time and location of your convenience. All data will be kept confidential. You will be given an appreciation gift for your participation in this study of a Starbucks gift card valued at £20 (or 100 S.R.).

Thank you for your consideration. If you would like to participate, please read the attached Information sheet and contact me at the email address below and leave your preferred contact information. I will set up a meeting to explain the study and data collection process for you. I will be happy to answer any questions you have about the study.

Sincerely yours,

Appendix 5 A: Demographic Data Sheet (For Preceptees)

Participant's Name: ……

Age: ..... Gender: .....

Clinical unit: ……

Date of graduation from nursing school: ……

Other university education: ……

Date of hire into nurse residency program: ……

Appendix 5 B: Demographic Data Sheet (For Preceptors)

Participant's Name: …….
Age: ..... Gender: .....
Clinical unit: ……
Nursing Education
- Diploma
- Baccalaureate
- Masters
- Other

Post graduate education: ……
Continuing education: ……
Total years of nursing experience: ……
Total years of experience as preceptor: ……
Brief description of the preparation you received for the role of preceptor:
……
Level of students for whom you have been preceptor:
……

Appendix 6 A: Participant Information Sheet (For Preceptees)

Study Title: An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabia intensive care units
Researcher: Amal Alasmari
ERGO number: 45537

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
This study is being conducted as part of a PhD in the Faculty of Environmental and Life Sciences at University of Southampton by Amal Alasmari. I am a Lecturer (Adult Nursing), at the Faculty of Applied Medical Sciences, Tabuk University, Saudi Arabia. I am a Registered Nurse; my clinical experience is in adult and critical care nursing. The study is funded by the Ministry of Higher Education in Saudi Arabia through the Saudi Cultural Bureau in London. The main aim of this study is to provide an in-depth understanding of current practice within the relationship between newly qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship. Based on this aim, the following research question was developed:
How are newly qualified graduate nurses in Saudi Arabia supported to work safely and independently in clinical practice during their period of preceptorship?
Objectives
1. To investigate the relationship between preceptor and preceptee by exploring how the nurse preceptors interact with preceptees in their everyday work practices to examine closely the social and interactive contexts of how what constitutes good practice.
2. To identify what, in the opinion of preceptors and preceptees, makes for a successful preceptor-preceptee relationship
3. To explore how the relationship between preceptor and preceptee impacts on the perceived success of the preceptee.
This study will contribute to efforts to enhance the preceptor–preceptee relationship to provide support to graduates build relationships that increase their confidence, and competence. Most importantly, the overall effect of this process of skill development is the provision of safe, effective care for critically ill patients.

Why have I been asked to participate?

You have been chosen to take part in the study because you are a Saudi new graduate nurse currently undergoing a preceptorship programme, in your first nursing job and your employment is directly related to Intensive Care Unit (ICU).

What will happen to me if I take part?

If you agree to be in this study the following will occur:

1- You will be asked to complete a demographic form and completion of this form will take no longer than 5-10 minutes. Both you and the preceptor will be interviewed separately. For your convenience, the individual interview time will be arranged to suit your schedule and conducted in the private meeting room in your unit. This part will be audio-recorded and take no more than an hour. All of the information that you give the researcher is confidential. You may withdraw from the interview at any point.

2- The researcher will observe you while you work with your preceptors in your everyday work practices to explore a rich variety of precepting activities. The researcher may ask you some questions to clarify or understand things related to observed situations. The plan is to conduct three hours of observations per day for two days per week for six months.

3- The second interview will be with both of you (preceptor and preceptee) as a pair. It will happen after the observation. It aims to deepen the researcher's understanding of the emerging findings from the observation and to look for causes and reasons. The interview guide will be developed based on findings from the observations and field notes. You will be interviewed at a time and place that is suitable to you and the researcher. These interviews will also be tape recorded and, to protect your identity, will be coded with a number. Only the researcher will know your names.

Are there any benefits in my taking part?

There will be no direct benefits to you. However, the findings of this study will help to promote the clinical education and training strategies and improve the quality of the preceptees' nursing practice. You will be given an appreciation gift for your participation in this study of a Starbucks gift card valued at £20 (or 100 S.R.).

Are there any risks involved?

The questions in this study should not cause any distress. There are no significant risks involved in this study beyond those you would encounter in daily nursing practice. However, some people may experience temporary feelings of negative emotions. If this were to happen, I will take every step to reduce any upset that may be experience. The researcher's contact details are at the end of this information sheet. If you would like some additional help, I will be able to advise you who to contact, for example, GP, nurse advisor or another key worker.

Additionally, during the interview, you may not feel comfortable answering some of the questions. However, if you do feel uncomfortable or you suddenly want to withdraw from the interview you can simply ask to stop the tape and leave the interview area or if you

want to carry on but do not want to answer a particular question, the researcher can omit that question and move on.

What data will be collected?

Once you agree to take part in the study, you will be given an identifying code known only to the researcher. Anonymity can, therefore, be maintained by referring to you using identifying codes only. Your demographic details and consent forms will be stored separately from other data to ensure that you cannot be identified. All the information the researcher collects will be kept on a password-protected computer. Written information and audio recordings will be kept in a locked filing cabinet within the researcher's locked office at the hospital.

Demographic data form asks you questions about yourself and your educational preparation. During the interview, the researcher will discuss with you, and to then agree on the expectations of and responsibilities between, you and your preceptor, and comment upon any issues which you consider pertinent to the study aims and require further exploration. The researcher will use a list of questions scheduled in the interview guide. During the observation, the researcher will record in field-notes all activities that you and your preceptor undertake in your normal working role. The researcher will not write any information that may identify you. In case of observing clinically unsafe practice, or negligence, the researcher will report this practice using the reporting system.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.

Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.

Interview transcripts and any written information will be kept confidential with only the researcher and her supervisors having access to them. Other than to these people, your names and any personal details will not be disclosed to anyone. To achieve confidentiality, any transcript generated from the interview will be coded. The results of this study will include some of your words, but your names will at no time be used. Information directly identifying you will not be used in any public report or document. You will remain anonymous and will not be identified, as codes will be used. The information will be destroyed after 10 years, as per the University of Southampton research guidelines.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part. The researcher will meet with you during the induction week prior to commencement of the nursing orientation week. Clear information regarding the study aim, its scope, data sources, data collection and modes of analysis, the type of information needed for the study and where and how the results will be used will be explained during this meeting. At this point you will have your consent to participation observed, recorded and held for the duration of the study. By the end of the week, the signed consent forms in the envelop provided should be received from you indicating your willingness, or otherwise, to participate.

What happens if I change my mind?

You have the right to change your mind and withdraw from the study. If you decide to withdraw your consent from the study early 'during or after the individual interviews or before observing your practice', all data will be deleted from the research data.
If you choose to enter the study and then decide to withdraw at a later time 'after observing your practice', the information collected up to the time that you withdraw from the study will be used for analysis, but no new information will be collected.

What will happen to the results of the research?

The findings from the study will be documented in the results section of the researcher's PhD thesis, which will be presented to the University of Southampton doctoral defence committee as part of the final report for obtaining the degree of Doctor of Philosophy. Furthermore, it is intended to publish the results of the study as academic journal papers, conference posters and/or oral conference presentations. Your personal details will remain strictly confidential. Research findings made
available in any reports or publications will not include information that can directly identify you without your specific consent.

Where can I get more information?

If you have any questions or you need any further information about the study do not hesitate to contact the researcher.
Amal Alasmari Tel#: 00966503633831 Email: aaa1m17@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher and her supervisors who will do their best to answer your questions.
Dr: Ellie Monger Supervisor Tel#: 02380597992 email: e.monger@soton.ac.uk
Dr: Sue Faulds Supervisor Tel#: 02380597952 email: s.j.faulds@soton.ac.uk
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

Data Protection Privacy Notice

The University of Southampton conducts research to the highest standards of research integrity. As a publicly funded organisation, the University has to ensure that it is in the public interest when we use personally-identifiable information about people who have agreed to take part in research. This means that when you agree to take part in a research study, we will use information about you in the ways needed, and for the purposes specified, to conduct and complete the research project. Under data protection law, 'Personal data' means any information that relates to and is capable of identifying a living individual. The University's data protection policy governing the use of personal data by the University can be found on its website (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page).

This Participant Information Sheet tells you what data will be collected for this project and whether this includes any personal data. Please ask the research team if you have any questions or are unclear what data is being collected about you.

Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years
after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page) where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read this information sheet and considering participation this study. Please keep a copy of this information sheet and consent form for your records.

Amal Alasmari
PhD Student

Appendix 6 B: Participant Information Sheet (For Preceptors)

Study Title: An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabia intensive care units
Researcher: Amal Alasmari
ERGO number: 45537

You are being invited to take part in the above research study. To help you decide whether you would like to take part or not, it is important that you understand why the research is being done and what it will involve. Please read the information below carefully and ask questions if anything is not clear or you would like more information before you decide to take part in this research. You may like to discuss it with others, but it is up to you to decide whether or not to take part. If you are happy to participate you will be asked to sign a consent form.

What is the research about?
This study is being conducted as part of a PhD in the Faculty of Environmental and Life Sciences at University of Southampton by Amal Alasmari. I am a Lecturer (Adult Nursing), at the Faculty of Applied Medical Sciences, Tabuk University, Saudi Arabia. I am a Registered Nurse; my clinical experience is in adult and critical care nursing. The study is funded by the Ministry of Higher Education in Saudi Arabia through the Saudi Cultural Bureau in London. The main aim of this study is to provide an in-depth understanding of current practice within the relationship between newly qualified Saudi Arabian graduate nurses and their preceptors during their period of preceptorship. Based on this aim, the following research question was developed:
How are newly qualified graduate nurses in Saudi Arabia supported to work safely and independently in clinical practice during their period of preceptorship?
Objectives
1. To investigate the relationship between preceptor and preceptee by exploring how the nurse preceptors interact with preceptees in their everyday work practices to examine closely the social and interactive contexts of how what constitutes good practice.
2. To identify what, in the opinion of preceptors and preceptees, makes for a successful preceptor-preceptee relationship
3. To explore how the relationship between preceptor and preceptee impacts on the perceived success of the preceptee.
This study will contribute to efforts to enhance the preceptor–preceptee relationship to provide support to graduates build relationships that increase their confidence, and competence. Most importantly, the overall effect of this process of skill development is the provision of safe, effective care for critically ill patients.

Why have I been asked to participate?

You have been chosen to take part in this study because you are one of the senior nurses who has experience of teaching and supporting a preceptee through the preceptorship programme in an Intensive Care Unit (ICU).

What will happen to me if I take part?

If you agree to be in this study the following will occur:

1- You will be asked to complete a demographic form and completion of this form will take no longer than 5-10 minutes. Both you and the preceptee will be interviewed separately. For your convenience, the individual interview time will be arranged to suit your schedule and conducted in the private meeting room in your unit. This part will be audio-recorded and take no more than an hour. All of the information that you give the researcher is confidential. You may withdraw from the interview at any point.

2- The researcher will observe you while you work with your preceptee in your everyday work practices to explore a rich variety of precepting activities. The researcher may ask you some questions to clarify or understand things related to observed situations. The plan is to conduct three hours of observations per day for two days per week for six months.

3- The second interview will be with both of you (preceptor and preceptee) as a pair. It will happen after the observation. It aims to deepen the researcher's understanding of the emerging findings from the observation and to look for causes and reasons. The interview guide will be developed based on findings from the observations and field notes. You will be interviewed at a time and place that is suitable to you and the researcher. These interviews will also be tape recorded and, to protect your identity, will be coded with a number. Only the researcher will know your names.

Are there any benefits in my taking part?

There will be no direct benefits to you. However, the findings of this study will help to promote the clinical education and training strategies and improve the quality of the preceptees' nursing practice. You will be given an appreciation gift for your participation in this study of a Starbucks gift card valued at £20 (or 100 S.R.).

Are there any risks involved?

The questions in this study should not cause any distress. There are no significant risks involved in this study beyond those you would encounter in daily nursing practice. However, some people may experience temporary feelings of negative emotions. If this were to happen, I will take every step to reduce any upset that may be experience. The researcher's contact details are at the end of this information sheet. If you would like some additional help, I will be able to advise you who to contact, for example, GP, nurse advisor or another key worker.

Additionally, during the interview, you may not feel comfortable answering some of the questions. However, if you do feel uncomfortable or you suddenly want to withdraw from the interview you can simply ask to stop the tape and leave the interview area or if you

want to carry on but do not want to answer a particular question, the researcher can omit that question and move on.

What data will be collected?

Once you agree to take part in the study, you will be given an identifying code known only to the researcher. Anonymity can, therefore, be maintained by referring to you using identifying codes
only. Your demographic details and consent forms will be stored separately from other data to ensure that you cannot be identified. All the information the researcher collects will be kept on a password-protected computer. Written information and audio recordings will be kept in a locked filing cabinet within the researcher's locked office at the hospital.
Demographic data form asks you questions about yourself, total years of your experience and the preparation you received for the role of preceptor. During the interview, the researcher will discuss with you, and to then agree on the expectations of and responsibilities between, you and your preceptee, and comment upon any issues which you consider pertinent to the study aims and require further exploration. The researcher will use a list of questions scheduled in the interview guide.
During the observation, the researcher will record in field-notes all activities that you and your preceptee undertake in your normal working role. The researcher will not write any information that may identify you. In case of observing clinically unsafe practice, or negligence, the researcher will report this practice using the reporting system.

Will my participation be confidential?

Your participation and the information we collect about you during the course of the research will be kept strictly confidential.
Only members of the research team and responsible members of the University of Southampton may be given access to data about you for monitoring purposes and/or to carry out an audit of the study to ensure that the research is complying with applicable regulations. Individuals from regulatory authorities (people who check that we are carrying out the study correctly) may require access to your data. All of these people have a duty to keep your information, as a research participant, strictly confidential.
Interview transcripts and any written information will be kept confidential with only the researcher and her supervisors having access to them. Other than to these people, your names and any personal details will not be disclosed to anyone. To achieve confidentiality, any transcript generated from the interview will be coded. The results of this study will include some of your words, but your names will at no time be used. Information directly identifying you will not be used in any public report or document. You will remain anonymous and will not be identified, as codes will be used. The information will be destroyed after 10 years, as per the University of Southampton research guidelines.

Do I have to take part?

No, it is entirely up to you to decide whether or not to take part. If you decide you want to take part, you will need to sign a consent form to show you have agreed to take part. The researcher will meet with you during the induction week prior to commencement of the nursing orientation week. Clear information regarding the study aim, its scope, data sources, data collection and modes of analysis, the type of information needed for the study and where and how the results will be used will be explained during this meeting. At this point you will have your consent to participation observed, recorded and held for the duration of the study. By the end of the week, the signed consent forms should be received from you indicating your willingness, or otherwise, to participate.

What happens if I change my mind?

You have the right to change your mind and withdraw from the study. If you decide to withdraw your consent from the study early 'during or after the individual interviews or before observing your practice', all data will be deleted from the research data.
If you choose to enter the study and then decide to withdraw at a later time 'after observing your practice', the information collected up to the time that you withdraw from the study will be used for analysis, but no new information will be collected.

What will happen to the results of the research?

The findings from the study will be documented in the results section of the researcher's PhD thesis, which will be presented to the University of Southampton doctoral defence committee as part of the final report for obtaining the degree of Doctor of Philosophy. Furthermore, it is intended to publish the results of the study as academic journal papers, conference posters and/or oral conference presentations. Your personal details will remain strictly confidential. Research findings made available in any reports or publications will not include information that can directly identify you without your specific consent.

Where can I get more information?

If you have any questions or you need any further information about the study do not hesitate to contact the researcher.
Amal Alasmari Tel#: 00966503633831 Email: aaa1m17@soton.ac.uk

What happens if there is a problem?

If you have a concern about any aspect of this study, you should speak to the researcher and her supervisors who will do their best to answer your questions.
Dr: Ellie Monger Supervisor Tel#: 02380597992 email: e.monger@soton.ac.uk
Dr: Sue Faulds Supervisor Tel#: 02380597952 email: s.j.faulds@soton.ac.uk
If you remain unhappy or have a complaint about any aspect of this study, please contact the University of Southampton Research Integrity and Governance Manager (023 8059 5058, rgoinfo@soton.ac.uk).

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Our privacy notice for research participants provides more information on how the University of Southampton collects and uses your personal data when you take part in one of our research projects and can be found at http://www.southampton.ac.uk/assets/sharepoint/intranet/ls/Public/Research%20and%20Integrity%20Privacy%20Notice/Privacy%20Notice%20for%20Research%20Participants.pdf

Any personal data we collect in this study will be used only for the purposes of carrying out our research and will be handled according to the University's policies in line with data protection law. If any personal data is used from which you can be identified directly, it will not be disclosed to anyone else without your consent unless the University of Southampton is required by law to disclose it.

Data protection law requires us to have a valid legal reason ('lawful Basis') to process and use your Personal data. The lawful basis for processing personal information in this research study is for the performance of a task carried out in the public interest. Personal data collected for research will not be used for any other purpose.

For the purposes of data protection law, the University of Southampton is the 'Data Controller' for this study, which means that we are responsible for looking after your information and using it properly. The University of Southampton will keep identifiable information about you for 10 years after the study has finished after which time any link between you and your information will be removed.

To safeguard your rights, we will use the minimum personal data necessary to achieve our research study objectives. Your data protection rights – such as to access, change, or transfer such information - may be limited, however, in order for the research output to be reliable and accurate. The University will not do anything with your personal data that you would not reasonably expect.

If you have any questions about how your personal data is used, or wish to exercise any of your rights, please consult the University's data protection webpage (https://www.southampton.ac.uk/legalservices/what-we-do/data-protection-and-foi.page)

where you can make a request using our online form. If you need further assistance, please contact the University's Data Protection Officer (data.protection@soton.ac.uk).

Thank you for taking the time to read this information sheet and considering participation this study. Please keep a copy of this information sheet and consent form for your records.

Amal Alasmari
PhD Student

Appendix 7: Consent Form

Study title: An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabia intensive care units

Researcher name: Amal Alasmari

ERGO number: 45537

Participant Identification Number (if applicable)

Please initial the box(es) if you agree with the statement(s):

I have read and understood the information sheet and have had the opportunity to ask questions about the study.	
I agree to take part in this research project and agree for my data to be used for the purpose of this study.	
I agree to take part in being interviewed.	
I agree to take part in having my practice observed.	
I understand my participation is voluntary and I may withdraw from the study early 'e.g. withdraw from the individual interview at any time or before observing my practice' for any reason without my participation rights being affected.	
If I decide to withdraw from the study at a later time 'e.g. after observing my practice', I agree that the information collected about me up to the point when I withdraw will still be used for the purposes of achieving the objectives of the study only but no new information will be collected.	
I understand that taking part in the interviews involves audio recording which will be transcribed and then destroyed for the purposes set out in the participation information sheet.	
I understand that I may be quoted directly in reports of the research but that I will not be directly identified (e.g. that my name will not be used).	
I understand that there are no risks to me.	
I understand that any information I provide will be kept confidential.	

Name of participant…… Name of researcher……

Signature of participant…… Signature of researcher ……

Date…… Date……

[Date: January 2019] [Version Number: 2] [Ethics reference: 45537]

Appendix 8: Semi-Structured Interview Guide

At the beginning of the interview, participants will be verbally reminded of the following points:

1. This interview is conducted as part of the data collection methods for a PhD research study which aims to explore the support provided for new graduate nurses (preceptees) during their preceptorship with a focus on examining the lived experiences of recently graduated registered nurses' interactions with preceptors during their preceptorship in Saudi Arabia.
2. If you agree, the interview will be audio-taped and fully transcribed into text. Common study themes will be identified and grouped into categories. These will then be documented in the results section of my PhD thesis, published as academic journal papers, conference posters and/or oral conference presentations.
3. Your participation is voluntary, and you can withdraw any time without giving a reason and without prejudice to your employment status.
4. Confidentiality and anonymity for your data will be assured throughout the study and thereafter. This means that none of your names will be mentioned in the transcripts, and nobody will have access to the data except myself, and my two supervisors. All tapes will be stored in a separate locked cupboard.
5. If you do not feel comfortable answering any of the questions that question will be omitted, and the discussion will move on.

Individual Semi-structured Interview Guide (For Preceptees)

1. How do you perceive your role? Can you tell me about your role as a new graduate nurse or nurse resident?
2. What expectations do you have regarding the preceptorship program?
3. How do you think the preceptor will help you in your new role at the ICU?
4. What specifically do you think you need from your preceptor?
5. What could you tell me about your relationship with preceptor? How would you describe your relationship with your preceptor?
6. Do you think your relationship with your preceptor will have any effect on the quality of the nursing care you give to patients in your new role? If so how? And why?
7. What do you think is the best way to support new graduate nurse to care for critically ill patients?
8. How do you feel this experience will prepare you to enter the workforce safely as professional nurses?
9. Do you have any other comments to share?

Individual Semi-structured Interview Guide (For Preceptors)

1. How do you perceive your role? Can you tell me about your role as a preceptor?
2. What could you tell me about your relationship with preceptees? How would you describe your relationship with you preceptee?
3. What do you feel about the time you spend with your preceptees?
4. How do you help in the socialization of the new graduate nurses and fostering integration into the work culture?
5. How do you balance between offering independence and offering assistance for your new nurse or preceptee?
6. What is the nature of support you provide to your new nurse to facilitate his/her transition into the ICU and fulfil her/his clinical needs?
7. Would you like to add anything before we end our interview?

Appendix 9: Observation Schedule

Names of the participants	**Days**	**Time**	**Date**	**Unit**
	Monday	5 hours/day		
	Wednesday			

Total observation months = 3
Total observation weeks = 12
Number of participants to observe a day: 1 pair (preceptor and preceptee)
Total participants to observe throughout the study: 5 pairs
Observation days per week: 2
Observation hours per day: 5
Observation hours per week: 10
Observation hours per pair: 20
Total observation hours throughout the study: 100

Appendix 10: Field Notes Template

Date	**Time** **Start:** **End:**	**Unit**	**Names of the participants**
Jotting	• Describe the physical setting and social boundaries that limit the observation. • The general impression of the situation. • Specific words, phrases, summaries of conversations and insider language.		
Description	• When and who performs what behaviors or tasks and how often they occur. • What is being said and how. • The tone of the conversations among preceptor and preceptee • Sequential patterns of behaviors. • Body language and facial expression.		
Analysis	• What I learned in the sitting. • Note why something happened. • What themes emerging in the field site. • Make links between the detailed described and how culture work in this context.		
Reflection	• Record my thoughts, ideas, questions, and concerns.		

Appendix 11: Participants' Stories

Case A

Description:

As regards Case A, Afnan was a Saudi preceptee (NGN) assigned to 2 preceptors (Alice, 49 years and Angela, 34 years) who were Filipino experienced staff members with 13 years and 6 years of experience respectively. Alice spent two months with Afnan while Angela took the preceptor role for the rest of the preceptorship period of 4 months. They were observed for four days, five hours a day, resulting in a total observation period of twenty hours.

Alice did not offer any guidance and when Afnan asked her to participate in providing patient care, she ignored her. Afnan's engagement was more like a nurse assistant. Alice followed Afnan each time she did something and was watching over her closely as if she did not trust her. Alice did not give Afnan the space or the time to practice confidently. Afnan seemed increasingly nervous as Alice wanted things done certain ways, or else she would visibly object. Alice humiliated Afnan publicly in front of patients when she made mistakes. Alice got short-tempered, and sometimes she blew up at Afnan.

In contrast, to increase Afnan's confidence, Angela occasionally approved her performance non-verbally by simply nodding her head or giving an approving look in the presence of patients, and sometimes this was done verbally by complimenting her on her knowledge and skills in the presence of her CRN and the manager. Angela helped Afnan get to know herself and generated confidence that she can autonomously handle patient care. She also encouraged Afnan to improve through learning and practising independently by gradually stepping back from direct patient care while being encouraged to ask questions. Socially, they shared their break time together.

Case B

Description:

Case B concerned Basma, who was the Saudi preceptee (NGN) and assigned two preceptors (Bayan, 34 years, and Basel, 45 years) who were experienced and competent staff members with 9 years and 13 years experience respectively. Basma and Bayan are Saudi but came from different religious and familial backgrounds and cultural differences. Bayan covered her face with a niqab when Basma did not wear a face covering. Bayan spent four months with Basma while Basel took the preceptor role for a day because Bayan was on sick vacation. Basel was an experienced Jordanian nurse who was also Muslim and an Arab; the same as Basma. Another nurse took the preceptor role for the rest of the preceptorship programme. They were observed five hours a day for four days, totaling 20 hours.

Between Basma and Bayan, Preceptee-preceptor interactions were negative and largely unsatisfactory and uninformative. Noticeably, there was a lack of communication with disappointments related to Basma's lack of knowledge. Basma and Bayan were not involved in that collaborative work. Bayan and Basma did not spend time together. They usually took their break time together but sat separately. Basma did not feel comfortable with Bayan as she always made her feel incompetent. The worst thing Bayan did was to indicate verbally or through body language (smirking, sighing, or quizzically raised eyebrow) that Basma's questions were somehow substandard. Bayan did not provide a safe environment in which Basma can openly discuss her concerns or motivations for certain behaviours. She did not seem to appreciate curiosity and being asked questions. Basma found it challenging to reach out to her preceptor for help and assistance. She even appeared scared of seeking help and may have found it easier to pretend she knew when she did not. Medical terminologies used by Bayan were not always clearly understood by Basma, which made her feel undermined.

Basma was also assigned to a male preceptor (Basel) for a day and, although it was their first day together, they worked together smoothly, communicated effectively and engaged in professional dialogue. He permitted her to administer medications and perform suctioning while he watched from a distance from the nursing station. Although she had not been given full autonomy, Basma appeared calm and confident.

Case C

Description:

Carmen was the Saudi preceptee (NGN) assigned to 1 preceptor (Clara, age 32) in Case C. Clara was an experienced Filipino nurse with 3 years' experience. Carmen considered herself lucky as she had a junior preceptor. Clara spent 5 months with Carmen while another nurse took the preceptor role for the rest of the preceptorship programme. They were observed five hours a day for four days, totaling a 20-hour observation period.

Clara was 5-months pregnant, and Carmen took advantage of her preceptor being pregnant by taking responsibility for the patient from A to Z. Carmen was working independently, super-active and energetic. She demonstrated very good communication skills with members of all disciplinary teams. She was respected by doctors as she showed them how responsible and competent she was. Most of the doctors called her 'boss'. Clara put Carmen high up in terms of power. The power balance was inclined in favour of the preceptee. Carmen was practising power over Clara, but Clara invested in the progress of the preceptee. It was obvious that there was a discrepancy in the power relationship between Carmen and Clara, that gave rise to specific behaviours, fuelled by Carmen's perceived superiority as a Saudi citizen. Carmen was overconfident and seemed capable of performing all care activities without her preceptor's support.

The pair nevertheless enjoyed a close working relationship and Clara treated Carmen as a staff nurse, so they did not spend their break time together, but rather, covered each other.

Case D

Description:

Case D pertained to Dalia who was the Saudi preceptee (NGN) assigned three experienced and competent preceptors (Daisy, 45 years, Demi, 36 years and Diana,32 years). Daisy was a senior Indian nurse with 18 years experience. Demi was a Malaysian Muslim expert nurse with 15 years experience. Diana was an experienced Filipino nurse with 8 years experience. Daisy spent three months with Dalia before Demi took over the preceptor role for the rest of the preceptorship programme. Diana, however, was only in that role for one day because Demi was off due to a lack of pre-arrangement in their schedules. They were observed over four days for five hours a day, totaling twenty hours of observation.

Dalia was Daisy's first Saudi NGN trainee. Daisy has done inductions for new foreign nurses who had previous experiences back home. Dalia expressed frustration over being treated as a heavy burden to her preceptor and not being accepted equally. She felt she was not listened to and was given the impression as she was untrustworthy. She felt Daisy discriminated against her and preferred other foreign nurses more than her. Daisy did not have a sociable personality and always looked serious with others. She was not flexible and had little patience to put up with people making excuses. Her strong personality intimidated Dalia and other staff members when working together. Warmth was absent from the team when she was around.

Demi however helped Dalia get to know herself better, she enthused her with confidence making her feel that she can handle patient care. Dalia was working independently, doing suction and changing patient position. Demi still kept a close eye on Dalia's work even when Dalia was seemingly alone. With regards to Diana, Dalia spoke of their strained relations, perceiving such tension as the result of the foreign nurses' discomfort with the presence of Saudi nurses within the workplace.

Case E

Description:

In Case E, Elham was the Saudi preceptee (NGN) who was assigned to 1 preceptor (Emma, 24 years), a Filipino experienced and competent nurse with 9 years experience. Emma spent 4 months with Elham and then Elham was able to work dependently without her preceptor's support before the end of the programme. She moved from being the observer to performing the ICU nursing tasks independently. Her performance developed dramatically. She became able to develop professional judgments before completing the program. They were observed over 4 days for 5 hours per day, resulting in a total observation of 20 hours.

Emma and Elham had a long-standing relationship. They have known each other since the internship and therefore have good chemistry. Their interactions just worked incredibly well and felt very natural. Emma does not have a serious countenance and has a genuine smile. They treat each other with respect and trust as persons and professionals. Emma was a sociable person, who communicated easily and freely. They spent their lunch break together. They were sharing food with each other and that strengthened their relationship. They joked and laughed together.

Emma inclined herself to the fact that she is working in Saudi Arabia temporarily and the priority is given to Saudi nationals. In spite of Elham wearing a face covering (Niqab), Emma did not find difficulties in communicating with Elham. Emma expressed that she understood Elham through her eyes and could discern her feelings. Elham had ability to figure things out on her own. She was very alert and observant notices small but important details that other may have overlooked. Emma stated that Elham is good at providing culturally quality care and communicating with doctors and other disciplinary teams. She has special qualities which enabled her to perform nursing care independently. She showed huge commitment, she was punctual and responsible for her patients.

Appendix 12: Poster

INFORMATION FOR PATIENTS AND RELATIVES ON (Insert name of ward as appropriate)

An ethnographic study exploring the relationship between the new graduate nurse and preceptor in Saudi Arabia intensive care units

There is a research study taking place on (insert name of ward). This involves a female researcher observing the work of new graduate nurses and their preceptors. The focus of the observations is on new graduate nurses and their preceptors as they care for you or your relative. None of you or your relative's personal details will be collected, recorded or reported.
Please let the ward staff know if you would like more information or do not want your care to be observed as part of this study.
Your decision will be respected and will not impact on your current or future care in any way.

Definition of Terms

Preceptorship

Represented an organised clinical education programme whereby an experienced, competent senior staff nurse facilitates the integration of a new graduate nurse into her/his role and responsibilities in a new clinical setting in order to provide the required quality of nursing care to patients competently and independently. This integration into the new practice environment is achieved via the instigation of a professional, supportive, one-to-one relationship between the preceptor (senior staff nurse) and the preceptee (new graduate nurse) over a flexible but limited time frame.
N.B. During the research, the terms 'residency', and 'preceptorship' were used interchangeably.

Preceptorship goal

Preceptorship goal represented the desires of the organisation which were to facilitate the preceptees' integration and socialisation into their new role in order to provide the required quality of nursing care to patients competently and independently, within the boundaries of the organisation's standards of care.

Preceptor

Equated to an experienced registered nurse (RN) who acted as a role model, guide, counsellor, teacher and resource person to assist the new graduate nurse adjust and adapt to the new clinical setting during the preceptorship period.

Preceptee - New Graduate Nurse

Equated to a person who had been employed in particular position for the first time. This includes newly qualified nurses or new graduate nurses who had just left the University with a bachelor's degree and is hired into a residency or preceptorship program in Intensive Care Unit. Represented a new graduate nurse who needs to learn the necessary skills and procedures to practice independently and competently and provide the required quality of nursing care to patients.

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