

A qualitative study into the experiences of newly qualified children's nurses during their transition into children's community nursing teams.

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Abstract

This thesis provides an analytical account of a qualitative research study into the experience of eight newly qualified children's nurses during their transition into children's community nursing teams in the North West of England.

The study took place at a time when the recruitment of newly qualified children's nurses into U.K. children's community nursing teams was not only a new professional endeavour, but one that met with some resistance due to the prevailing attitude that the community was an inappropriate first post destination for them. The transition experience of their contemporaries, whose first post was within hospital based services, has been well researched. Indeed the resulting notion of "reality shock" led to major changes in clinical practice. However, little research attention has been paid to the experiences of transition of those who take up first posts in the community.

The findings indicate that there were factors that both facilitated and hindered the development of their professional identity as children's community nurses. Of significance is that the participants did not report the shock like reactions described by their contemporaries in acute hospital based settings. They described an ideal transition experience as one which included a period of lengthy and consistent support, the allocation of contrived workloads and continued support during independent visits. However, this ideal experience of transition was often disrupted through circumstances such as perceptions of being undervalued, lack of colleagues' acknowledgement of the value of their undergraduate learning experiences and the allocation of complex cases requiring skills and knowledge beyond their competence level.

The notion of an ideal experience of transition which accommodates individual differences during transition as described in this thesis offers a pragmatic solution to other children's community nursing teams seeking to ease the transition experience of newly qualified children's nurses. It also challenges the assumption that they are an inappropriate first post destination for newly qualified children's nurses.

Chapter 1 Introduction

This thesis focuses on the experiences of newly qualified children's nurses during their transition into children's community nursing teams. This study was framed by local and national policy changes regarding the care of sick children in the community and their access to community nursing care in their home environments.

At the same time there was a drive to recruit newly qualified children's nurses into children's community nursing teams. At a national level the Department of Health had commissioned a report (Drennan, Andrews & Sidhu 2004) which aimed to assist Primary Care Trusts and Workforce Development Confederations to establish flexible and supportive entry routes and programmes that would enable nurses to work in primary care settings at registered nurse level (staff nurse). This included a recommendation that recruitment strategies should target newly qualified nurses as well as more experienced staff (Drennan, Andrews & Sidhu 2004).

The impact of the national strategy on the local picture was a wide ranging reconfiguration of National Health Service (NHS) provision for children in the North West. The reconfiguration that started in 2006 had forced a shift such that newly qualified children's nurses were, actively recruited by some children's community nursing teams. In the latter part of 2006 all the children's community nursing teams in the area where the study took place were asked by the Greater Manchester Children and Young Person and Families' Network to submit bids to support an increase in staffing numbers. They were also asked to stipulate the numbers of staff nurses they required. A briefing paper published by the Network in 2007 detailed the intention to offer 20 newly qualified nurses a 'junior'

community post, at band 5, by 2007/2008, and to increase the numbers of these posts year on year depending on demand. Generic job descriptions were created and the posts were advertised on the National Health Service jobs website in December 2007. This represented a significant shift with teams looking to employ newly qualified nurses for the first time.

However, this shift to targeting newly qualified children's nurses raised a number of questions. I was unsure about the extent to which the undergraduate programme which I lead had prepared these newly qualified children's nurses to be fit for purpose and practice in a community setting and how the newly qualified children's nurses would manage and make sense of their integration into community teams.

I have been a registered children's nurse since 1986. For the last 10 years I have worked as a senior lecturer with special responsibility as the programme leader for the undergraduate nursing programmes at Diploma and BSc levels in children's nursing. As part of this role I have monitored the 'first post destinations' of many students and I have been intrigued by how few have gained employment in children's community nursing teams, despite recommendations to the contrary. I was intrigued to know what their experiences of those that had been employed were, as this was a new endeavour. These questions were important as the successful transition of newly qualified children's nurses into the workforce may have major implications for their careers in their chosen field and the results would be of interest to policy makers, employers who wish to retain and develop staff, and educationalists involved in this venture.

1.1 The Historical Development of Children's Community Nursing: UK Political Context

Concern for the plight of children in hospital has existed for many decades. The evidence of harm that may follow periods of hospitalisation has grown rapidly and includes sleep disturbance, behavioural difficulties, anxiety, with some children exhibiting signs of post traumatic stress (Sylva & Stein 1990; Shields 2001; Rennick *et al.*, 2002 and Wright & Stewart 2007). Calls for children to be nursed at home to ameliorate these effects are not new and the antecedent for home care was embedded in concerns voiced by medical practitioners as far afield as the United States of America and New Zealand (van der Horst and van der Veer 2009). In the UK the Platt Report (Central Health Services Council Committee on the Welfare of Children in Hospital 1959) recommended that children should be cared for at home in the community and only admitted to hospital when it was entirely necessary. Their recommendation was founded on the seminal work of Bowlby (1952) and Bowlby and Robertson (1952) which had demonstrated the potential for significant harms that could follow a period of hospitalisation. Despite this recommendation and successive government administrations producing policy re-emphasising the benefit of caring for children at home, where possible and appropriate; the lack of sufficient children's community nursing services in the UK was repeatedly highlighted (DHSS 1976; Department of Health 1991; Audit Commission 1993; NHS Executive 1996). While there was some increase in the number of community services available (Whiting (1988) identified a total of 24 services in England, including one in the North West in 1988), there continued to be a lack of equity in the availability of services across the country (Fradd 1994; Bradley 1997). The House of Commons Health Select Committee (HCSC, 1997) re-emphasised that there was a persistent and tolerated inadequate provision in the community to meet the needs of

sick children and young people. Despite the Health Select Committee reasserting the requirement for children to have access to a community nursing service staffed by qualified children's nurses, (albeit that there was steady progress with 198 teams established in the UK by 2005) still 50% of the country had no provision of a comprehensive children's community nursing service (Whiting, 2005). Regardless, the development of community nursing services for children remained erratic and ad-hoc (Eaton, 2000; Whiting, 2005) and seemed to rest on the initiative of interested and pragmatic individuals (Cash *et al.*, 1994). There was little evidence of a coherent and organised national strategy.

The National Service Framework for Children and Young People's Health in England¹ (DH 2004) herald a coherent strategic approach. This national policy signalled a political determination to shift children's health services towards a child-centred ethos with services designed and delivered around the needs of children, young people and their families; bringing "Care Closer to Home" as advocated by the DH (2006). The aim of the NSF was to ensure that children, young people and their families had equal access to high quality co-ordinated services. A key part of this was the development of children's community nursing teams across each locality. These teams were charged with the facilitation of the care of sick children at home, reduced hospital admissions, and, a reduction in the duration of hospital stays when this was inevitable through early discharge (DH 2004; Independent Reconfiguration Review Panel (IRRP) 2007).

One of the key messages of the NSF (DH 2004) was to improve access to services for all children according to their needs, by co-locating services and developing managed local Children's Clinical Networks for children who were ill. These networks were established

^{at1} Hereafter NSF

with the remit of ensuring that access to services for all children and young people was provided according to their needs.

1.2 Reconfiguration of Children's Health Care Services in the North West of England

At the same time in 2006 in the North West of England (where this study was undertaken) was the reconfiguration, redesign and relocation of children's NHS services. At the end of the 1990s a number of leading paediatricians voiced their concerns that the configuration of the children's health care services in the North West was, in their view, clinically unsustainable resulting in poorer quality than should be the case. Following extensive public consultation in December 2006 a radical new model for the development of primary, secondary and tertiary children's NHS services across Greater Manchester was published entitled Making it Better (Greater Manchester Children and Young People and Families' Network² 2006). This report reiterated the need to prioritise the development and expansion of children's community nursing teams, especially those aimed at providing care to children with short term acute health needs. They argued that changes to in-patient hospital services would not be possible until the community teams were sufficiently robust to provide quality substitute care for children and young people in their homes.

This strategic vision was published in 2006 (Care Closer Making it Better Subgroup 2006). However it was noted that children's community nursing teams operating in all localities in the North West had significant nursing staff shortfalls. This meant that they were unable to provide the effective and efficient service needed. For the first time, the skill mix of the

²Available at <http://www.makingitbetter.nhs.uk/index.php/public-consultation>

teams came under close scrutiny and, although contentious for some, the recruitment of newly qualified children's nurses was proposed as a pragmatic way of meeting the shortfall. That the employment of newly qualified children's nurses was contentious is borne out by several analyses of the composition of children's community nursing teams (Tatman & Woodruffe 1993; While & Dyson 2000; Eaton 2000; Cramp *et al.*, 2003; Royal College of Nursing 2007; Carter & Coad 2009; Department of Health 2011; Parker *et al.*, 2011). These analyses are mostly concerned with the evaluation of services, the availability of services and the models of care delivery of children's community nursing teams rather than the specific skill mix although they reported the composition of teams. For instance, Tatman and Woodruffe (1993) surveyed 216 UK health districts to establish the characteristics of community children's teams. They concluded that the teams were composed of "highly qualified staff". Although not explicit this suggests that it was unlikely that newly qualified nurses were working in the teams. Similarly, While and Dyson (2000) surveyed 137 teams in England and reported that some teams had low core staffing numbers and that the clinical grades varied across the teams, none indicated if any were newly qualified.

The Nursing Research Unit at Kings College, London conducted a longitudinal national study to determine the relationship between nurses' career plans, and careers followed. They recruited a nationally representative sample of graduates from degree and diploma programmes from each branch of nursing from those qualifying in England between July 1997 and August 1998. From this study, Robinson *et al* (2001) reported that 98% of the children's nurses' population surveyed had obtained their first job in a hospital setting. However, the participants had reported that their placement experiences had led 63% to

consider working in the community. Yet only 2% had taken up a community post. The study also reported that 70% of those surveyed hoped to work in the community in the future. Three main explanations were offered for the mismatch between aspirations and actual first post destinations. These included that participants did not want their first job in the community setting, that they felt inadequately prepared at that stage to work in the community and that they wanted to gain experience in a hospital setting first. (Robinson *et al.* 2001).

This was followed by a number of other research studies that focused specifically on children's community nursing teams. Eaton (2000) undertook a review of the UK literature to ascertain the types of models of care delivery represented in children's community nursing teams but did not mention newly qualified nurses in the review. Cramp *et al.*, (2003) surveyed 152 children's home nursing teams in the UK to establish the characteristics of children's nursing teams and reported different skill mixes within teams but again did not mention newly qualified nurses. While the Royal College of Nursing (2007) Community Children's Nursing Forum produced a list giving details of the teams in the UK, no figures or discussion of skill mix was included. Whilst research has identified that newly qualified nurses are employed in some community settings such as health visiting and school nursing (Forbes, While & Dyson 2001), there is little evidence of this previously occurring in children's community nursing teams. This is further supported by research that has sought to identify the number of posts available to newly qualified nurses (Winter & Teare 2002). Analysing 100 job advertisements for children's community nurses in the Nursing Times journal between August 1999 and April 2000 they reported that the lowest grade listed was

E. At that time newly qualified nurses were initially employed at grade D. More recently, since the implementation of Agenda for Change (DH 2004) Grade D and Grade E posts were merged into the current Band 5 and while Parker *et al.*, (2011) reported that some teams included band 5 nurses it was not possible to know if any of these were newly qualified first post destinations. However, of note is that two recent studies have identified the need for workforce planning in order to get the skill mix in community children's teams right (Carter & Coad 2009; Parker *et al.*, 2011). Should these recommendations be taken forward, the results may challenge current practice.

It seems reasonable to conclude that historically, the recruitment of newly qualified children's nurses to children's community nursing teams has not been considered an option, although there is little evidence to explain the reason for this. It was perhaps this lack of evidence that led the Greater Manchester Children and Young People's Network³ to call for the current shortfall of community children's nurses to be corrected in part through the recruitment of newly qualified children's nurses.

It seems that the employment of newly qualified children's nurses had been hampered by two considerable challenges. As identified by Hickey (2000) the first had been the limited access to positions in established children's community nursing teams. Some teams were well established but they were often small and had employed only experienced children's nurses. This seemed in part, driven by a consensus that a community children's nurse should be an expert, skilled and confident practitioner (Carter, 2000). According to the RCN (2000)

³ Information available at <http://www.makingitbetter.nhs.uk/>

children's nurses were registered children's nurses with a community nursing qualification who had direct involvement with children at home or in school, assisting parents to provide treatment and monitoring the children's progress. Children's community nurses provide home-based assessment of needs and care for acutely ill children and may provide care and support for children and young people in the community with long-term disorders as well as for those with palliative care needs. In keeping with the strategy of providing care closer to home children's community nursing services were established to provide support, advice and treatment, and to monitor progress of children, young people and their families, responding to local needs and taking account of the need to prevent hospital admission, and facilitate early discharge (Department for Children, Schools and Families, Department. of Health 2009).

Eaton (2000) also suggested that all children's nurses working in the community should have both a community and children's nursing qualification. O'Neill (2005) added that the most appropriate person to care for acutely ill children at home would possess a qualification as a specialist practitioner, and be a children's nurse. Although this had been the case previously, the expansion of children's community nursing teams and reconfiguration of children's health services meant that this position was no longer sustainable and with a new focus on the skill mix within these teams, the nursing landscape and workforce in the community was set to change.

The second challenge was identified in educational reform evaluations (DH 1999, UKCC 1999) and as a result of the availability of sufficient and appropriate community experience

during undergraduate nurse education (Hickey 2000). This is discussed further in what follows.

1.3 Undergraduate nursing preparation for working in the community

Following educational reforms in 1986 (UKCC 1986) which became known as “Project 2000, it had been recognised that nurses should be equipped to gain first post destinations in both the community and hospital settings. Project 2000 nurses were educated for three years at undergraduate level exiting with either a diploma or a degree. Preparation for registration as a qualified nurse was organised as a single registration in the format of branch programmes that aimed to facilitate qualification in a specialist area e.g. children and young people’s nursing. Prior to these reforms clinical placements were mostly hospital based leading to substantial deficits in community experience. Project 2000 (UKCC 1986) therefore identified that this was problematic as it impacted on qualified nurses’ fitness for practice and purpose at the point of registration in a community setting. The UKCC (1986) recommended that the new practitioners should be able to assess, plan, implement and evaluate care across a range of institutional and non-institutional settings. More specifically, they reiterated the requirement for students to be competent to practice in both community and hospital settings.

A number of research studies followed that evaluated the effects of Project 2000 (UKCC 1986) courses. These studies highlighted concerns regarding the perceived deficits in clinical and managerial skills of newly qualified nurses despite them having a “good” knowledge base. There was a general consensus that the educational programme had failed to equip

newly qualified nurses with the skills necessary to work in community settings (Macleod-Clark Maben & Jones 1996; Luker *et al.*, 1997; Maben & Macleod Clark 1998).

Interestingly, this was particularly pertinent to the child branch (Macleod-Clark Maben & Jones 1996). However it is worth noting that the total number of child branch students enrolled into the study was small compared to the total sample. Still managers, practitioners and teachers doubted that there was a role for newly qualified children's nurses in children's community teams and there was no infrastructure to integrate Project 2000 nurses into community services. Added to this there was an enduring perception that it was necessary to gain hospital experience first yet many newly qualified children's nurses aspired to working in the community. Runciman, Dewar and Goulbourne (1998) reported resistance amongst community teams to the employment of newly qualified nurses because they were seen as lacking in skills and the ability to work autonomously. They also claimed that the teams were too busy to effectively supervise them.

The UKCC (1999) Fitness for practice, Commission for Nursing and Midwifery Education. and the DH (1999) Making a Difference, Strengthening the Nursing, Midwifery and health Visiting Contribution to Health and Healthcare recommendations were key to developments in nursing and midwifery education. Curricula based on these reports were developed to overcome the perceived deficiencies in the Project 2000 curriculum. These reiterated the needs to prepare nurses to work both in community and acute hospital settings on qualification and to ensure that all student nurses had clinical placements in both acute and community services. However, it is worth noting here that providing placements with children's community teams was challenging and it was not possible to offer all students

such a placement as part of their programme of study. In part, this was down to pragmatics. Some teams consisted of only 1 or 2 members of staff making it impossible to offer a meaningful placement experience for students. In a critical discussion of the recommendations from the UKCC (1999), Long (2003) noted the incompatibility of reforms that introduced an increased emphasis on supervised clinical learning in practice in the context of insufficient practice placements and practice supervisors. The paradox was that students needed quality placements and supervision by appropriately qualified staff; but both were in short supply. This paradox was acknowledged in a report commissioned by the Association of Chief Children's Nurses (Glasper, McEwing & Richardson 2004) which aimed to investigate the strengths and weaknesses, opportunities and threats surrounding the current method of preparing children's nurses in the UK. Allocations to children's community nursing teams had proved perennially difficult to organise and schedule (Glasper, McEwing & Richardson 2004).

1.4 Summary

It is clear then that targeting newly qualified children's nurses for recruitment into children's community nursing teams signals a significant shift from the custom and practice that has pre-existed. However, it seems that this shift is a top down strategy and not always consistent with the views of staff working in children's community nursing teams, managers, educators and students. The continuing shortfall of suitably qualified children's nurses in children's community nursing teams (Drennan, Andrews & Sidhu 2004, DH 2006, and Carter & Coad 2009) is impacting on the care and equity of access for children and families to care closer to home, and in turn, this leads to a perennial problem of too few placements for too many students. This feeds the ongoing notion that children's community nursing

teams are unsuitable as first post destinations for newly qualified children's nurses. Yet it is this shortfall and lack of evidence to support the status quo that has led to the recruitment of newly qualified children's nurses into some children's community nursing teams in the North West of England. This raises interesting and important questions. Not least the extent to which newly qualified children's nurses can be effectively supported during their transition into first post destinations with children's community nursing teams.

I was particularly interested to explore newly qualified children's nurses' perceptions of this unique experience from their perspective. However before I could proceed I needed to understand more fully how others had investigated newly qualified nurses' experience of entering the world of work and identify what was currently known about this topic so that this study would offer new insights and contribute to the body of knowledge related to the interpretations of newly qualified children's nurses experiences of integrating into children's community nursing teams.

1.5 Structure of the Thesis

In an attempt to unpick the complexity underpinning the recruitment of newly qualified children's nurses in the community this chapter has set out the historical development of children's community nursing teams, and highlights how the seemingly persistent reluctance to appoint newly qualified children's nurses to children's community nursing teams is facing a considerable challenge. However, this challenge, driven largely by an impetus to establish and sustain equitable access to community nursing services for all children, poses a number of important questions, such as whether they were sufficiently prepared to work as a children's community nurses and the extent to which newly qualified children's nurses can

be effectively supported during their transition into first post destinations with children's community nursing teams.

Much of what is known about the experience of newly qualified nurses' experience of transition to becoming qualified nurses has been framed in the context of acute care settings; there is a dearth of research into the experiences of newly qualified children's nurses employed by community children's teams. Chapter 2, an integrative review, explores this further by discussing the findings from a critical review of research related to the topic of transition of newly qualified nurses and other health professionals. This includes a critical appraisal of the quality of the research that has been undertaken. Previous studies had already highlighted the difficulties faced by experienced qualified hospital nurses during their transition to community teams (Drennan, Goodman & Leyshon 2005; Wright 2005; Simpson et al., 2006). Yet there remains a dearth of evidence relating to newly qualified children's nurses being employed as children's community nurses, despite current signals suggesting that increasing numbers of newly qualified children's nurses will be needed to establish and maintain equitable access to community children's nursing services for all families.

Chapter 3 presents the research question, aims and objectives and the philosophical foundations that underpin the research methods used. It also offers an account of how the research was undertaken and the challenges involved. Chapters 4, 5, 6 and 7 present a critical discussion of the findings of the study. Chapter 8 draws together the findings to present my final thesis and sets out the unique contribution that this work makes to the body of evidence related to newly qualified nurses experiences of their transition into children's

community nursing teams. Limitations of the study are also presented. Finally recommendations for practice, research and education are made.

Chapter 2 Literature Review

This chapter provides an integrative review of literature pertinent to this study. An integrative approach was chosen as it allowed for the exploration of concepts, the review of pertinent theories, the critical appraisal of evidence and interpretive explanation and analysis of potential methodological issues in others' research (Broome 1993). It also enabled a critical and in-depth understanding of the phenomenon of interest, the theoretical constructs of transition, and developing insight into what was known about individuals' subjective interpretation of their journey into the world of work (in this case, children's community nursing teams).

What follows begins by reviewing the work of key theorists including Van Gennep (1960) anthropology; Glaser and Strauss (1971) sociology; Kramer (1974) nursing; and Meleis; nursing (Meleis 1975; Chick & Meleis 1986; Schumacher & Meleis 1994; Meleis & Trangenstein 1994; & Meleis, Sawyer, Im, Hilfinger, DeAnne, & Schumacher 2000). This discussion includes an in-depth critical discussion of the antecedents and contemporary construction of transition in relation to nursing and in particular newly qualified nurses. I then consider the contemporary formulation of transition developed by Boychuk Duchscher (2007).

This is followed by a critical appraisal of research pertinent to transition in nursing in order to establish what was already known, to identify the key issues and persistent challenges, to

assess the quality of evidence that currently exists and to identify any persistent challenges or gaps in the existing knowledge base.

It has been argued that beginning with an extensive literature review risks prejudicing the research as the researcher may attend only to the data that supports what is already known about the phenomenon (Miles & Huberman 1994). However, as the phenomenon of transition has been explored in some depth, ignoring what was already known seemed incongruous with the research standpoint adopted for this work, (this is discussed further later). I also wanted to advance the current body of knowledge and produce findings that would be useful in practice, education and research. Ignoring what was already known was not an option. That said it was necessary to be acutely aware of how what follows in this chapter influenced the later data analysis (as discussed further in chapter 3).

2.1 The theoretical constructs of transition

Arnold van Gennep's (1960) anthropological work "The Rites of Passage" has had an enduring influence on theorists in many disciplines and is clearly apparent in contemporary research studies concerned with transition. Initially published in 1908, his work became more accessible to English speaking academics following translation into English in 1960. According to Zumwalk (1982) and Turner (1988), van Gennep, a French folklorist and ethnologist, developed his theoretical insights from studies of French folklore and folk life. van Gennep's unique contribution was the identification that individuals pass from one social position to another through a series of stages. His work has enriched the understanding of ritual behaviour and its relation to the dynamics of individual and group life.

As an ethnologist, van Gennep drew on existing data that he, and other anthropologists of the time, had. Systematic analysis was used by van Gennep to derive abstract concepts to examine and explain the nature of social ceremonies such as birth, marriage and funerals (Kimball 1960). According to Zumbalt (1982) van Gennep's initial work was largely ignored by his contemporary academics, but his work has since found favour with contemporary researchers examining the concept of transition. An early example of this was Glaser and Strauss' (1971) and Turner's (1982) use of his work to further delineate and describe the processes, conditions and nature of specific rituals and rites of passage experienced by individuals in different social contexts. More recently, other researchers such as Tierney *et al.*, (2012) have drawn on van Gennep's work to develop insight into children's experience of their transition from children's to adult health services.

In particular, van Gennep's (1960) work has been used by others who have gone on to develop further conceptual understandings of transition which will be discussed later (Kramer 1974, Boychuk Duchscher 2007). Still others claim to have developed mid-range theories of transition (Meleis *et al.*, 2000). This work has enabled a more coherent theory of transition relating to nursing and nurses. Of note is that the concept of a "Rites of Passage" has been used repeatedly as a theoretical position to underpin studies concerned with the experiences of nurses as they move from being a student nurse to becoming a newly qualified staff nurse.

2.2 Rites of passage

van Gennep (1960) coined the term 'rites of passage' to describe various stages that he discerned as discrete over time and named these "rites of separation", "rites of transition"

and “rites of incorporation”. According to van Gennep (1960) the first stage of any rites of passage is “rites of separation”. He asserted that this stage was characterised by the removal of the individual from their existing social position; and that they acknowledged that a prior way of life had ended. The next stage, an intermediate stage was termed the “rites of transition”. This involved individuals appropriating the customs and rituals of the new social position and that this brought a sense of order. According to van Gennep (1960) customs or rituals include stereotypical behaviour associated with the conventions of the new social position. He argued that these communicated the most cherished values. Of importance was that engaging in these customs and rituals was an essential part of the experience for the individual experiencing this intermediate stage of transition. For van Gennep (1960) an individual could not pass from one social position to another without going through this intermediate stage.

However this is further complicated by the notion of being on the threshold. For van Gennep (1960) the concept of liminality was used to further explain the notion of being on the threshold. Liminality is the term used to describe a temporary state during which an individual lacks rank or status. Those in this liminal stage are described as being on the threshold, or on the margins (Turner 1982). Of note for my study was the understanding that during the liminal period individuals may experience feelings of uncertainty, unpredictability and isolation (Turner 1988), which in turn may lead to significant disruption (van Gennep 1960). However, Kimball’s (1960) interpretation of van Gennep’s work was that taking part regularly in the customs and rituals of the new group, especially those of significance could ease the disruption experienced.

For van Gennep, the final stage of the rites of passage was the “rites of incorporation”. This was characterised by the individual taking up their new status and identity, and them being accepted by the group (van Gennep 1960). This concept was particularly useful in developing a critical insight into how newly qualified nurses integrate into their new world of work.

However, Glaser & Strauss’ (1965a, 1965b) groundbreaking studies in medical sociology on dying, work and organisations furthered van Gennep’s work by suggesting that any individual may be in transition for a period of time. Glaser and Strauss (1971) argued that passages or transitions are not always regularised, scheduled or prescribed. They went on to present their formal theory of status passage arguing that the consideration of the nature of the passage should consider time in relation to the rate, pace or speed of the passage. They also asserted that rites of passage were not necessarily linear or future oriented. However, they agreed with van Gennep that status passage within occupations involves movement from one part of a social structure to another, that it involves a change in identity, sense of self, and behaviour.

2.3 Transition and nursing

No review of transition theory would be complete without review of Kramer’s (1974) work that explored nurses’ experiences of moving into the world of work as qualified nurses.

2.3.1 Reality shock

Kramer commenced an eight year research programme whilst Dean of an undergraduate nursing programme at the University of California, in the United States of America. She

sought to identify the processes, facilitators and deterrents to effective incorporation of nursing students into the nursing world of work. Kramer's work is credited with developing an understanding of the experiences of conflict resolution and the socialisation of student nurses. Her work has been used extensively in subsequent studies of newly qualified nurses' experiences of transition.

Kramer drew on Nostrand's (1966) earlier theory of culture shock defined by as a state of anxiety, precipitated by the loss of familiar signs and symbols, when an individual is suddenly immersed into a cultural system markedly different from their home or familiar culture (Kramer 1974). Kramer proposed that nursing students were moving from the subculture of the school of nursing into the world of work. More specifically Kramer's study focused on the realities of clinical practice as manifested and dealt with by new graduate nurses. Her study enhanced insight into what is now commonly understood as the first stage of transition. Kramer's coined the term "reality shock" to describe as the

"specific shock like reactions of new workers where they find themselves in a work situation for which they have spent several years preparing for which they thought they were prepared and suddenly find they are not (p8)".

Kramer identified that new graduates experienced this shock most significantly, because of the professional-bureaucratic conflict arising from the differences in culture from the "idealism" of the school of nursing and the "reality" of the world of clinical practice. She identified that the professional ideals and values inculcated in the schools of nursing were not operational in a hospital environment. Kramer argued that the newly qualified nurse is immersed in a firmly entrenched culture that exposes them to routine ritual based care, and that they were not able to implement the ideals they valued, in the work setting. As a result

the response was termed reality shock; a total social, physical and emotional response. According to Kramer this led to job dissatisfaction and career disillusionment. Her work has particular resonance for my study given the persistent challenge of finding sufficient good quality community placements for students of children's nursing, and subsequent lack of employment into children's community nursing teams, as discussed previously in chapter 1. This in part, may go some way to explain the seeming reluctance to employ newly qualified children's nurses in children's community nursing teams.

2.3.2 Mid-range theory of nursing transitions

Whilst Kramer studied the specific shock like reaction of transition for newly qualified nurses other nurse academics have explored transition and its relevance to nursing practice. Drawing on the seminal work of van Gennep (1960) and Glaser & Strauss (1971), Meleis (1975) also began to develop an understanding of the experience of transition pertinent to nursing which included a concept analysis of transition (Chick & Meleis 1986). Chick and Meleis' (1986) conceptualisation of transition was developed in response to the perceived need of nurses to understand the experiences of the transition of patients, in order that they could assist people to achieve a positive outcome and mastery of their new status, life phase or condition.

Chick and Meleis (1986 p239) defined transition as the

“passage from one life phase, condition or status to another, embracing the elements of process, time span and perception”

As such, transition is understood to be complex phenomenon with multiple factors (Schumacher & Meleis 1994). Transition involves processes that suggest phases and sequence, that are time-bound, and perception. All relate to the meanings of transition for the

person experiencing it. Chick and Meleis (1986) argued that transitions in nursing should be recognised as passages similar to those in life phases, for example the transition to parenthood or adolescence; or conditions such as the impact of a diagnosis of chronic illness; or status, such as retirement. They added that passages may be understood as involving not only the changes and demands involved but the individual's response to these. Understanding transition in this way supports the notion of transition beginning with the first anticipation of the change and that it continues until stability occurs in the new status (Chick & Meleis 1986). Of note is that while all individuals will experience transition, each will interpret the experience from subjective and unique perspectives.

The original work of Meleis (1975), and that undertaken with colleagues (Schumacher & Meleis 1994, Meleis & Trangenstein 1994) continued to develop the concept and subsequent framework of transition. This was used by Meleis & colleagues to analyse their research studies, such as parents of children diagnosed with congenital heart defects (Messias *et al.*, 1995) caregivers of persons with cancer receiving chemotherapy (Schumacher 1994) and Korean immigrant women's experiences of menopause (Im & Meleis 1999). This analysis was used to support their claim that they had developed a mid range theory of transition (Meleis *et al.*, 2000). A particular strength in Chick and Meleis' (1986) formulation is that it anticipates the whole rather than a partial experience involving both the process and the outcome, and that the transition is contextually embedded in the individual's situation.

Types and patterns of transition

For Meleis *et al.*, (2000), there were 3 types and patterns of transition; developmental transitions, such as those related to health and illness; situational transitions that relate to

changes in situations in various educational and professional roles; and organisational transitions that affect the lives of people working in them or the experience of their clients. Meleis *et al.*, (2000) went on to describe a number of universal properties relating to transition that included awareness, engagement, change and difference, time span and critical points and events. Although, it is worth noting that these are not discrete or mutually exclusive.

Properties of transition

Awareness was explained to be a universal property of experience of transition. It was argued that during any transition the person undergoing this must have some awareness of the changes taking place. Furthermore, this awareness was thought to be dependent upon their knowledge, perception and recognition of the transition experience (Meleis *et al.*, 2000). Indeed a lack of awareness signifies that the individual may not be ready for the experience at all (Kralik, Visentin & van Loon 2006). Engagement was defined as

“the degree to which a person demonstrates involvement in the processes inherent in the transition” (Meleis *et al.*, 2000 pg 5).

Indicators that would suggest that a person is “engaging” include actively preparing for the transition and then seeking information and proactively modifying activities. Change and difference relates to the process of internalising and coming to terms with the details of the new situation that the change brings about (Bridges 2003). To fully understand a transition process it is necessary to uncover and describe the effects of the meanings of the changes involved. Change can be related to critical events, disruptions in relationships and routines or to ideas, perceptions and identities.

Time-span relates to the process of transition that takes place over time and commonly involves movement. According to Meleis *et al.*, (2000) although transitions are characterised by movement and variability they may not follow any particular time trajectory. Time may be dependent on the individual, their perception, personal and organisational variables. Critical points and events involve critical turning points (Meleis *et al.*, 2000). It is suggested that to achieve a successful transition these events could be crucial in the individuals' ability to successfully integrate.

Transition conditions: facilitators and inhibitors

While many individuals may share the experience of transition each will derive unique, subjective interpretations and meanings of this. This is acknowledged in Meleis *et al.*'s (2000) framework. Individual perceptions and meanings are influenced by certain conditions; conditions that determine the nature of responses. Thus, to understand individual experiences during transition it is necessary to uncover the conditions that facilitate and hinder the process (Meleis *et al.* 2000). Therefore, the important factors influencing transitions should be made explicit, and these may include personal, community and societal conditions that facilitate or disrupt progress towards a "healthy" outcome.

Personal conditions may affect the meaning of the transition for the individual, and it is important to remember that, "*meanings are constructed by human beings as they engage with the world they are interpreting*" (Crotty 1998 p43). Attributing meaning to the transition experience by the individual is inevitable. Meanings may be positive, negative or neutral. It has been suggested that the subjective appraisal and evaluation attributed to an anticipated or experienced transition may facilitate or hinder the process of transition (Meleis & Trangenstein 1994, Meleis *et al.*, .2000, Davies 2005). Meleis *et al.*, (2000) assert that

perceptions and experiences of transition may vary across cultural groups. If the transition experience is perceived negatively, for example by a group, then the nature of responses and adaptation may be disrupted. They also identify socioeconomic status as a condition that may constrain or facilitate transition. Low socioeconomic status for example may affect a person's experiences during transition. Preparation and knowledge of what to expect during a transition is a significant condition of the transition process. Anticipatory preparation and knowledge can aid the transition whereas lack of preparation can inhibit the process and outcome. Identifying the strategies that might be helpful for managing it may enhance the process and outcome (Meleis *et al.*, 2000).

Meleis and colleagues identified conditions in society and the community as factors that may shape the transition experience. Societal conditions appear to vary based on the type of transition. One such societal condition is socialisation. Socialisation itself is not a condition of transition; although it has been argued that socialisation may affect the gaining of knowledge, skills and behaviours of the group (Tradewell 1996). According to Davies (2005) awareness of the socio-cultural context of a transition can enable nurses to develop interventions at a societal level. Understanding the effects of the social change is crucial for understanding transition experiences (Im & Meleis 1999).

Community conditions, in the form of resources within the person's community or environment, are significant in the transition experience. Resources in the form of social support from family members, colleagues and others can enhance the experience, whereas

lack of social support can lead to feelings of frustration and powerlessness (Schumacher & Meleis 1994).

Patterns of response

Process and outcome indicators are identified in the framework that facilitate or disrupt smooth transition towards this state of well being. According to Meleis *et al.*, (2000) identifying process indicators or methods used to facilitate or disrupt people in transition can aid in their understanding and subsequent recommendations for future transitions. Process indicators include feeling connected, interacting, location and being situated, and developing confidence and coping. The need to feel and stay connected is a prominent topic in many transition stories (Meleis *et al.*, 2000). Making connections with the new group and keeping in contact with the old are an important element. Through interaction with others, the meaning of the transition and the behaviours developed in response are uncovered, clarified and acknowledged. According to Meleis *et al.*, (2000) location is important to most transition experiences although it may be more obvious in some than others. A recurring pattern in the literature is what Meleis *et al.* (2000) describe as the extent to which individuals involved experience changes in their level of confidence and the ability to cope with the changes occurring in the transition experience.

According to Meleis *et al.*, (2000) and Kralik, Visentin and van Loon (2006) the outcome of the transition process involves attaining a new sense of identity which is developed through mastery. Davies (2005) identifies mastery as the sense of achievement and development of skilled performance and taking control of the situation. Transition experiences have been

characterised as resulting in identity reformulation. The determination of when a transition is complete is flexible and variable depending on the nature and patterns of the transition.

Nursing therapeutics

The final component of the framework is nursing therapeutics. They highlight the importance of knowledge of types of transition in order for nurses or individuals who support people undergoing transitions. Schumacher & Meleis (1994) advocate that these should include both promotive, preventive and interventive initiatives to help and support persons undergoing transition.

Meleis *et al's.*, (2000) framework offers a comprehensive framework for the consideration of, the description of, and the interpretation of the complexities of the data in this study. Understanding the properties and conditions inherent in a transition process will lead to the development of knowledge about the unique interpretations of newly qualified children's nurses' experiences of transition into children's community nursing teams. Using this framework provided me with a broad understanding of the complex, situated and individual nature of the experiences of newly qualified children's nurses transitioning into children's community nursing terms.

2.4 Critical Review of Research

The following section of this chapter presents a critical review of the research concerned with the experience of transition from student nurse to qualified nurse published between 1999 and 2013. The purpose of this section of the integrative review was to present the extent to which transition in nursing had been previously researched, to provide further context and background to the study, and to highlight areas for further investigation.

Regardless of the type of review it is recommended that it should be as comprehensive as possible within the given constraints and undertaken in a systematic manner (Centre for Reviews and Dissemination (CRD) 2009, Evidence for Policy and Practice Information and Co-ordinating Centre (EPPI) 2009). Whittemore and Knafl (2005) list five steps to guide integrative reviews. These include problem identification stage, literature search stage, data evaluation and analysis stage and a presentation stage. What follows is organised under this headings

2.5 Problem identification stage

According to Whittemore and Knafl (2005) this stage involves the clear identification of the question that the review is addressing. To begin I used the Setting, Perspective, Intervention, Comparison, Evaluation (SPICE) model described by Beecroft, Rees, and Booth, (2006) to establish and refine my search question and identify key terms. This model was especially useful when undertaking the search for both quantitative and qualitative research as in this work. Beecroft, Rees, and Booth, (2006) maintain that it is not necessary to identify terms for each specific element of the SPICE model. As I wanted to explore newly qualified nurses' experiences of transition in either a hospital or community setting I selected the Setting, Perspective and Intervention elements to develop the search question as follows:

What is known about the transition of newly qualified health professionals in first post destination jobs?

2.6 Literature search stage

According to Whittemore and Knafl (2005) it is important to define the research strategy to enhance the rigour of the review. The key terms of newly qualified, new graduate and

transition were used as key terms to search nursing, health and social care databases including Ovid, Internurse, CINAHL, Applied Social Sciences, Medline and the Cochrane data base. As newly qualified is a UK centric term newly qualified and new graduate were included to ensure that the search retrieved studies undertaken elsewhere than the UK. However, throughout this work the terms are used interchangeably. The review included quantitative and qualitative research to enable a more complete understanding of transition. Dissertations and theses were also included however Dearmun's (2000) publication was a report of a PhD thesis completed in 1997. While outside the date limit set for the search, the original thesis has been included in the review as it focused on the experience of children's nurses during their first year of qualified practice. Opinion and discussion papers were excluded. I had not included the term nurse in the initial search so that studies relating to non-nurse health professionals were retrieved. However studies that related to other professional groups, for example teachers were excluded. The search was limited to papers published in English between 1999 and 2013. The language limits were set on pragmatic grounds. Although CRD (2009) criticise this approach facilities for translation were not available. When retrieving the studies it became apparent that some studies and their results were replicated. Any duplications were excluded. Citation tracking and a review of the references cited in retrieved papers was also undertaken. In total 39 studies were included in the review.

2.7 Data evaluation and analysis

Data analysis in reviews requires the data from primary sources to be ordered, coded, categorised and summarised (Whittemore & Knafl 2005). This process began with data

evaluation which is the process of obtaining the necessary information about study characteristics and findings from the included studies (CRD 2009). To do this I constructed a data extraction form (see appendix 1) that enabled the same data to be extracted from each study thus reducing the risk of bias and improving the validity and reliability of the analysis (CRD 2009). The CRD (2009) recommends that this form should include the information such as study details, participants' demographics, geographical location, research design and study findings, along with any additional information that is specific to meeting the aims of the review and the research question. The additional information was the timing of the data collection as this was significant to the analysis of the timing and stages of newly qualified nurses' experiences of transition.

Rolfe (2006) and Thomas and Harden (2008) indicate that there are no accepted or empirically tested methods for excluding qualitative studies from synthesis on the basis of their quality. Lucas et al., (2007) concur and suggest that the rigid application of quality criteria may lead to the exclusion of relevant studies that fail to meet particular reporting requirements. While no study was excluded on the grounds of poor quality when poor quality research was identified, the limitations for inclusion in the findings reported here have been acknowledged. Moreover, research of low rigour contributed less to the analytic process. I assessed the quality of the studies using the questions identified by the Critical Appraisal Skills Programme (CASP) critical appraisals checklists⁴ as a guide. As noted earlier the quality of the studies varied. While some studies provided a detailed rationale for choosing the research approach adopted and its application to the study (for Dearmun 1997 example Boychuk Duchscher 2007; Farasat 2011), some provided some rationale (for example

⁴ <http://www.casp-uk.net/find-appraise-act/appraising-the-evidence/>

Gerrish 2000; Andersson and Edberg 2010) however others did not (for example Bick 1999; Amos 2001). To some extent this may have been dependent on the requirements of the publication and type of study. Twenty six of the studies included in the review were qualitative (see appendix 1). This is not surprising as the studies were seeking to describe and explain newly qualified health care practitioners' experiences and behaviours in social contexts and they were seeking to understand human experiences through description and interpretation of their social world (Creswell 1998; Fossey *et al.*, 2002; Vivar *et al.*, 2007). Of these 26 qualitative studies, 6 studies were influenced by phenomenology with 3 described as phenomenological (Jackson 2005; O'Shea and Kelly 2007; Farasat 2011), and the other 3 described using a phenomenological approach (Tryseenaar & Perkins 2001; Toal-Sullivan 2006; van der Putten 2008). A further 4 studies were described as being grounded theory studies (Gerrish 2000; Runcapadiachy, Madill, & Gough, 2006; Boychuk Duchscher 2007; Mooney 2007), but 2 of these being described as using a grounded theory approach (Gerrish 2000; Runcapadiachy, Madill, & Gough, 2006). Some researchers that claimed to be using a particular approach guided by a philosophical framework used some or all of the elements congruent with that approach. For example see Gerrish (2000). However some elements of the approach were not described i.e. theoretical sampling. Other researchers were less rigorous in reporting all aspects of the work. For example Jackson (2005) described her study as phenomenological but did not describe how the data was analysed. Of note however that was no ethnographic studies were found. That said Dearmun (1997) discussed how ethnographic approaches had informed her study though she had not undertaken any participant observation or fieldwork.

A further 6 of the studies were described as evaluations. These studies ranged from a small scale evaluation of 10 newly qualified nurses' experiences of transition working in one acute care setting in the UK (Amos 2001) to a large scale national review of pre-registration nursing and midwifery education exploring the impact of Fitness For Practice (UKCC 1999) and the early implementation of Flying Start NHS®, a structured programme for newly qualified nurses in Scotland. This study had 2011 participants, which was the largest sample size reported (Lauder *et al.*, 2008). Of these 5 studies sought to evaluate strategies put in place to ease the transition experiences for nurses and newly qualified health care practitioners including an evaluation of Flying Start®, mentorship, preceptorship and orientation programmes in the USA, UK and Australia (Beecroft *et al.*, 2006 (USA); Berridge *et al.*, 2007 (UK); Lauder *et al.*, 2008 (UK); O'Malley Floyd, Kretschmann, & Young 2005 (USA); and Smith & Pilling 2007 (Australia). The other study evaluated the staff nurse role transition (Amos 2001). All of the evaluation studies included some qualitative approaches to data collection and data analysis.

A further 2 studies were described as surveys (Bick 1999 and Cave *et al.*, 2007). Both used questionnaires as the data collection tool which elicited both quantitative and qualitative data. A further 2 studies were described as longitudinal studies (Brown & Edelmann 2000; and Maben, Latter and Macleod Clark 2006). Another 2 studies used mixed methods design and a combination of data collection tools which elicited both qualitative and quantitative data (Ross & Clifford 2002; Brumfitt, Enderby & Hoben 2005,). No single method was appropriate to investigate the phenomena of newly qualified nurses entering children's community teams. Indeed as Mason (2006) notes multi-method designs are appropriate and

can enhance the understanding of the problem. It is also worth noting that funding bodies may favour studies that contain both qualitative and quantitative methods and such approaches may lead to greater confidence in reported findings (Bryman 1988). However, as Mason (2006) suggests, multi-method approaches are not without criticism. For instance there may be difficulty in meshing the findings from the analysis of narrative and numerical data. This difficulty may explain why some researchers failed to report all aspects of their work. For example Ross and Clifford (2002) only presented the qualitative findings.

Overall the data collection tools used in individual studies was congruent with the research approach reported. Quantitative studies used a variety of appropriate data collection tools (see appendix 1), but the most frequently used was questionnaires. The most frequently used data collection tool used in the qualitative studies was interviews. Other methods included focus groups, self report written accounts and journaling (see appendix 1). There were no examples of fieldwork or participant observation as methods of data collection reported in any of the studies. This was surprising given that the use of field work methods can enable deeper understanding of the informants' world compared to data collection methods which are restricted to verbal inquiry (Savage 2000).

There were notable differences in the amount of detail reported regarding the development of data collection tools. For example while Runcapadiachy, Madill, & Gough (2006) discussed the rigour involved in the development of their interview schedule no example of the schedule was provided. At times the lack of detailed description made it difficult to assess which topic areas were explored in depth. The studies that used more than one data collection

method did so to enable researchers to confirm and verify the findings and develop them further. For example see Brumfitt, Enderby and Holden (2005).

There were also differences in the timeline used to collect data for instance Dearmun 1997; Brown & Edelmann 2000; Tryssenaar & Perkins 2001; Ross & Clifford 2002; Brumfitt Enderby & Holden 2005; Maben, Latter & Macleod Clark 2006; Berridge *et al.*, 2007; Boychuk Duchscher 2007; Newton & McKenna 2007; Smith and Pilling 2007; Morley 2009a Morley 2009b; Brennan *et al.*, 2010; and Farasat 2011) collected data on a number of occasions. The benefits of doing include the ability to determine significance of how the experience might change over time. Those studies that used a one off data collection strategy were interested in retrospective accounts and events. A strength of this was that participants could recollect their experience and the meanings they attached to them.

As expected, a variety of data analysis techniques were used appropriately. These included descriptive statistics, and inferential statistical analysis to analyse quantitative data (see appendix 1). Qualitative content analysis, thematic analysis, constant comparative analysis, template analysis and Colaizzi's framework analysis was used to analyse qualitative data (see appendix 1). This reflects the rich variety of qualitative analysis strategies available as noted by Patton (2002). However, each has distinct elements that can generate creative approaches as each study is unique and depends on the insights and style of the inquiry and inquirer (Patton 2002). Regardless it is important to report the details of the analysis to ensure rigour (Rolfe 2006). At times the procedures relating to data analysis were poorly described. Three studies did not report the type of data analysis used (Bick 1999; Jackson 2005; Smith & Pilling 2007). Some studies named the method used but did not attribute this to a published

source (for example Toal-Sullivan 2006). Others provided a comprehensive discussion of the analysis for example Farasat (2011).

Of the 39 studies included in this review 26 of the papers explored the experiences of newly qualified nurses during their transition into qualified posts, another 2 included both nurses and health care professionals the remaining 11 considered the experiences of non nursing health care professionals including doctors and midwives. In total 27 of the studies were UK based, 4 completed in the USA, 2 undertaken in Canada, 2 in Australia, 2 in Ireland and a further 2 in Sweden.

Just 6 of the studies focused solely on children's nurses alone reporting on their experiences of their first employment (Dearmun 1997 (UK); Evans 2001 (UK); Andersson, Cederfjäll and Klang 2005 (Sweden); Jackson 2005 (UK); Beecroft et al., 2006 (USA); and Farasat 2011 (UK). A further 2 studies included nurses working with children, Thomas et al.,(2008) (UK) included 6 children's nurses as well as other health care professionals while Boychuk Duchscher (2007) (Canada) reported that the participants in her study worked in adult and paediatric settings. This supports the contention that children's nurses are under- reported in this body of work and that more research is needed to further understand the experiences of this particular group. All of these studies report experiences of participants in acute care settings apart from Maxwell *et al.*, (2011). No studies were found that focused on children's nurses' experiences of transition into community settings as a first post destination.

As the majority of the studies were qualitative the sample sizes were generally small with the smallest number being 4 participants (Morley 2009). This is not surprising given the fact that

the purpose of qualitative research is to provide valuable in-depth and rich information from a small number of participants (Patton 2002). However, the selection of participants was not always well described. Some studies lacked any detail regarding the rationale for participant inclusion while others did. For example several studies reported the use of purposive sampling (see appendix 1). An example was O'Shea and Kelly (2007) who discussed that the participants in their research would have enough experience to describe adequately what the experience was like for them. This is consistent with the views of Spiezale and Carpenter (2003) who note that individual participants should be selected based on their first hand experience of the topic being investigated. Unfortunately, in other studies the sampling strategies were poorly reported. Sample sizes in the quantitative studies ranged from 31 (Brennan *et al.*, 2010) to 2011 (Lauder *et al.*, 2008).

Data analysis

According to Whittemore and Knafl (2005) the next step in an integrative review involves an iterative process of examining the data to identify patterns, themes or relationships. To do this I used an approach illustrated by Boyatzis, (1998) who described a systematic approach to the organisation, analysis, synthesis and presentation of the findings derived from different sources of literature. This involves encoding information and focuses on identifying themes and patterns in the data (Boyatzis 1998). The coding process involved recognising (seeing) an important moment and encoding it (seeing it as something) prior to the process of interpretation (Boyatzis, 1998). Encoding the information helps to organise the findings in order to derive themes from them. In this context a theme is defined as:

“a pattern in the information that at minimum describes and organizes the possible observations and at maximum interprets aspects of the phenomenon”

(Boyatzis (1998) p. 161).

Braun and Clarke (2007) add that once descriptive themes have been identified from the studies synthesis of analytical themes can be generated. This stage was the most difficult as it depended on my insight and judgment and there were some challenges to this process; not least that the views of research participants were often presented through the descriptive themes generated by individual researchers which had already been interpreted. However, an iterative approach to this aspect of the review helped. This cyclical process of reading and re-reading papers was repeated until the themes generated were sufficiently abstract to describe or explain what was known. What follows here, the synthesis, goes beyond reporting the content of the original studies by presenting a coherent overview of the current body of knowledge to answer the review question under the headings of 'stages of new graduate experiences of transition, a disconnect between education and the realities of practice; responsibility and accountability; preparedness; confidence; support; and the outcome of experiences of transition.

2.8 Presentation of the Review Findings

The stages of new graduate experiences of transition

4 research studies contributed to this theme, Dearmun (1997) (UK), Tryssenaar & Perkins 2001 (USA), Newton & McKenna 2007 (Australia), and Boychuk Duchscher 2007 (Canada). Overall there was an international consensus in these studies that stages were identified and that there were discernible patterns and similarities to these. This indicates that there may be some universal aspects of the transition experience. However there were some discrepancies in the exact time-frame for the stages, though it is not clear the extent to which this maybe

due to the different time scales of the data collection used by the researchers. All the data was collected at different intervals throughout the first year to eighteen months of the studies. All of the studies focusing on nurses (Dearmun (1997), Newton & McKenna (2007), and Boychuk Duchscher (2007) began after or at the point of qualification. Of the studies included in this theme Tryssenaar & Perkins (2001) were the only researchers to commence their study during the final placement of an education programme continuing into the first year of practice. While novel, this may lead to some confusion as they have included a stage of being a student in the first stage of transition (see figure 1). It is not that this is wrong, rather that it is inconsistent with the approaches taken by other researchers and, at odds with van Gennep's (1960) assertion that transition represents the period between states (as in student and staff nurse). This confusion continues to be a challenge. There was also no consensus in relation to the naming of the stages which could lead to confusion.

The first stage of transition

There was some general agreement that the first stage of transition occupies the time between the first month and the third or fourth month after qualification. This first stage was also identified as the most difficult period of transition by newly qualified nurses (Dearmun 1997; Newton & McKenna 2007; and Boychuk Duchscher 2007). These findings are consistent with those reported by Kramer (1974) and re-emphasise that this may be the most important stage. More recently Kramer's conceptualisation of reality shock has been extended by Boychuk Duchscher (2007). Boychuk Duchscher (2007) developed a theoretical framework of the initial stage of role adaptation for newly graduated nurses. Her findings extend Kramer's work by outlining how the contemporary new graduate engaging in a professional

practice role is confronted with a broad range of emotional, physical, intellectual, developmental and socio-cultural changes that are expressions of, and mitigating factors within the experience of transition. She termed this 'transition shock'. According to Boychuk Duchscher (2007) transition shock occurs within the first four months of being a new graduate. Boychuk Duchscher (2007) expands Kramer's work through attempts to correlate the feelings of anxiety, insecurity, instability and inadequacy with dimensions of inadequate support, lack of practice experience and confidence, relationships with new colleagues and the inability to enact their ideal professional practice values. This is a significant piece of research that outlines clearly the emotional impact felt by newly qualified nurses when they felt unprepared for the world of work. The research further advanced the understanding of transition of new graduate nurses by deconstructing what "being prepared" meant for the participants and elaborated more fully on the consideration of socio-cultural and developmental change. For Kramer (1974) socio-cultural and developmental changes, explains are about

"finding their way in a world for which they had been prepared but were not wholly ready" (p6).

This initial transition period was dominated by the realities of the practice environment and how it facilitated, supported, reinforced, challenged or censored professional codes of behaviour. Here, the participants attempted to find a way to connect what they had learned during their undergraduate education with what they were seeing and doing in the 'real' world. Kramer (1974) established that student nurses leave their educational programme with a set of beliefs and ideals about nursing practice, and it was clear in the literature reviewed that similar findings endure. Both Kramer and Boychuk Duchscher made recommendations to alleviate this initial shock like reaction. Kramer worked with Benner (1974) to test an

anticipatory socialization programme designed to acquaint new graduates with the dilemmas of practice and help them to develop strategies to smooth the transition period (Kramer 1974). Boychuk Duchscher (2007) suggested that extending workplace orientations and structured mentorship programmes may assist in this.

Whilst Kramer's (1974) and Boychuk Duchscher's (2007) work has been extremely influential regarding the understanding of transition it is important to note that both explore the experiences of newly qualified nurses' integrating into hospital settings and that the participants in their research had undertaken educational programmes and integration into work settings that differ from those in the UK.

As previously discussed, Boychuk Duchscher (2007) added further insight into this initial stage of transition by explaining that it was dominated by an increased awareness of accountability and a perception of being unprepared for the added responsibility of becoming qualified in clinical practice. Agreeing with Kramer (1974), Boychuk Duchscher (2007) concluded that new graduates entered practice with idealistic rather than realistic expectations. Kramer (1974) described the shock like reaction during this initial stage. In contrast, Dearmun (1997) found little evidence of 'reality shock' but described children's nurses as experiencing a "psychological shift". Boychuk Duchscher (2007) proposed that the feelings experienced during this early transition stage are caused by a shift from a structured, relatively predictable life to a new set of expectations and responsibilities. It seems that the initial excitement associated with gaining employment quickly turns to feeling unprepared for the responsibility and functional workload of their new roles. This shift poses numerous challenges to their personal and professional selves. This was also associated with being an

accountable practitioner and being answerable for the practice decisions they made. Again there was a strong consensus that new graduates experience a lack of confidence in their abilities during this early stage. This is discussed in more detail later in this chapter. Trysennaar and Perkins (2001) demonstrated that self doubt and concerns about competence not only manifest in newly qualified nurses but also in newly qualified physical and occupational therapists.

The Second Stage of Transition

Following the initial stage of transition, the second or intermediate stage is thought to operate from three to four months to six months of the newly qualified nurses' experience in a first post destination. The studies reported that this stage was marked by a consistent and rapid advancement in new graduates thinking; knowledge level, skill and competency (refs). It seemed that this period of time was dominated by learning to establish their place in the organisation. Nurses reported that they were able to integrate the knowledge developed during their undergraduate programme with practical skills they had developed since qualifying (Dearmun 1997). During this stage they reported that their confidence increased. At this juncture it is worth considering the findings discussed so far with those reported by Benner (1984) and Benner, Tanner and Chelsa (1996). The findings of this important work have etched a profile of the emergent expert practitioner in nursing. This stage of the new graduates' journey appears to be commensurate with the advanced beginner level described by Benner. According to Benner (1984) and Benner, Tanner and Chelsa's work (1996) at this stage, the nurse's performance improves to a marginally acceptable level following experience of coping with real situations (p54). However this is still a stage of transition for

these new nurses and new graduates. In addition, this is not always experienced as pleasant as it is about fitting in, learning the rules and their position in the hierarchy (Trysenaar & Perkins 2001; Boychuk Duchscher 2007). Boychuk Duchscher (2007) highlights that at this stage that some nurses were placed in positions beyond their competence without the necessary support. Dearmun (1997) also identified that while necessary, the support needed was not always provided. Of note is that all the researchers' report that by six months practitioners begin to adapt more readily to the 'real-world' model of practice and that they were able to integrate the necessary knowledge and skills.

The final stage of Transition

The final stage of transition is articulated by the 4 studies as a continued increase in the performance, knowledge and skill development of newly qualified nurses (Dearmun (1997, 2000; Trysenaar & Perkins 2001; Boychuk Duchscher 2007 and Newton & McKenna 2007). The participants in the studies considered themselves to have achieved a relatively stable level of comfort and confidence with their roles, responsibilities, and routines. Meleis *et al.*, (2000) suggest that the end of an experience of transition is marked by the extent to which individuals demonstrate mastery of the skills and behaviour needed to manage their situations. However there is some debate as to whether there is a full incorporation (van Gennepe 1960) or mastery (Meleis *et al.*, 2000) at this stage. While the studies reported that new graduates towards the end of the first year are able to demonstrate capability, there is recognition that there is still a long way to go and still more to learn and achieve. As Benner's (1984) and Benner, Tanner and Chelsa (1996) assert, reaching the status of expert through the acquisition of skills takes a considerable length of time. Farasat (2011) has

recently suggested that the participants in her study had not completed the transition process at 14 months, the point at which she concluded data collection with them.

The findings of these studies have contributed to the body of knowledge related to the experiences of newly qualified nurses by identifying and reporting the existence of stages and time frames. In part the researchers' intentions were to recommend strategies that could be used by organisations and newly qualified practitioners to guide and help the individual undergoing the process of transition.

Although the other studies considered in this review do not explicitly report stages in their findings they are implicit and to some extent concur with the findings in each of the stages (Please see figure 1).

Figure 1- Comparison of the stages of transition identified by Dearmun (1997); Tryssenaar & Perkins (2001); Boychuk Duchscher (2007); and Newton & McKenna (2007).

Rites of separation (van Genneep)	Rites of transition	Rites of transition	Rites of incorporation
Final placement and start of new role	0-3 months	3-6 months	12 months +
Honeymoon phase Kramer (1974)	Shock or Rejection	Recovery	Resolution
	The Initiation stage (Dearmun 1997, 2000)	The consolidation stage	Outgrowing the role, stagnation, confusion and uncertainty
Transition (Tryssenaar & Perkins 2001)	Euphoria and angst	Reality of practice	Adaptation
Gliding through (Newton & McKenna 2007)	Surviving	Beginning to understand	Knowing how to We've come a long way
	Transition shock (Boychuk Duchscher 2007, 2008, 2009)	Being	Knowing

The Disconnect Between Education and the Realities of Practice

As previously noted, Kramer (1974) established that student nurses leave their educational programme with a set of beliefs and ideals about nursing practice. Kramer (1974) described how during the initial stages of their experiences of transition new graduates discover an inability to maintain these ideals in practice. Because practice differs from their expectations they discover that they lack knowledge and skills to respond to the different clinical situations. More recent research concurs. Maben, Latter & Macleod Clark (2006) reported that newly qualified nurses completed their university programme with a coherent set of values and ideals that largely reflected academic theories and approaches promoted in nurse education. Putting these ideals and values into practice however, was often hindered by the realities of practice. Boychuk Duchscher (2007) describes this as disconcerting doubt about

their emerging professional identity. It was also identified by Trysennaar & Perkins (2001); Maben, Latter and MacLeod Clark et al., (2006); van der Putten (2008); and Morley (2009a, 2009b) that idealism of the new graduates, whether nurses, occupational therapists or midwives, is tempered by the reality of the workplace.

Maben, Latter and MacLeod Clark (2006) add that newly qualified nurses are faced with an ideological dissonance, which is the difference between the perceptions attached to their expectations and their experiences in reality, and, that this can disrupt the process of transition. Mooney (2007) who studied the process of professional socialisation during transition in newly qualified nurses in Ireland reported that although newly qualified nurses have a desire to challenge practice and implement the ideals they have internalised, they often cannot. Of importance here is how the experience of transition, whilst not completely separate from the concept of socialisation, is differentiated. Toal-Sullivan (2006) argued that the socialisation process from a student nurse to a newly qualified nurse involves learning the skills, behaviours and attitudes of their chosen profession and the norms of their work settings. This process is referred to in the literature by Melia (1987) as occupational socialization. However, as noted earlier occupational socialization is only one of the social processes involved in the experience of transition.

What is evident is a disconnect between undergraduate education and the realities of practice. A point originally outlined by Kramer (1974). Further work has advanced the notion of this disconnect to include both physical experiences of clinical practice (Mooney, 2007) and an ideological disconnect (Maben, Latter & MacLeod Clark 2006). Kramer (1974) describes

various ways that a new graduate attempts to overcome this. In part, this is managed by identity reformulation which is understood by new graduates as compromise (Boyчук Duchscher 2007). They may relinquish both the school-led idealism and the professional work value system, accept the values of either or hold onto their own but compromise behaviour; or leave.

In keeping with Kramer (1974), Maben, Latter and MacLeod Clark (2006) suggest that this may result in “crushed idealists” who identify that ideals are impossible to implement and that expectations have to be lowered. Others may be “compromised idealists” experiencing frustration due to being unable or only partially able to implement their own ideals and values into practice. Indeed Maben, Latter and MacLeod Clark (2006) found very few nurses who were “sustained idealists” who retained and implemented care that was consistent with their ideals. Interestingly, studies of doctors (Lempp, Cochrane & Rees 2005, Berridge et al.,2007, Cave et al.,2007, Brennan et al.,2010) indicate that whilst newly qualified doctors experience stress on qualifying and have concerns about their practice they do not report a clash between practice and their undergraduate courses in terms of differing values and ideals. The reasons for this remain uncertain but are worthy of further investigation. Kramer (1974) acknowledges that while a professional bureaucratic dissonance may occur strategies should be considered to overcome it. Hughes (1984) called the ideals and culture of a profession the profession’s mandate. Allen (2004) believes that a new viable future should be pursued that fits more with the realities of today’s nursing practice. Allen (2004) however argues that the continuation of the current ideals and values will do little to ease the transition experiences of newly qualified nurses. It remains uncertain how the recent drive to

implement compassionate care⁵ will become a mandate for nurses in the UK and how this will impact on the experience of transition.

Responsibility and Accountability

Another key theme in the literature related to transition was the concepts of responsibility and accountability. On qualifying nurses become accountable for their practice and professional nurses are:

“personally accountable for actions and omissions in [their] practice and must always be able to justify [their] decisions” (NMC, 2008, page 2).

The concepts of responsibility and accountability became embedded in UK nursing practice following the introduction of the United Kingdom Central Council’s (UKCC, 1989) “Exercising Accountability” advisory document. This advice signalled a change for qualified nurses in that it established the extent of accountability and indicated that nurses, midwives and health visitors were accountable for their actions at all times. That said, perceptions of an increase in responsibility and accountability on qualifying is not new. Gerrish (2000) compared her data with that from Walker’s (1986) study and reported that both studies confirmed that newly qualified nurses experienced stress and a heightened awareness of the burden of individual responsibility and accountability in the immediate post qualifying period. It seems that this is a persistent challenge. This matters because notions of “professional accountability” may have had some impact on student nurses’ perceptions of their preparedness and thereby impact on their experience of transition. For example a perceived awareness of the increase in accountability was found in mental health nursing students (Runcapadiachy, Madill & Gough, 2006) and adult nursing students (Amos 2001)

⁵ Compassion in Practice Strategy is available at <http://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf>

where increased responsibility and accountability was identified as the main difference between the student's and the staff nurse's role. A recognition of the increased responsibility of the role was also found in children's nursing students in Sweden (Andersson, Cederfjäll & Klang, 2005) and in other professions such as occupational therapy, physiotherapy, podiatry, social work and speech and language therapy (Brumfitt, Enderby & Hoben 2005; Toal-Sullivan 2006) and doctors (Brennan *et al.*, 2010). It appears that the concepts of accountability and responsibility not only cross all branches of nursing, but span other health care professions in and beyond the UK. Perceptions of increased accountability are reported as a stressful aspect of transition (Gerrish, 2000; Whitehead, 2001) where the perceived increase in responsibility provokes anxiety. Indeed, Gerrish (2000) compared the experiences of nurses qualifying in 1985 and 1998 and found that the nurses qualifying in 1998 felt greater concern about their accountability, which she attributed to an increased emphasis on professional accountability by the UKCC in the Code of Conduct and the Guidelines for Professional Practice (UKCC 1992, 1996).

This suggests that the concepts of responsibility and accountability, in part, provide recognisable concepts on which newly qualified health professionals 'hang' their transition anxiety. Newly qualified nurses report that they fear making mistakes in this initial post qualifying period; therefore the concepts of responsibility and accountability represent something tangible that are strongly associated with change for newly qualified nurses. In turn, they perceive a shift from being a supervised individual with responsibility for their own actions to an individual not only fully accountable for their own actions but also in some cases for the actions of others. The step change to accountability is recognised as a change by

the newly qualified practitioners, and the process of adapting and coming to terms with this is embodied in the transition process.

Preparedness

Preparedness also emerged as a theme in the literature, where newly qualified practitioners expressed concerns and feelings about not being fully prepared for some aspects of their clinical practice. This was evident in the papers studying newly qualified nurses for example Bick (1999); Charnley (1999); Gerrish (2000); Amos (2001); and Whitehead (2001). Worthy of note is that this is reported most often at the start of the first stage of their experiences of transition.

In Amos' (2001) study the participants felt unprepared as they perceived knowledge and skill deficits, where the skills deficits were thought to arise because of lack of practical experience in their undergraduate programme. Examples of knowledge and skill deficits reported by Amos (2001) were in pharmacology, physiology and knowledge relating to various medical conditions. A lack of knowledge in physiology was also a finding identified by participants in Gerrish's (2000) study. A specific area of concern was drug administration. Similar experiences of perceived deficits were reported by Bick (1999); Charnley (1999); and Whitehead (2001).

All of these studies were undertaken in the UK and the participants in the research studies had all undertaken Project 2000 programmes (Dearmun 1997; Bick 1999, Charnley 1999, Gerrish 2000, Brown & Edelmann 2000; Amos 2001; Whitehead 2001, Clark & Holmes 2007). It is not surprising that the findings reflect those of earlier seminal studies examining the evaluation and effectiveness of Project 2000 programmes which raised concerns about

the perceived deficits in clinical and managerial skills of newly qualified nurses despite them having a “good” knowledge base (Luker et al., 1996; Macleod-Clark et al., 1996; Maben and Macleod Clark 1998). Clinical and managerial skill deficits of nurses qualifying from Project 2000 courses had been one of the factors justifying reform in nurse education in the UK (DH 1999, UKCC 1999). In recognition of the difficulties faced in this area the United Kingdom Central Council (now NMC) and the Department of Health recommended that programmes which prepared nurses should have as a priority increasing levels of practical skills embedded into the curriculum (DH 1999; UKCC 1999).

More recently in a study exploring newly qualified staff nurses' experiences of being on clinical placement in Ireland O'Shea and Kelly (2007) identified concerns about lack of exposure to practical experiences during undergraduate programmes. Their analysis of interviews with newly qualified nurses reported that they experienced stress related to clinical and managerial skill deficits as a result of their lack of exposure and experience to these during their undergraduate education. These findings are consistent with van der Putten's (2008) research findings which report that midwives in Ireland felt that more practice experience and preparation would have been invaluable.

Clark and Holmes' (2007) study investigating whether newly qualified nurses were fit for practice in the UK, attempted to gain an understanding of the way that competency developed amongst newly qualified nurses studying on a post project 2000 curriculum and reported that the majority of nurses felt they were not ready for independent practice; but had islands of knowledge. This meant they had in-depth knowledge of some subjects but lacked depth in others. Similar concerns about knowledge and skill deficits were also reported in a

Canadian study (Ellerton & Gregor 2003), where new graduate nurses perceived that they lacked knowledge and skills to manage their workload independently and safely. Ellerton and Gregor (2003) reported that the 11 graduate nurses they interviewed rated themselves as seven out of ten for their readiness to practice, feeling “unready” but not “incompetent”. Similar findings were discussed by Farasat (2011), who reported that the 6 children’s nurses interviewed in the mid final year of their undergraduate programme rated themselves between 5-8 on a self-rating scale of 1-10 with 0 being unready and 10 being ready, regarding their perceived readiness to take on a newly qualified nurse position. Ellerton and Gregor (2003), Clark and Holmes (2007) and Farasat’s (2011) findings concur that their participants concern seemed to relate to moving towards becoming an independent practitioner which was different from being a student where practice is supervised by a qualified practitioner. Had these studies relied less on interviews and undertaken fieldwork alongside this, greater depth regarding what was going on may have been discovered.

The research included here highlighted that this issue is not just relevant to newly qualified nurses indicating that it may not be the specific educational programme that is at fault. Interestingly some concerns are shared across professional groups. While medical students do not report ideological dissonance (as discussed earlier) Berridge et al.,(2007), Cave et al.,(2007) and Brennan et al.,(2010) all emphasised that newly qualified doctors felt inadequately prepared for the demands of the role as a qualified doctor. Similar concerns had been noted in medical education regarding new graduates being insufficiently prepared for their first clinical post and in response the General Medical Council have implemented curriculum changes (General Medical Council 2003, 2009). In addition, Berridge et al.,

(2007) noted newly qualified doctors' concerns about prescribing medication. However, Brumfitt (2005) reported slightly different findings regarding newly qualified speech and language therapists in which 69% of their respondents felt confident in their skills on qualification. That said, they had some concerns related to effective client management but the significance of this in terms of comparison to the experience of other health-care professionals is difficult to determine. Thomas et al's (2008) comparison of four professional groups and their impressions of initial training may give some insight. They reported differences in the four groups, with nurses in particular and to some extent radiographers, criticising the lack of emphasis on gaining experience in clinical settings. The two children's nurses in the study worked in hospital and community placements. However, they pointed to a lack of experience with children with medical conditions and reported feeling that they had insufficient knowledge. Interestingly, this was much less apparent with the pharmacists and dentists in the study. This is particularly interesting given that the children's nurses' educational preparation in the UK is founded on the principles from Making a Difference Fitness for Practice curriculum with an emphasis on skills (UKCC 1999, DH 1999).

The notion of "preparedness" is an interesting one in that some studies suggest that the feeling of "not being ready" will always be present for new graduates who will never feel fully prepared. Cave *et al.*, (2007) and Brennan *et al.*, (2010) for example both report findings that suggest a lack of preparedness is inevitable since undergraduate programmes could never replicate the realities of practice. Gerrish (2000) for example suggested that the realities of the qualified nurses' role are simply not accessible to those who are not qualified and as a result cannot truly prepare as it is only when nurses are in this position that they start

to learn. Similarly, Charnock (1999); Amos (2001); and Brennan *et al.*, (2010) all suggest that newly qualified practitioners feel that they could and did only learn to perform the role once qualified. Phrases such as “learning the ropes” (Gerrish 2000) and “learning the job” (Ellerton & Gregor 2003) are used by newly qualified nurses to describe how they engage with the transition process. That said there were some reported improvements in perceived preparation in the literature reviewed. Two studies compared current newly qualified graduates to their colleagues on earlier programmes (Gerrish 2000; Cave *et al.*, 2007). Cave *et al.*, (2007) identified that changes in curricula between 2003 and 2005 lead doctors to feel more prepared than in 2000/1. Similarly, Gerrish (2000) compared experiences of transition in nurses in 1985 and 1998 and found that although nurses still felt inadequately prepared though this was not as marked as had been reported in the earlier study (Gerrish 1990).

Confidence

From the literature reviewed it appears that a lack confidence is intrinsically linked to newly qualified nurses’ perceptions of their preparation for their new role. A recurring pattern is the researchers’ consideration of the extent to which study participants experienced changes in their level of confidence. Professional confidence is an internal feeling of self assurance and comfort (Crooks *et al.*, 2005). New graduates experience a crisis of confidence in the early stages of their transition (Newton & McKenna 2007). Boychuk Duchscher’s (2007) study highlighted that at the end of their undergraduate studies, nurses had developed a solid professional identity. Yet, on qualifying they experienced wavering confidence levels and as a result performance anxiety and self doubt. Studies by Gerrish (2000); Amos (2001), Whitehead (2001), Jackson (2005); O’Berridge *et al.*,(2007); Clark & Holmes (2007); O’Shea and Kelly (2007); and O’Malley Floyd, Kretschmann & Young (2007), all reported

that newly qualified practitioners perceive a lack of confidence on qualifying. The studies all identified that during the early part of the transition many had to constantly learn new things. Newton and McKenna (2007) reported a lack of confidence in some areas such as time management. It seems that confidence is a complex multi-dimensional concept.

Roberts and Johnson (2009) have indicated that confidence is important in learning to be a nurse and that this concept has not been afforded the attention it deserves. From the literature reviewed it is difficult to ascertain whether this lack of confidence is inevitable or what, if any, strategies or factors can help the newly qualified practitioner overcome this. It appears from the literature reviewed that newly qualified nurses develop their confidence over a period of time. According to Meleis *et al.*, (2000) there is a pattern to the way individuals develop confidence during their experiences of transition indicating that those involved develop strategies for managing the roles, responsibilities and routines accompanying the change in status. All the studies highlight that strategies, such as gaining experience, result in increased confidence. Clark and Holmes (2007) and Whitehead (2001) both acknowledge that time is a significant factor in allowing for consolidation of skills with experience to enhance confidence. These findings emphasise the importance of Glaser and Strauss's (1967) notion of temporality in the transitional stage and van Gennep's (1960) concept of liminality discussed hitherto.

These findings clearly suggest that newly qualified practitioners identify concerns about their preparedness for practice, particularly in relation to clinical and managerial skill deficits. Indeed Lauder *et al.*, (2008) suggest that the measurement of the problems faced by the new

practitioners has proved more challenging than the simple recognition that the problem exists. As O’Conner *et al.*, (2001) observe:

“the ability to gauge the performance of newly qualified nurses remains a largely subjective exercise relying upon anecdotal *evidence* or general statements of newly qualified nurses’ feelings of inadequacy on qualification” .

Spending time in the field, working with newly qualified nurses as they go about their day-to-day work seemed to present a valuable opportunity to delve deeper into what was going on.

Support

It is apparent that the initial stage of transition can be a time of anxiety and stress, and that this is linked to a feeling a lack of preparedness, and changes in responsibility and accountability upon qualification. A number of studies included in this review identified both the need for support and the lack of support as a main theme in their findings (Dearmun1997; Bick 1999, Gerrish 2000, Amos 2001; Whitehead 2001; Ross and Clifford 2002; Ellerton & Gregor 2003; Jackson 2005, Lempp, Cochrane & Rees 2005; Beecroft, *et al.*,2006, Gould, Carr & Kelly 2006; Runcapadiachy *et al.*,2006, Maben, Latter & Macleod Clark 2006; Clark & Holmes 2007, Thomas *et al.*,2008; van der Putten2008; Morley 2009a; and Brennan *et al.*,2010). This it seems is another persistent problem since it was first identified as critical to the success of the experience of transition by Kramer in 1974 and certainly worthy of further exploration and examination. As early as the 1970’s, Meleis and Kramer identified the importance of developing strategies such as support to aid transition to decrease feelings of inadequacy.

Several studies undertaken in the U.K in the 1990s focused on support mechanisms for newly qualified graduates with a view to the amelioration of some of the negative effects. Many of these (e.g. Jowett, 1994; Jasper, 1996; Maben and McLeod Clark. 1998; and Holland, 1999) reviewed the experiences of transition with a particular interest in nurses who had undertaken the newly developed Project 2000 curriculum. The studies found that formalised support for newly qualified nurses was valued by them and was described as easing the transition period. The studies also recommended a period of supervised experience upon qualification, or preceptorship for newly qualified nurses. In its Framework of Preceptorship the DH (2009) define preceptorship as

‘a period of transition for the newly registered nurse during which time he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning’
(2009 p12).

A preceptor is defined as a qualified nurse who works in the same area of practice and setting as the newly qualified nurse and who is available to help, to advise and to support them (NMC 2006).

Researchers repeatedly point to a lack of support for new graduates, and that the nature and quality of support available varied from well-structured programmes to no support at all. In the UK, Amos (2001) reported that 5 out of 10 participants had received some type of preceptorship or support in their first post, while 5 had received nothing. Gerrish (2000) also reported that while respondents in her study had been allocated a preceptor, the actual provision varied. Many of her participants reported positive experiences of working alongside their preceptor initially and then meeting to review progress, whereas others reported that their preceptors provided little in the way of support and constructive feedback.

Variation in the provision of preceptorship was also reported by Bick (1999) who suggested support ranged from being very effective to little more than a paper exercise. However, provision improved considerably after introduction of a more formalized framework (Bick, 1999). These findings also resonate with studies nationally, internationally and across other professional groups (Bick 1999; Gerrish 2000; Ross and Clifford 2002; Jackson 2005; Beecroft, *et al.*, 2006; Runcapadiachy *et al.*, 2006; Clark and Holmes 2007; and Thomas *et al.*, 2008). They are also supported by a scoping review of preceptorship undertaken by the National Nursing Research Unit for the Department of Health (Robinson & Griffiths 2009).

Other professions viewed support as an important facilitator to a successful transition. Many of the studies of newly qualified nurses, midwives, health care professions and doctors found that support from senior colleagues was highly valued, and was perceived as having a significant impact on their ability to cope with the demands of the job, an increase in confidence levels and that it could lead to perceived stress reduction (Amos 1999; Gerrish, 2000; Brumfitt *et al.*, 2005; Jackson 2005; Beecroft *et al.*, 2006; Maben, Latter, and MacLeod Clark, 2006; Berridge *et al.*, 2007; Clark and Holmes, 2007; Thomas *et al.*, 2008; van der Putten, 2008 and Morley, 2009, Lauder *et al.*, 2008; Brennan *et al.*, 2010). Furthermore, lack of support in the period of transition was found to increase anxiety and feelings of disillusionment and inadequacy in these groups (Charnley, 1999; Runcapadiachy *et al.*, 2006; Brennan *et al.*, 2010).

Whilst it has been established that newly qualified graduates benefit enormously from the support of qualified staff during their transition, it seems that those who support them often received little preparation for the role or that they experienced role overload given the levels

of supervision needed to support students, newly qualified staff and health care assistants (Gould Carr & Kelly 2006; Clark & Holmes 2007). O'Malley Floyd *et al.*, (2005) highlighted that preceptors felt prepared but that their workload issues prevented them from carrying out the role in a satisfactory manner. This resulted in an unsatisfactory experience not only for the transition experiences of the newly qualified practitioner but also the person trying to provide the support.

There are several reports of induction and preceptorship programmes from Australia, the UK and North America, including Godinez *et al.*,(1999); Bick (2000); O'Malley Floyd *et al.*,(2005); Beecroft *et al.*,(2006); Berridge *et al.*,(2007); Newton and McKenna (2007); Smith and Pilling (2007); Lauder *et al.*,, 2008; Morley 2009a, 2009b) and. Each has considered different aspects of such programmes. Interestingly there appears to be no consensus in the literature reviewed on the time frame required for effective preceptorship support with programmes ranging from two weeks (Berridge *et al.*, 2007) in the UK to a formal graduate year in Australia (Newton & McKenna 2007). The studies also report considerable variations in the type and content of these programmes, with many adopting a combination of orientation and preceptorship support.

However there are some common findings in the studies reviewed that help in the understanding of how these programmes can aid the experiences of transition. For example Beecroft *et al.*, (2006) acknowledged that having a mentor on structured mentoring programme helps assimilation into the new role both socially and clinically, instilling professional behaviours by role modelling and feedback. Godinez *et al.*,(1999) also support

this finding claiming that having regular contact with a supervisor for feedback, advice and answering questions helped during the initial transition period. Berridge *et al.*, (2007) addressed the issue of new graduates being insufficiently prepared by implementing a two week preparation for practice programme which aimed to improve the perceived confidence and skill deficits. They incorporated skills training and the shadowing of a qualified doctor into the preparation programme. They reported an increase in confidence in clinical skills as a result, a finding confirmed with nurses by O'Malley Floyd *et al.*, (2005) and with nurses, midwives and allied health care professionals by Lauder *et al.*, (2008).

However, the most valued aspect of the programme described by Berridge *et al.*, (2007) was the shadowing of a qualified doctor. Shadowing was found to have assisted the participants' ability to prioritise and organise. The notion that shadowing aided the experiences of transition by a supporting individual also emerged from Bick's (1999) studies, and Morley (2009a) places clear emphasis on the importance of joint working and role modelling to strengthen confidence in the newly qualified graduates, where observed practice bolstered their confidence. This confirms the notion that this aspect can help newly qualified practitioners during their experiences of transition. A further factor identified by Bick (1999) was that a supernumerary period helped build confidence. There were however varied interpretations of the time frame of this period ranging from seven to twelve weeks.

The Outcome of the Experiences of Transition

As previously discussed and as discussed by Meleis *et al.* (2000) and Kralik *et al.* (2006) the outcome of the transition process involves attaining a new sense of identity which is developed through mastery. The experiences of transition have been characterised as

resulting in identity reformulation. The determination of when a transition is complete is flexible and variable depending on the nature and patterns of the transition. Davies (2005) who utilised Meleis' *et al.* (2000) framework also describes the outcome of experiences of transition as mastery. She described this as the sense of achievement and development of skilled performance and taking control of the situation. Only two studies from those included in this review explored mastery and discussed the outcome indicator. It is reasonable to transpose Dearmun's (1997) consolidation phase with this outcome as the nurses in her study stated that within six months they were able to integrate existing knowledge with skills they had developed in practice. Trysennaar and Perkins (2001) identify adaptation as an outcome of the transition experience for newly qualified occupational therapists. It was claimed that they began to adapt their practice to develop their competence in order to master the role. As Benner (1984) explains it is with experience and mastery that clinicians move to a higher level of expertise.

2.9 Summary

This chapter has provided an integrative review of literature pertinent to this study. It has been acknowledged that this situation specific transition is experienced as a series of stages and there were a number of discernible patterns to these stages. It was clear that the initial stage has been described as the most challenging. This is attributed to the perceived awareness of the stress of an increase in responsibility and accountability and perceived knowledge skills and confidence deficits leading to feelings of stress and shock. The negative reactions are also attributed to the difference in expectations and the realities of the new environment. Support is recognised as a factor that can ease these feelings during this initial stage however lack of support is frequently reported. During the period of transition there is a

subsequent ease to the shock like reactions and confidence begins to increase with experience in the world of work. Newly qualified healthcare practitioners are reported to be able to integrate knowledge and skills and this results in an outcome of a relative stable level of confidence and capability. It is also recognised that final incorporation may not be fully achieved.

As this review has demonstrated, theoretical and conceptual understandings of transition have been used to generate knowledge and insight into the experience of newly qualified health professionals on completion of their educational programmes as they enter the world of work for which they have been preparing. van Genneep's (1960) work has had an enduring influence of this work and Meleis and Kramer have been influential in advancing van Genneep's theoretical insights. In particular, Meleis' *et al.*, (2000) middle range theory of transition was thought to offer a reasonable starting point from which to develop my understanding further. However, it was important that from the outset I took account of others' contribution to the field. I took a novel approach to this by meshing Meleis' *et al* (2000) framework with other key messages from research concerned with the transition of newly qualified health professionals, with an emphasis on good quality studies that had focused on nurses. This is presented in figure 2.

This was instrumental in initially helping me to establish the most appropriate research approach and methods that would best enable an in-depth exploration and analysis of newly qualified nurses as they enter the world of work in children's community nursing teams.

There have been a number of studies considering the nature and experience of transition for newly qualified nurses and the findings have been presented here. While there were a number of robust high quality studies others suffered from under-reporting of methods a lack of description and a failure to identify the methodological approach used. These details are listed in appendix 1. However, regardless, combined, these studies enabled me to understand more fully the key issues, persistent problems and gaps in knowledge requiring further investigation. However, there are a number of limitations which included the lack of fieldwork and participant observation methods and the evidence which examines the experiences of newly qualified nurses working in community based services. This means that a number of question remain – not least regarding the experiences of newly qualified children's nurses Their experiences have not been researched so little is known about this, yet they are the least likely to have received the extended experience identified by Gerrish (2000) and others that makes a difference. It seems that the most appropriate way of finding out would be to use field work methods to investigate their experiences.

Figure 2 Synthesis of Findings and Applied Relevance to the Initial Development of this Study

Elements of Meleis <i>et al</i> (2000) framework	Contributions from Others' Research	Relevance to the current study
Types and patterns of transitions		The focus of this study is the situational transition exploring the experience of newly qualified children's nurses experiences of their first post destinations in children's community nursing teams
Properties of transition		
Awareness	Heightened awareness of the differences of being a student and a newly qualified nurse	How or do the participants demonstrate awareness that changes are taking place and what are their interpreted responses to these?
Engagement	Develop knowledge and skills with experience	What are the participants' perceptions of their engagement in the process of transition?
Change and difference	Perceived increase in responsibility and accountability	What meanings do the participants attribute to their experiences of moving from being a student to a children's community nurse?
Time span	Stages of transition	What is the time span for this transition and do they experience it in a series of stages? How do they interpret this?
Critical points and events	Ideological dissonance	What from the perspective of the participants are the critical points and events that they experience?
Transition conditions: facilitators and inhibitors		
Personal conditions		
<ul style="list-style-type: none"> Meaning 	Reality shock transition shock	What meanings do newly qualified nurses ascribe to their transition experiences?
<ul style="list-style-type: none"> Cultural beliefs and attitudes 		What part if any, if any do cultural beliefs and attitudes play with regard to the participants experience of facilitating or disrupting transition?
<ul style="list-style-type: none"> Socioeconomic status 		Is socioeconomic status a factor that is important in their transition?
<ul style="list-style-type: none"> Preparation and knowledge 	Feelings of lack of preparation Perceived deficits in clinical and managerial skills	How do the participants perceive preparation and knowledge and to what extent does this assist or impact their experiences of transition?
Community conditions	Support is viewed as facilitative	What community factors affect their transition? e.g. what do the participants' experience as supportive?
Societal conditions	Socialisation involves learning the skills, behaviours and attitudes of their chosen profession and the norms of their work settings.	What societal factors affect their transition? e.g. socialisation, marginalisation,

Patterns of response Process indicators		
<ul style="list-style-type: none"> Developing confidence and coping 	Confidence increases with experience	What happens to their confidence and what coping strategies do they develop during their transition?
<ul style="list-style-type: none"> Feeling connected 	Feeling respected and valued is facilitative	How do the participants describe their connectedness to the children's community nursing team?
<ul style="list-style-type: none"> Interacting 	Support is varied	How do they interact with others during their transition and how do they make sense of these interactions?
<ul style="list-style-type: none"> Location and being situated 	Majority of studies based in acute care settings	How do the participants make sense of the work place location and how does this impact on their transition experiences?
Outcome indicators		
<ul style="list-style-type: none"> Mastery 	Adapt to practice and integrate knowledge and skills with experience	Do the participants develop knowledge, skill and mastery?
<ul style="list-style-type: none"> Fluid integrative identities 	Identity reformulation can be compromise	What happens to their identity reformulation?
Nursing therapeutics	Support, preceptorship	What initiatives to help and support them?

Chapter 3 Research design

This chapter sets out the aim, research question and objectives of the study. It also presents a critical discussion of why a qualitative descriptive design, field-work and non-participant observation were the most appropriate methods to answer the research question. Throughout this chapter I reflect upon key issues and the challenges encountered in undertaking this work.

3.2 Aim

The aim of this study was to elicit, explore and describe the meanings that newly qualified children's nurses attributed to their transition into children's community nursing teams (in the North West of England).

Research question

How do newly qualified children's nurses describe and interpret their experiences of entering the work-world of children's community nursing teams as first post destinations?

The research question was further broken down into 3 research objectives.

Research Objectives

- To identify, explore and describe the meanings that newly qualified children's nurses attribute to their experiences during their transition into children's community nursing teams?
- To identify and explore those factors, if any, that the participants perceive as facilitating, helpful or necessary to assist in their transition
- To identify and explore those factors, if any, that the participants perceive as disrupting or impacting adversely on their transition?

- To make recommendations for practice, education and research regarding the transition of newly qualified children's nurses entering the world of work in children's community teams that are grounded in the experiences of the participants.

3.3 Philosophical Framework

As the central premise of this study was to elicit, explore and describe the meanings that newly qualified children's nurses attributed to their experience of being employed in first post destinations as children's community nurses in children's community nursing teams, it was important to explore the participants' subjective views of their world of work. To do this it was necessary to elicit, explore and emphasise individual participant meanings to uncover the knowledge which could only be derived from social interactions.

Burr (2003) and Seale (2004) identified that ways of understanding the world are culturally and historically defined and therefore the social world of individuals is best understood through an appreciation of the social and cultural meanings that individuals, and in this work, newly qualified children's nurses, assign to their experiences and subsequent actions during their transition into children's community nursing teams. Blumer (1969), Williams and May (1996), and Hammersley and Atkinson (2007) have all asserted that understanding actions requires the development of insight into the intentions, motives, beliefs, rules and values of the individuals of interest. This acknowledges that each individual experience is influenced by the cultural and time bound context in which it is situated. In other words, the participants in this study are in part, the product of the specific social processes and interactions that they encounter in their day to day lives.

As Mason (2002) notes, this means that whilst the participants all shared the common experience of transition into a new world of work, it was possible and expected that each would interpret and construct meaning from this experience through individual, unique and subjective realities. To ensure that the participants' individual subjective interpretations remained central to this work I needed to select a methodological framework that was consistent with my research standpoint that individual experiences are shaped as people interpret events in their environment and that these influence their behaviour (Lauder *et al.*, 1996; Hammersley & Atkinson 2007).

Central to the research question for this study was my understanding that subjective knowledge is an important form of knowledge, and that this knowledge was key in understanding the participant's experiences, interpretations and meanings from their subjective point of view. In agreement with Söderbäck (1999), I also contend that it was appropriate to undertake this research in the natural work setting of the participants, as a contextual understanding of their experience of transition was essential. Observing them in the real time and real work context of their work enabled me to view their actions and to explore their subjective interpretations of these. Charmaz (2000) describes this as a social constructivist standpoint where there can be mutual creation of knowledge between the researcher and the participants to derive an interpretive understanding of the studied world.

In keeping with Berger and Luckmann's (1966) argument that knowledge is derived from social interactions it was necessary to discover the participants' knowledge of their social world. This meant that it was necessary to enter the participants' work-world, spending time with them as they went about their ordinary day-to-day work with children, young people, families and other members of the team.

Qualitative research is a broad umbrella term for research methods that describe and explain peoples' experiences and behaviours in social contexts, (Fossey *et al.*, 2002) seeking to understand human experiences (Vivar *et al.*, 2007) through description and interpretation of the social world (Creswell 1998). Blumer (1969) and Hammersley and Atkinson (2007) suggest that people construct unique identities through every day encounters with each other in social interaction and that they interpret events in the social world, which influence their behaviour. These interpretations are continually under revision as events unfold and shape their actions. It seemed that a qualitative approach would be particularly useful to uncover the processes and interpreted meanings involved in this. Especially as this involved identity reformulation. A conclusion reached by other researchers working in this field (see chapter 2).

According to Crotty (1998) qualitative descriptive approaches enable understanding and explanation of society or, as in this case, context specific situations, such as transition. Key in taking a qualitative approach is that it enables the communication of meaning through data collection methods using language (Blumer 1969). Blumer (1969) suggests that this helps to determine an individual's understanding and interpretation of an event and what the event means to them. Hammersley & Atkinson (2007) agree and state that as human actions are based on social meanings the same event can mean different things to different people. Therefore, this research approach is consistent with individually constructed meanings.

That said qualitative research does not have a single unified set of techniques or philosophies (Mason 2002) making it difficult to define. This has led to considerable debate regarding the choice of a single philosophical approach and 'rightness' of combining different qualitative

philosophies. Many researchers have argued that it is important to adhere closely to a set of rules associated with particular philosophical approaches, claiming that any reinterpretation of the original elements of the approach can “erode” the method (Glaser 1992, 2002) resulting in a methodological incongruity which threatens the credibility of the study findings (Rolfe 2006). Others for example Stern, (1994) and Johnson, Long, & White, (2001) support the combining of methods, suggesting that movement from a rigid structure can also produce a truthful, logical and knowledgeable account of a phenomenon. Indeed Hammersley & Atkinson (2007) also support flexibility in methodological approaches suggesting that:

“A first requirement of social research, according to this view, then, is fidelity to the phenomena under study, not to any set of particular methodological principles, however, strongly supported by philosophical arguments” (p. 6).

There is also some debate related to the description or labelling of qualitative research, specifically in relation to methodological influences or philosophical perspectives and the use of specific research methods. Much of this stems from early debates about the scientific value of qualitative research and attempts to shake off the perception of qualitative work as a soft science. Sandelowski (2000) for example, suggests that many qualitative researchers describe their studies as phenomenological, grounded theory, ethnographic, or narrative in an effort to increase the credibility of their work. Indeed Wolcott (1992) and Sandelowski (2000) suggest that in too many cases this simply results in posturing rather than a correct interpretation of the approach.

As noted in chapter 2 other researchers working in the field of transition have used different qualitative approaches to explore subjective interpretations of experience and actions in the social world. For instance Dearmun (1997) drew on a number of qualitative approaches and claimed that her work was informed by ethnography, phenomenology and grounded theory. In

contrast, Boychuk Duchscher (2007) used grounded theory and Farasat (2011) drew on phenomenology as her philosophical approach.

Having considered the arguments on both sides of this debate I concurred with the position of Smith (2010). Smith (2010) explored the merits of undertaking qualitative research without specifying a single philosophical approach such as ethnography or grounded theory. She suggested that as qualitative inquiry evolves; the methods of undertaking qualitative research should stand alone without having to be underpinned by a particular philosophical perspective. I elected to describe my work as a qualitative descriptive study. This does not mean however that this method is any less valuable than a grounded theory study for example, as Sandelowski (2000) argues, qualitative description is one of the most frequently employed methodological approaches and an important method in itself and that it still presents a considerable challenge to any researcher.

Qualitative descriptive studies are often undertaken to provide a comprehensive summary of events in every day terms of those events. The research question related to gaining an understanding of newly qualified children's nurses' experience, therefore a qualitative descriptive design was an appropriate choice to ensure that the findings of this study were firmly grounded in experiences of the participants.

3.4 Field-Work and Non-Participant Observations

According to Whyte (1984) fieldwork can elicit data not achieved by other means. I began this research with some idea about what aspects of the field were likely to yield data. These included

formal and informal meetings with other members of the children's community nurses, handovers, allocation of work to children and families' homes, visits to NHS hospitals and visits to children and families' homes. I had some grounding in the literature related to transition (see previous chapter) and had read studies that had used field work including the work by Street (1992) and Allen (2004). I had also been fortunate to receive sponsorship by the University of Salford to spend a week with a community nursing team and I was an experienced senior lecturer working with undergraduate and post registration children's nurses.

Combined, these experiences and being heavily influenced by the rigour of Street's (1992) work helped me to see the potential of spending time in the field with participants as they went about their daily work. Street asserted that this enabled her to develop a deeper knowledge of her participants' experiences. Having critiqued her work I wanted to emulate her methods (field-work) which were consistent with my philosophical standpoint.

Field-work and participant observation are key terms used in the literature to refer to the circumstances of being in the social setting for the purpose of making a qualitative analysis of that setting (Patton 2002). Participant observation is broadly described by Schulte (2000) and Hammersley and Atkinson (2007) as a data collection method that involves the researcher participating in people's lives for a period of time. They continue, stating that it can be used to focus on the discovery of values, behaviours and cognitions of participants in a cultural context to throw light on issues that are central to the research. Participant observation is a data generating method fundamental to ethnographic methods of inquiry. Similarly, Spradley (1980), Emerson, Fretz & Shaw (2001) and Bryman (2004) explain that field-work is an approach to data

collection where the researcher is immersed in the participants' social world and natural setting to investigate, experience and represent the social processes and cultural life that occur in that setting.

As I sought to collect individual subjective descriptive accounts of the participants' actions and interpretations as a basis for theorising and critique, field-work and participant observation were appropriate research methods and these terms are used interchangeably in this work. I wanted to learn about the social group of newly qualified children's nurses working as children's community nurses from individual participants. I began with the assumption that I could get to know something about their personal knowledge derived from their experience of entering the world of work while accepting that this knowledge was embedded in their socio-cultural world. Given this, spending time in the field with them was paramount to understanding something of the context and their interpretations. In keeping with Wolcott (1999), my role as the researcher was to identify and describe individual and collective meanings of shared experience and to gain insight into this as far as possible from the individual perspective of the participants. It seemed that spending time in the field would provide the best means of achieving my aim. As Mason (2002) suggests, observing, questioning, participating, listening and communicating with the participants are essential aspects of discovering personal knowledge. The challenges of field-work and data collection are considered later in this chapter.

3.5 Participant Sampling

The assumption in the choice of sample was that newly qualified children's nurses would have the situation specific experience of being newly qualified nurses, recruited into children's community teams as first post destinations. In this study purposive sampling as described by

Mason (2002) was used. Purposeful sampling is used when participants are selected on the basis of their experience which is directly relevant to the research question (Chenitz & Swanson 1986; Silverman 2000; Mason 2002; and Bryman 2004).

Inclusion criteria

Any newly qualified children's nurse that had been recruited into children's community nursing teams involved in the Making it Better (2006) Greater Manchester recruitment initiative as a first post destination was eligible to participate. No distinction was made between those working full or part time hours. All newly qualified children's nurses recruited into the community teams were employed as generalist nurses. It is worth noting here that the generalist-specialist distinction is concerned with the skills and experience of the staff (Winter & Teare 1997 and Gibson, Fletcher & Casey 2003). As generalist nurses the participants recruited to this study looked after children with a variety of acute and chronic conditions.

Each children's community nursing team had, under agreement with the Making it Better initiative, agreed to employ a minimum of one newly qualified nurse. This meant that there was the potential to recruit at least one participant from each of the ten teams. In reality, only 4 of the 10 teams recruited newly qualified children's nurses. These 4 teams recruited a total of 9 newly qualified children's nurses.

According to Sandelowski and Barroso (2002) all qualitative research studies are vulnerable to the very elements that provide them with their rich thematic insights. This is particularly so with small sample sizes that have the potential to infuse a narrow superficial focus and bias interpretive processes in the analysis of data (Creswell 2007). This can limit the usability of the ultimate end product for others. However, Mason (2002) and Ritchie, Lewis & Elam (2003)

argue that whether the sample is big enough to make inferences is not the concern of qualitative research. Rather, the information that rigorous qualitative studies yield, even with small samples, is rich in detail. That said, it is important to ensure that the data acquired is subject to rigorous analysis and that this is presented in the context of a rich description of the situation. Still, the sample size must be sufficient to provide enough data to answer the research aim and questions. This was achieved in this study.

3.6 Access to the Field

According to Bryman (2004) and Seale (2004) gaining access to the field is an entirely practical matter using interpersonal resources, skills and strategy. For this study I contacted the Clinical Workforce Lead of the Greater Manchester Children and Young People's Forum Network who advised me that there were a number of team manager meetings taking place which I could attend. These team managers were the gatekeepers to potential participants. Bryman (2004) explained that gatekeepers are often concerned to understand the potential organisational consequences that may follow permission for researchers to access members of staff. Such concerns in this study could have included staff time or any potential damage to the image of the team. This concern could have been heightened further as my work involved research with those working with vulnerable children. As Coyne (2010a, 2010b) notes, any research in healthcare settings involving children creates a number of challenges, not least that of access.

In addition, there may have been concerns about my suitability to accompany participants and enter the homes of children and their families. To ensure that the organisations' gate-keepers were fully informed I arranged to meet with individual managers, informed them of the purpose of the study and confirmed that I had ethics approval and that the study was compliant with

research governance processes (this is discussed in more detail later). As suggested by Powdermaker (1967) I explained that I sought their sponsorship and agreement for the research to take place. None of the managers refused permission for me to invite participants that were employed in their service to take part in the study. Some managers explained they had no plans at that time to recruit newly qualified children's nurses but they agreed to inform me if this position changed.

The progress of access is illustrated in table 1. Numbers have been assigned to each of the children's community teams to maintain anonymity and protect confidentiality.

Table 1 Children's Community Teams and Number of Study Participants Recruited

Team	Governance approval	Contact type with team manager	Newly qualified	Number of participants involved in the study
1	ReGroup	Phone /email/ meeting	No newly qualified employed at the time of the study	
2	ReGroup	Phone	Team manager not expecting to employ newly qualified nurses	
3	ReGroup	Phone/email	No newly qualified employed at the time of the study	
4	ReGroup	Phone/email/ meeting	Four	Five
5	Regroup	Phone/email/ Meeting	One	One
6	ReGroup	Email	None	
7A 7B ⁶	ReGroup	Email and meeting	two	Two
8	R and D ref number 2009007	Phoned and sent email	No newly qualified employed at the time of the study	
9	R and D ref PD/yk	Phone/ email	No newly qualified Not recruiting at present time	
10	Email confirmation	Phone/email	One	No contact

⁶ Team 7A and 7B consisted of two teams based on one site but serving two geographical locations

3.7 Designing the information materials

All the materials used for information and consent purposes were designed using the combined National Patient Safety Agency National Research Ethics Service (2007) guidance.

Information sheets

Information sheets were provided for the participants, for members of the children's community nursing teams, and for children aged 5 and under, 6–10, 11–15, and for parents (see appendices 2, 3,4,5,6 and 7). The information sheets differed in terms of the use of language and layout and this was dependent on the target recipient. These sheets outlined the purpose and nature of the study, the potential risks and benefits, the procedures involved in maintaining confidentiality and anonymity, the option to withdraw at any time, and issues related to child protection. My contact email and work address was also included.

Written consent forms

According to the National Patient Safety Agency National Research Ethics Service (2007) guidance, consent can be written, oral or non-verbal. However, the purpose of a consent form is to record the decision made by the participants and I decided to gain written consent, checking this verbally throughout the study before undertaking any episode of field-work (see appendices 8, 9,10 and 11). In keeping with the RCN (2009) guidance, written consent was sought from the participants only after the potential risks and benefits had been explained to them. As noted by the DH (2009), consent is valid only if it is given on the basis of sufficient information, and given on a voluntary basis. Therefore the principle of process consent was used throughout the study, with each participant asked at each stage of their involvement if they wished to continue; the opportunity to withdraw from the study was reinforced prior to each subsequent field-work

observation.

When the consent form was signed by the parent, children's permission was still sought, if appropriate (again this is explained in more detail later), before any observation was undertaken.

If the consent form was completed by children the agreement of the person with parental responsibility was also sought. Signed consent forms were kept in a secure, locked filing cabinet in the University of Salford, separate from any other data.

3.8 Approach to Participants

The children's community nursing teams' managers were asked to forward my research proposal and information sheets to the newly qualified children's nurses. They were asked to contact me via email or telephone if they were interested in taking part. All newly qualified children's nurses that met the inclusion criteria were invited to take part. Following initial contact with the participants via email or telephone, I arranged an individual meeting with each of the potential participants to discuss the research in more detail. In total, 9 newly qualified children's nurses were invited to take part in the study; 8 attended a meeting to discuss the research. However, one nurse made no contact and, in keeping with ethical principles, I made no further attempt to contact her. In total, 8 newly qualified nurses agreed to participate in the study. There were 7 female participants and 1 male. One of the participants worked part time and the others full time.

3.9 Approach to children and families

The children and their families visited by the research participants were not directly involved in the study nor were they viewed as active informants for research purposes. However as the some

of the field-work observations took place within their home setting it was important to ensure that they were fully cognisant with the study aims and objectives, that they gave their consent for me to be present whilst their care was being carried out, and that they gave permission for what was observed in their home to be used within the study. It was important that children, young people and families were informed of my research prior to the visits taking place.

This was managed by asking the research participants to telephone the parents the day before a planned visit to explain that they were involved in a research study and to explain the aims of the research. It was also suggested that when possible, the parents and children were given the information sheets prior to the fieldwork observation so that they had time to read about the research and have any questions answered. However this was not always feasible as in some cases it would have meant that the participants had to make an extra visit. In other cases it was impossible to inform the family the day before as the visit was only scheduled on the given day. In this case it was agreed that I would remain in the car until the family and children had sufficient time to read about the research and ask any question they had before consenting for me to observe their interactions with the nurse. No-one refused me entry to their house.

Having gained permission from parents to approach children I followed guidance on undertaking research with children from The Royal College of Paediatrics and Child Health (2000), The National Children's Bureau (2004), and Involve (2004). This meant that when appropriate children were asked if I could observe their care being carried out. Determined efforts were made to ensure that no child was coerced by me, the research participants or parents. I tried my best to make sure that the children were actively involved and listened to regarding their decision to allow me to observe their care. On entering the house I introduced myself and the aims and

purpose of the research. I gave them the choice of whether or not I should be allowed to observe what the nurse did with them in line with my judgment regarding the extent of their capacity to understand, as suggested by Coyne (2010a, 2010b). I also explained that should they decline then their wishes would be respected. None of the children refused. It is worth noting however, that one child was reluctant to come downstairs to have their wound dressed. When they were persuaded to come downstairs I was careful to take the time to ask if they minded me being there. It transpired that I was not the problem, the intended wound dressing was.

3.10 Approach to children's community nursing team

As with the children and families, other members of the children's community nursing teams were not the focus of the study. However, it was important, and polite that they were fully informed of what I was doing. The children's community nursing teams' managers were asked to forward my research proposal and information sheets to all members of the participating children's community nursing teams. They were also invited to ask me any questions regarding the study.

3.11 Benefits and Harms

Research relationships should be based on trust and integrity and sound ethical principles (Royal College of Nursing (RCN, 2009). According to Beauchamp & Childress (2008) beneficence is to act "for the benefit of". Although the participants did not stand to benefit directly from being involved in the study, they understood that the findings could be used to inform the integration of other newly qualified children's nurses' into children's community teams. However, an unexpected but welcome consequence of their involvement was the feeling of satisfaction that they reported from talking about their experiences; which they found cathartic.

There was always a potential that I would observe practice that was below par or that I would witness unacceptable behaviour, especially that which could be detrimental to the welfare of the children and young people. As a registered nurse I have a professional responsibility to the NMC (2008), and I have a personal and moral obligation to intervene to act in the best interests of children and their families. Had I needed to intervene to prevent harm I had planned to ask the nurse to discontinue what it was that was of concern and ensure that a careful explanation was communicated to the children and families involved. Necessary actions would have included the reporting of the incident to a senior manager of the service and to the Associate Dean for Health and Social Care Research at the University of Salford. Poor practice that would not have caused immediate concern for children's welfare would be discussed with the participants after the visit, and reported to the nurse and the senior manager of the service. None of these situations occurred. These processes were explained and agreed with the participants beforehand.

Another possible harm to the participants, although extremely unlikely, could have been emotional distress. This could have occurred following conversations or interviews during which personal information could have been divulged that could subsequently result in loss of privacy (Long 2007). I informed the research participants of this risk prior to any data collection activity. It was agreed that I would offer support through debriefing – checking how they felt after any conversation, and if necessary, refer them to an appropriate supportive network, for example their preceptor, the NHS trust counselling services, or other relevant organisations such as the Royal College of Nursing counselling service.

A further possible harm was the potential for added stress for the children from an additional person being present whilst the participants carried out their work. To engender trust and reassure the parents I made sure that they were made aware of my credentials and told that I a Criminal Records Bureau check had been undertaken and was available for them to check. My safety and that of the research participants was assured by adhering to the participating NHS Trust Health and Safety Regulations as recommended by the RCN (2009) and seeking ethics approval from the University of Salford and the NHS Research Ethics Service.

Children, young people, families and participants were made aware that should anyone disclose that they were at risk of harm or being harmed, or that they had intentions to harm others, I would have to report this to the appropriate authorities. Any researcher has a duty to take steps to protect children. Researchers work within the law and the principles of child protection and safeguarding children apply (Children Act 2004, Working Together to Safeguard Children 2006). Fortunately no such incidents occurred.

3.12 Ethics Approval

Prior to any work taking place ethics approval was gained from the University of Salford's Research Governance and Ethics sub-committee (RGEC07/109). Recruiting participants from National Health Service (NHS) settings also required adherence to the principles of the NHS Research Governance Framework for Health and Social care (DH 2005). National Research Ethics Service approval was gained. As this was a multi-site study, permission was gained from the Multi-Centre Research Ethics Committee (REC reference number 08/H1013/69). NHS Research Governance Approval was also sought. A total of 7 NHS trusts in which recruitment for this study took place came under the remit of the Primary Care Trusts ReGroup, and NHS

research and governance approval was gained (08/H101/69). The other 3 trusts gave approval separately. This approval was subject to satisfactory enhanced criminal record bureau check (see earlier discussion) and indemnity insurance (provided by the University of Salford). Of the 10 sites involved in this study, 1 required an honorary research contract and research passport to be negotiated.

The process of gaining ethics approval was unwieldy and time consuming. While it could be argued that there is a trend towards an emphasis on approval by a committee rather than on self-regulation and acceptance of personal responsibility in research, recent research catastrophes have marred the image of research in the NHS. Still, commentators such as Long and Fallon (2007) suggest that a common view of research ethics is one of a troublesome barrier that has to be negotiated before the real business of doing research can begin. Murphy and Dingwall (2007) also express the view that the practices of ethics approval are bureaucratic and create barriers for researchers. However, the regulations are clear, and approval was sought even though this meant applying for approval to NHS trusts from which no participants were recruited. The only inconvenience in my case was the time element and the fact that permission was applied for in sites where no research was undertaken.

3.13 Informed consent (1) Research participants

Following initial contact with the potential participants I arranged a meeting to discuss the research. At this meeting the risks, benefits and alternatives were explained to them (RCN 2005). Written informed consent was obtained from all the nurses before the fieldwork observations or interviews took place. Clear written details of the study in the form of a participant information sheets were provided again via email, prior to the briefing meeting taking place. At no time were they coerced to participate. Opportunities to withdraw from the study were reinforced prior to

each subsequent field visit, which, as noted by Hoeyer *et al.*, (2005) is considered to be good practice. It was always possible that a research participant could give their consent to be involved, but later change their mind. Had they done so their decision would have been respected and any of the data related to them identified and removed from the study. However, no-one withdrew from the study. .

3.14 Informed consent (2) Children, Young People and Families

Seeking consent from children remains a contested matter. However it is generally accepted that consent from children should be sought and they should be given a voice. Given this, I decided to follow Alderson & Morrow's (2004) and Coyne's (2010) lead and use the term consent to communicate those procedures that I used when seeking permission from the children regardless of their age. However, both suggest that the pragmatic step of seeking permission from parents before approaching children is advisable. Current guidance on research advises researchers to seek parental consent before involving children and young people less than eighteen years of age (DH 2009). Therefore the consent of the person with parental responsibility was sought using the definition for this provided in the Children Act (1989) and the Adoption and Children Act (2002). This was obtained in both verbal and written formats. It was made clear to the person with parental responsibility that they could agree or refuse to allow an observation of the participant to take place in their home without any impact or adverse consequence on their child's care and that if they initially agreed they were also entitled to change their mind and withdraw their consent at any point.

Coyne (2010) notes that, as far as the Gillick principle is concerned, children's consent to research has not been tested in the courts. However, current guidance from the National Patient Safety Agency National Research Ethics Service (2007) suggests that in research studies not

governed by the Medicines for Human Use (Clinical Trials) Regulations (2004) the principle of Gillick competence for research in the UK can be applied. Therefore children who are considered to be competent to understand the aims and intended consequences of the research can make decisions and can give consent on their own behalf. That said, current guidance suggests caution when working with children of 10 years and younger. In this study, the principles laid down in *Gillick v West Norfolk and Wisbech Area Health Authority* 1985 and Fraser guidelines, was dependent on several factors including the child's ability to understand and retain the information to make a reasoned and autonomous decision to allow me to observe their care as discussed by the Department of Health (2009).

3.15 Informed Consent (3) Staff Members of the Children's Community Nursing Teams

As with the children and families, other members of the children's community nursing teams were not the focus of the study, however the same principles of consent applied to them. Their informed consent to be observed working with one of the research participants was sought prior to any field work taking place. Information about the study was made available to them in both a written and verbal format. In addition, briefing meetings were held prior to any data collection taking place. The team members gave verbal and written consent for their involvement. Their participation was voluntary and they were assured they could withdraw from the study at any time. No-one withdrew.

3.16 Confidentiality and anonymity

Procedures to maintain the confidentiality and anonymity of the research participants, children and families, and members of the community teams were followed throughout this study. The DH (2003) Economic Social Research Council (2006), Williamson (2007) and NMC (2008) all emphasise the need to protect confidentiality and anonymity. Data storage was compliant with

the Data Protection Act (1998) and the Caldicott guidelines and the DH (2003). Digitally recorded interviews and conversations were transferred to a password protected computer as soon as possible, but always on the day of data collection, with access restricted to the researcher. All but one of the interviews and digitally recorded field notes were transcribed by professional secretarial services working to high standards of legal and medical ethics. I transcribed the other myself. Pseudonyms were used for all participants. Non gender specific pseudonyms have been used to protect the identity of the male participant. However, it was also necessary to avoid unintended disclosure of the male participant's identity through the use of gendered personal pronouns such as 'he'. That said, removing all personal pronouns would have made the reading of the report unwieldy and for this reason female personal pronouns such as 'she' are used throughout.

Paper copies of the transcribed data were stored in a secure locked archive at the University of Salford; and kept separate from the signed consent forms. The data will remain in secure storage for a period of ten years (DH 2003), after which all paper records will be shredded and computer records destroyed. Supervisors were privy to anonymised data only.

3.17 The Study Context

The setting for this study was 4 children's community nursing teams' in the North West of England. Their workplace was diverse and covered a number of locations. These included primary health care centres in which the teams' offices where, the homes of children and their families, schools, and hospital wards. Having such a diverse range of settings further emphasised the benefit of spending time in the field with the participants whilst they engaged in their day-to-day work. Of particular worth was spending time with them in the car while they travelled between locations.

The model of service delivery in operation was the community care model described by Eaton (2000) and Carter and Coad (2009). This meant they were based in the community and provided care to children in a defined geographical location. The teams consisted of both specialist and generalist nurses. The specialist nurses amongst others included asthma and diabetes nurse specialists.

The care delivered by the teams included post operative care, wound checks, monitoring of home oxygen, home traction, removal of stitches and the administration of intravenous antibiotics. Other elements included the education of children, family and other care workers. Additionally treatment, support and training of the management of children with severe eczema, constipation, diabetes, complex epilepsy and children with complex needs such as those that required enteral feeding was also undertaken.

The working day for the participants usually started in the office, where the visits for the day were discussed and the allocation of visits organised. Visits were allocated to the participants by the shift leader via the team 'visits book' which listed the names of all the children who had a nursing need and those requiring nursing care during that shift. Their workload involved going to see children and their families in their homes. However, none of the participants worked in health care clinics during the field-work observations.

Team 4.

The participants in team 4 were employed by a primary care trust and worked seven days a week in shifts covering 8am till 8pm. The team looked after children and young people from 0-19 years and included nurses that worked in the special needs school and other children's community nurses that were located initially in the health centre in the village before moving to offices in a large, purpose-built building. The special needs school was a school for children and

young people that had special educational needs due to severe learning difficulties or physical disability, or those needing gastrostomy feeds, the administering of medications or treatment for epilepsy. These duties were usually covered by community nurses allocated to the school, but occasionally covered by other members of the team. Working hours were organised 7 in shifts from 8am-4pm or 12noon-8pm or 10 hour days.

Team 5

This children's community nursing team was based in an office on the first floor of a building which housed a centre for services for children with disabilities. The centre and the children's community team were part of the local primary care trust. The office was shared between a team of nurses caring for children with disabilities, the children's community nursing team and a children's diabetic nurse specialist. Working hours were organised Monday to Friday from 8am-8pm with shifts of either 8am-4pm or 12noon-8pm.

Teams 7A and 7B

This team was a combined team but divided to cover two geographical locations. The nurses were employed by the same primary care trust. During initial fieldwork both teams were based in a health centre in a village. However team 7B later moved to a different location in the city when a new hospital based service including an inpatient facility and an observation and assessment unit for children and young people. There had been a tertiary referral hospital but this had closed as a result of the Making it Better (2006) initiative. Working hours were organised 7 days a week, covering hours between 8.30 am to 10 pm with two shifts within this period.

3.18 Data Collection

As noted earlier, my starting point was that observing others would enable theoretical insights into the cultural and social world of the research participants (Walsh 2004). Lauder *et al.*, (2008) maintain that perceptions are very different from actual behaviour, and that the scrutiny of behaviour should always be at forefront for those seeking to evaluate and understand experience. I contend that interviews alone would have limited the extent to which I would have been able to understand the situated context of the participants' experience and that spending time in the field with newly qualified children's nurses in their work setting would help me to understand more fully why they acted and behaved in the way they did. Savage (2000) supports this view and suggests that being placed in the same situation as participants in the field enables a deeper understanding of the informants' world, and that these methods are better suited to the discovery of personal knowledge than data collection methods which are restricted to verbal inquiry alone. In hindsight and in keeping with Kennedy (1999) I determined that observing the participants' actions and behaviour would enable me to probe the participants constructed subjective understandings, interpretations and meanings. In other words, it was not possible to understand the participants' interpretations and meanings separate from the context that framed their experiences. For me and in keeping with Mack *et al.*, (2005) field-work was integral to understanding the breadth and complexities of the participants' experience of transition.

Some of the decisions with regards to the amount of time spent in the field were based on logistics and pragmatics. I had scheduled a 12 month period for data collection but this was dependent on the participants' employment. I was also unable to spend time with them during their initial supernumerary period during which they worked with their preceptors as it would have meant 3 people going into the children's homes. However, I decided to spend two full

nursing shifts with each of the participants, each shift was approximately eight hours long. A strength of this was that I could observe the newly qualified children's nurses on a one to one basis.

I arranged to meet each of the participants at the start of their shift at the office. I travelled with them in their cars to children and families homes, and I attended meetings with them. I began the fieldwork with the idea that I would act as a "non-participant observer" (Wolcott 1999). While I did not intend that I should hide that I was a children's nurse, I did not want to take an active role as a nurse. I did not dress as a nurse and I introduced myself as a researcher. Interestingly, the participants generally introduced me to the children and families as a lecturer in the School of Nursing. I wanted to follow the participants through as many day-to-day experiences as possible without participating in specific nursing activities, or as termed by Johnson (1997) nursing care.

Savage (2000) explained that she wanted to learn as much as possible about the everyday activities of nurses in her study by participating in the same everyday nursing activities as her participants; however she also stated that there were limits to achieving this, because like me, she had not practiced as a nurse or been a newly qualified nurse for many years and therefore was not competent to attempt many aspects of the nurses' work. Koch (1994) and Savage (2000) add that that being a nurse researching nurses means that some of what is being observed may not attract sufficient research attention because it is perceived as normal. However, when I commenced this study I had no previous nursing experience as a qualified nurse in a community setting and I contend that the field was sufficiently unfamiliar to me to avoid me taken things for granted. Besides, it would have been inappropriate to carry out nursing care as my intention was

to observe the nurses' actions and interactions as part of their experiences of transition, not my own. I positioned myself as a 'marginal native' (Gerrish 1997) and as noted by Geertz (1973) as a researcher, I was not seeking to become part of the workforce but aiming to understand as fully as possible the participants' subjective interpretations and meanings.

However, it was always possible or desirable to be completely non participant. Chesney (2001) explains that the development of a research persona in the field is a unique and totally individual process. I found myself acting in different guises in different settings. Allen (2004) describes this as developing one of 3 potential social niches: the research as 'helper', the researcher as 'observer' and the researcher as 'shadow'. I came to understand that at times I acted in all 3 ways but that these elements were often acted out simultaneously. For example in the children's homes I attempted to act as an observer. I would stand back and observe, but when invited to join in activities and conversations by the research participants, children or parents, I did so. I acted as a helper when involved in interacting and communicating with children and families. One example to illustrate this occurred as I observed Tyler. The young girl with whom she was working became distressed and I tried to calm her.

However, I would add a 4th element to Allen's (2004) classification. An extension to the researcher as 'helper' was researcher as 'sounding board'. During time spent in the field I became involved in communication with children, families and other members of the children's community nursing teams. For example, a parent asked me to read a letter about her child's attendance at school, a father talked to me and told me how bad his son's wound had been and how this has had an effect on his child's education, and a mother told me about her daughter's bad experiences in hospital. Children accepted me and involved me in their worlds; for example a child took me into the kitchen to show me an object she had made. This meant I was able to

observe the interactions of the participants with the children and families while at times engaging on a more intimate level with the parents. Borbasi *et al.*, (2005) suggest that an advantage of being a nurse in a research setting is that it may be easier for a nurse to slot into the social setting of nurses' worlds of work. Feeling comfortable and confident in the social setting facilitates successful interaction (Borbasi *et al.*, 2005).

That said the field work observations were not without challenges. Like Allen (2004) and Allan (2006) my identity as a nurse and a lecturer at times impacted on my relationships in the field. I was already known to some of the participants and members of the children's community nursing teams. However, Roberts' (2007) comments were helpful here. In a response to Johnson's (2004) argument that it is difficult for researchers to study participants that are known to them, Roberts argued that this required careful consideration and skill. In my case the participants were no longer students but qualified nurses. The following example illustrates that Lee recognised this difference. Following an episode of field-work with Lee I had written in my field-work notes a comment made by Lee that "*was that alright, did that go well*"? It is possible that she was treating me as an expert academic as described by Allen (2004). In response I did as Roberts (2007) suggested by being as open and honest with her and I had stressed that my role was that of researcher rather than that of an academic giving feedback on her performance. However, there were also benefits to being known to some of the participants, as identified by Eraut (2000). I found that knowing them previously was an advantage rather than disadvantage and enabled me to quickly establish a rapport and trusting relationship with them.

3.19 Field notes

During the field-work recording and collecting data was undertaken in the form of field notes (Spradley 1980). Spradley (1979) and Atkinson (1992) identify that field notes are

transformations of experiences, observations and reflections in written form. Emerson *et al.*, (2001) describe them as writings produced contemporaneously in or in close proximity to the field. According to Lofland and Lofland (1995) jottings occur as a result of the researcher orientating their consciousness to remember happenings to be written down later in the form of unfolding mental notes.

As advised by Lofland and Lofland (1995) and Condell (2008) I initially made jottings of the fieldwork observations in the offices and cars immediately after the observation. I used a note book and recorded issues that happened in note form as they occurred. These notes contained partial descriptions of incidents, key words, or phrases to represent activities. It is worth noting here that I never wrote notes while in the families' homes as this would have been inappropriate. Rather I waited until I was in the car or back at the office. Substantive issues about what to record were guided by the research question and included foreshadowed issues identified in the literature (Mason 2002). I utilised a framework for the observation outlined by Whyte (1984), which is based on Chapple's (1949) work, and considers the questions "who does what? with whom? when? and where? Asking why is not included as part of this observational framework as it is suggested that the answers to the question why are based on inferences from the data.

However, it was impossible to make notes about everything that happened, but as Atkinson (1992) notes, omissions in field note texts are inevitable. Emerson *et al.*, (2001) explain that field notes are notes rather than descriptive accounts but involve an active process of interpretation and sense-making. They go on to advise that the researcher should focus their observations on events significant to the research in order to produce a written account. I did this by focusing on my observations and subsequent conversations with participants on their experiences and meanings attributed to transition along with the conditions that facilitated or

disrupted this. In addition, following each field trip, I digitally-recorded more detailed notes from memory and recall. Spradley (1980) refers to this as the expanded account which Fetterman (1998) also advocates. When doing so I was guided by Whyte's (1984) framework.

Informal conversations

Throughout the fieldwork the participants were eager to tell me their stories and offer me examples of situations that had been significant to them in relation to their experiences of transition. This was particularly noticeable in the car when travelling between visits, a time when we were alone. Allen (2004) records similar findings where nurses in her study into the role of nurses in the division of labour in hospital, talked to her during periods of observation. In my study, the talking was focused on their experiences of transition. What I at first understood to be little more than casual conversations became central to the development of my theoretical abstractions during data analysis. Spradley (1979) concurs, noting that both the researcher and the participants may come to realise that talking is more than just friendly conversation but that it has a purpose. Therefore a decision was made to record these conversations in my field notes and to include them as data.

Often the participants talked openly and freely about their work experiences during these journeys. Although I was surprised by this I was also grateful for their frankness and openness. Rather than simply telling me something, I came to understand that the conversations were used by the participants as a means to help them interpret and make sense of their experience. Crotty (1998) and Burr (2003) have argued that human beings construct their own version of reality as they engage with the world that they are interpreting. In this way, and as Denzin and Lincoln (1998) suggest these conversations aided my developing theoretical insights regarding what I thought was going on.

3.20 Interviews

Interviewing has been described as one of the most powerful ways to understand other human beings (Denzin & Lincoln 2000). I used digitally-recorded focused conversations as interviews in this study. This was congruent with my philosophical standpoint as the interviews provided an opportunity for the participants to give voice to their views, interpretations and understandings of events. Digitally-recorded face to face interviews took place with the participants during the fieldwork in order to add to and further my developing conceptual understanding. The interviews were an opportunity for me to explore the participants' subjective interpretations and meanings and, as Byrne (2004) noted, the level of insight gained from this would not have been possible from observation alone. As discussed by Hammersley (1992), relying on observation alone without talking to the participants would have risked misinterpretation of their actions.

A flexible interview guide (see appendix 12) was developed in order to provide a loose focus for the interviews; this was based on the research question and developed by what I witnessed and what the research participants told me in the field. This allowed for flexibility, greater depth and more sensitivity to contextual variations as suggested by Bloch (2004). In this way, the topic guide was tailored to each participant. The participants were also encouraged to raise issues considered pertinent by them during the interviews. An example of this occurred during an interview with Chris. She had told me during one episode of fieldwork that she though being newly qualified was considered as a negative attribute by other qualified staff. Following her lead, I asked her to expand on what she meant and why she had come to understand this in this way. This later enabled me to understand more fully that this was a disruptive factor to Chris' transition, but that this could be interpreted differently by different participants (see chapter 4)

Each participant was interviewed on one occasion at the end of the shift following the first episode of fieldwork observation with them. All digitally recorded interviews were transcribed verbatim to aid in the data analysis. The formal interviews took place at the end of the shift. The interviews lasted for approximately one hour and took place in a private room in the health-centres where the participants were based.

I undertook a total of 94 hours of field work over a twelve month period (April 2009 – April 2010), with 8 participants in 4 children's community nursing teams. (please see table 2).

Participant Pseudonym	Time of qualifying and date commenced in post	Observation 1	Observation 2	Employing team
1. Max	Qualified Sept 2007 Commenced in post April 2008	April 2009	May 2009	5
2. Chris	Qualified September 2008 Commenced in post September 2008	May 2009	September 2009	4
3. Jesse	Qualified and Commenced in post September 2008	June 2009	August 2009	7A
4. Lee	Qualified March 2006 Commenced in post March 2008	July 2009	Sept 2009	7B
5. Harley	Qualified March 2009 Commenced in post July 2009	October 2009	Feb 2010	4
6. Yan	Qualified and Commenced in post Sept 2009	February 2010	April 2010	4
7. Nasim	Qualified and post job Sept 2009	March 2010	March 2010	4
8. Tyler	Qualified and job Sept 2009	March 2010	April 2010	4

Table 2 Record of Field-Work Observations with Participants

3.21 Data analysis

Approaches to the analysis of qualitative data are incredibly diverse with different purposes derived from different ontological and epistemological understandings (Morse & Richards 2002). Despite that there is a general agreement that the analysis of qualitative data involves the use of analytical categories or themes to describe and explain social phenomena (Pope, Ziebland & May 2000). Nevertheless it is important that the process of analysis is transparent and this can be achieved by using carefully described principles and processes (Seale (2004). The importance of this cannot be overstated in relation to establishing the validity and rigour of the findings. This is discussed in more detail later. In this work I used both descriptive and interpretive analysis by combining aspects of framework analysis with qualitative thematic analysis across all types of data, as follows.

The main influences for the step by step approach that I followed were qualitative thematic analysis described by Braun & Clarke (2006) and the framework approach (Ritchie & Lewis 2003; Smith 2010; Smith & Firth 2011). I found the descriptions of both these step by step approaches useful not least because they helped me to manage the data and undertake the analysis in a logical way. Both methods are suited to the analysis of different types of descriptive data and can be used to highlight similarities and differences in the data set. In other words, combining these methods enabled me to present an analytical summary of the data in answer to the research question. In addition, the approach taken enabled me to make my interpretations and descriptions of the participants' experiences transparent and the interconnected and iterative stages allowed movement and enabled the description of the process in a systematic way (Braun & Clarke 2006; Smith & Firth 2011).

My data consisted of interviews and field notes, the field notes consisted of hand written notes and the additional digital recorded thoughts. These included snippets of the conversations that I had with the participants. The interview data consisted of digital-recordings and transcribed conversations. To begin, the data analysis was highly dependent on my immersion and familiarity with the data, but it was not a simple staged linear process, rather I engaged in an iterative process, repeating each step many times until I had derived the abstract theoretical insights presented in the findings chapters.

The first step in the analysis involved repeated reading and listening to the data noting early features, patterns and what I thought may be significant aspects. I also repeatedly listened to the digital-recordings of the interviews and field notes while reading the interview transcripts and hand written field-notes. I did this to develop an in-depth and detailed insight of the participant's accounts.

Organising the Data

The organisation of the field-notes for data analysis presented a considerable challenge. I decided to use a set of questions (framework) devised by Charmaz and Mitchell (2001). These helped me to organise the data. This required that I ask basic questions about the studied phenomena. (see figure 3). I used the questions to create a template (see appendix 13) that I then used to guide the initial organisation of data. An excerpt from the Yan's fieldwork observation data as an example of how this template was used can be found in appendix 14. This proved invaluable. In keeping with Charmaz and Mitchell's (2001) and Eraut's (2000) arguments using this template helped me to learn more about the content of the data, the work context, meanings and actions, structures and the participants' perceptions. However, this task was made easier as I

had spent a considerable amount of time in the field and had developed a good understanding of the context in which the study had taken place.

Figure 3 taken from Charmaz and Mitchell (2001) basic questions about the phenomena

1. What is the setting of action? When and how does action take place?
2. What is going on? What is the overall activity being studied, the relatively long term behaviour about which participants organise themselves? What specific acts comprise this activity?
3. What is the distribution of participants over space and time in these locales?
4. How are the actors organised? What organizations effect, oversees, regulate or promote this activity?
5. How are members stratified? Who is ostensibly in charge? Does being in charge vary by activity? How is membership achieved and maintained?
6. What do actors pay attention to? What is important, preoccupying, critical?
7. What do they pointedly ignore that others might pay attention to?
8. What symbols do actors invoke to understand their worlds, the participants and processes within them and the objects and events they encounter? What names do they attach to objects, events, persons, roles, settings, equipment?
9. What practices, skills, stratagems, methods of operation do the actors employ?
10. Which theories, motives, excuses, justifications or other explanations do actors use in their accounting for their participation? How do they explain to each other, not to outside investigators, what they do and why they do it?
11. What goals do actors seek? When, from their perspective, is an act well or poorly done? How do the judge their action – by what standards, developed and applied by whom?
12. What rewards do various actors gain from their participation?

I then applied the principles and procedures of thematic analysis described by Braun & Clarke (2006) following each step - organising the data, manual coding of the data, entering all codes into NVivo®, development of themes, reorganisation of themes and subthemes and producing the report, and aspects of the framework approach described by Ritchie & Lewis (2003) and Smith (2010) and Smith & Firth's (2011) later interpretation of this. Using this novel approach provided rich insights into individual accounts in the context of the participants' sociocultural world of work and subsequent and unique experiences of transition (Braun and Clarke 2006).

This was important as regardless of the debate concerning the value of specific criteria against which to judge the veracity, reliability or validity of qualitative data analysis, (see for instance Crotty 1998; Long & Johnson 2000; Patton 2002; Seale 2004) interpretive data analysis requires the careful documentation of a decision trail (Koch 1994) such that others can determine the extent to which the findings are consistent with and derived from the data. What follows here is a detailed description of the steps I took and my decision trail.

Manual coding of the data

The next step was to manually code the data. Seale (2004) noted that coding schemes emerge both inductively from the data itself and deductively from pre-existing concerns and questions evident in the literature or the researchers' knowledge of the topic. Coyne and Cowley (2006) advise researchers to read data transcripts, looking for incidents and facts which are then coded with a word or phrase. Coffey and Atkinson (1996) and Blaikie (2000) agree with this and describe this process as moving between theoretical concepts (transition) and the meaning assigned to the experience of this by the participants. I began by developing a manual coding index. To do so I followed the processes outlined by Charmaz and Mitchell (2001). This

involved reviewing all the transcripts, assigning labels to the component parts that seemed to be of potential significance. From these I created codes; these were a constellation of words or statements that related to the central meaning (Graneheim & Lundman 2004). The codes were used to represent the meaning of each section of data in a largely descriptive manner. Selective coding of the data was undertaken rather than line by line coding. Coyne and Cowley (2006) describe similar procedures. They argued that analysing each piece of data as advocated by Glaser (1978) is not always feasible. Charmaz and Mitchell (2001) also do not advocate line by line coding as some data consists of observed mundane behaviour for example with little contextual framing meaning that line by line coding may not make sense of the whole story. I also decided to begin the analysis by working with one participant's (Max) interview before checking what I thought might be happening by comparing this with other aspects of the data. The analysis of the interviews was undertaken contemporaneously with the analysis of the field-notes. When similar situations or meanings were identified by the other participants or identified in the field-notes the same code was assigned. As suggested by Corbin (1986) codes were placed in the margin of the text. However, initially, some sections of the data were assigned to more than one code (see figure 4).

Figure 4 Excerpt from a coded interview

Code	Interview data
<ul style="list-style-type: none"> • Lone working • Safety 	<p>Yeah, you're on your own, you haven't got any other nurses around you, they're at the other end of the phone if they're available, but you are solely on your own so you've got to be aware of that fact. Safety for yourself and safety for the ... if there's anyone else in your car, and safety for the people you're going to see as well. So it's making sure that if anything does happen you know what to do while you're there. And if you're not happy at going in then don't go in and let someone know. And just letting people know where you are, and if you're going to finish late let them know when you've finished as well.</p>

It became clear that the process of analysis had already begun in the field and was evident in my field notes. This was especially noticeable as I develop both inductive and deductive coding that was relevant to the field-note data. According to Braun and Clarke (2000) engagement with the literature can enhance the analysis by sensitizing the researcher to the more subtle features of the data however some argue that early reading can narrow the researchers' analytical field of vision. What I tried to do was relate the codes to the participants' individual experience observed during the fieldwork and, from their informal conversations with me throughout the fieldwork as advised by Charmaz and Mitchell (2001). It became clear (as noted earlier) that in these informal conversations, issues raised by the participants were related to the concept of transition. For an example see figure 5.

Figure 5 excerpt from a coded field note observation

Code	Field note text
<ul style="list-style-type: none"> • Newly qualified/new starter label • Confidence (code generated from the participants' data but also evident in the concept of transition) 	<p>Chris tells me she has a positive attitude about herself but she does not always feel the team recognise that. She is positive and confident about her skills but she feels the team see her just as a newly qualified nurse</p>

Initial manual coding resulted in the identification of 65 codes. Alongside these I had written memos. As suggested by Corbin (1986) and Strauss and Corbin (1998) memos were written alongside this coding process. The memos were used to explain what the codes meant and they represented the early stages of my analytical thinking. The writing of memos was useful as they helped me to articulate recurring themes noted in the data. They were useful as both analytical and reflective tools as they enabled me to continuously challenge my descriptions and early conceptual interpretations of the data to make sure that all alternative explanations had been explored. This was also in keeping with the iterative process of data analysis described in the framework approach (Smith & Firth 2011).

Entering all codes into NVivo©

The purpose of this stage was to organise the data and illuminate similarities and differences between the data sets in order to explain key features. Alongside the manual coding of the data this enabled me to thoroughly examine the data and my initial construction of theoretical explanations for what was going on. NVivo© was then used to pool and manage the large amounts of coded data which helped me to make sense of the whole data set. It aided in sorting and arranging the information (QRS International⁷ 2012). It is possible for codes to be generated in NVivo©, however I did not do this.

Prior to the study I had not been familiar with using computer based software packages to organise data. As part of my PhD training I was fortunate enough to attend a two day Nvivo© workshop this illustrated the usefulness of such an approach. As I had a considerable amount of text based material that might have been difficult to organise and make the necessary

⁷ Available at <http://www.qsrinternational.com/>

comparisons that were necessary Nvivo© proved useful. It enabled me to establish all the coded instances together in an index system. These indexes were then reviewed to uncover the meaning of the code across all the participants' account. As described by Bryman (2004) Nvivo© invites the analyst to think about codes and combine all the instances of the codes in the data and possible connections between the codes. It does not however replace interpretation of the data. During this process the links are still being developed and refined.

Development of themes

The next step involved searching for patterns in the codes and reduce this in themes arising from and associated sub themes from the data. Mason (1994) advises researchers to search the data for a set of themes and to develop analytical groupings and index the data accordingly. At this stage it was also useful to consider the different levels of themes so this was organised as a system of an overarching theme and the subthemes within these as described by Braun and Clarke (1996). However, the serendipitous nature of this process should be acknowledged. Fine and Deegan (1996) coined the term “analytical serendipity” to describe how researchers may *‘establish linkages without being certain of why they make sense’*. They suggested that *‘ah-ha’* moments represented developing insights. For me, the decision to use knowledge derived from the literature and from the participants insights helped to reveal important links and patterns to enable me to make sense of what was going on. Like Livesley (2013) for me, the *‘ah-ha’* moments sometimes came during my field work or discussion with my supervisors but they were also revealed during my analysis and through the use of pictorial diagrams. As suggested by Mason (2002) pictorial diagrams or thematic maps were constructed as analytical tools to help me understand and describe all the dimensions of the theme and subthemes. They enabled me to

unpick and spot connections between the elements involved in the subthemes. An example can be seen in appendix 16.

Reorganisation of themes and subthemes

This stage involved the final analysis and writing up of the thesis. I continued to move back and forth across the data until a coherent account emerged which was consistent with the framework approach (Smith & Firth 2011). Figure 6 shows an example of the reorganisation of themes into overarching themes and subthemes.

Initial codes	Initial overarching theme	Initial Sub themes	Final sub themes	Final overarching theme
Preceptorship Learning Training Accountability Advice Confidence Support Preparedness Shadowing Expertise Gatekeepers Feedback Experience/exposure	From Shadowing to Independence	Shadowing Variety ideal Protection Moving to independence Having a choice Feeling ready Support from a distance Having time and making time Developing competence and confidence Independence	Protection versus surveillance Starting from scratch Being signed off - assessment of competencies as a key milestone to lone visits	Shadowing

Figure 6 an example of the reorganisation of themes into overarching themes and subthemes.

Figure 7: Steps taken in the qualitative data analysis from Ritchie and Lewis (2003) and Braun and Clarke (2006)

1. Establishing the data types for analysis	The field note data consisted of hand written notes and additional digital recorded thoughts. The interview data consisted of digital-recordings and transcribed conversations.
2. Immersion in the data	- Close reading of and listening to the data to immerse oneself in the data noting early features/patterns/significant aspects.
3. Organising the field work data	– using Charmaz and Mitchell’s questions to structure the data but also learn about the context, content, meanings and actions, structures and the participants’ perceptions.
4. Manual coding of the data	- by looking for incidents and facts which are then coded with a word or phrase. Codes were generated both inductively and deductively from the data
5. Entering all codes into NVIVO©	- allowed for focus on each subject in turn and details and distinctions made
6. Development of themes	- searching the data and codes for patterns to develop themes – arising spontaneously from the data and evident from transition theory.
7. Reorganisation of themes and subthemes	– themes and subthemes evolved and were refined
8. Producing the report	– to provide an account of the participants’ descriptions and interpretations of their experiences of transition based on the research question

Producing the report

According to Braun and Clarke (1996) the final task is to tell the story which convinces the reader of the merit and validity of the analysis. This next stage involved the refinement of the themes to ensure that what I had constructed provided a coherent picture that was firmly grounded in the data (Braun & Clark 1996). I chose to present the findings using illustrative data extracts to shed light on the participants' meanings, to contextualise the study findings, and enable judgements about the credibility of my work. I also attempted to do this so that the coherent whole made sense, demonstrated transparency and ensured a depth and richness of the participants' accounts and my observations. For me the final test of coherence came in the writing up of the thesis. However, for others who read this work, the final and most important judgement on coherence will come from their interpretation of what they read.

3.22 Introducing the findings

The following section of the thesis outlines the findings. The findings reflect the participants' perceptions of their transition by charting their journey from '**shadowing**' established children's community nurses through to independent **visiting**. It also involves the **challenges of working in a community setting** and their **emerging identity** as a children's community nurse.

Chapter 4 Shadowing

This chapter considers the notion of ‘shadowing’ or working closely with a qualified member of staff. In this study, shadowing marked the initial experience of transition and was a type of closely supervised working interpreted by the participants as both beneficial and disruptive to their entry into the world of work. The shadowing experience is explored in terms of the development of their identity as a children’s community nurse and was implicated as a period of “movement” between supported, observed practice to more independent working. Here, key issues included the importance of the acknowledgement of their undergraduate experience by established staff and the difficulties they had with ‘starting from scratch’. A further issue during the shadowing period related to the participants perception of the support they received, or their perceptions of the role of their preceptor. There were times when the participants interpreted this in terms of ‘protection’ while at other times they perceived this as ‘surveillance’ which was considered to be less helpful by some. These issues are then contextualised in terms of how the participants considered them helpful or disruptive.

The shadowing period also introduced the notion of the achievement of milestones. Therefore their interpretations of their experiences of being assessed as competent to begin to undertake visits independently are also considered in this chapter. Their experiences are also considered with reference to the completion of the ‘tasks’ of transition or what van Gennep (1960) termed the “rites of transition”. This involved the appropriation of the customs, rituals and stereotypical behaviours associated with the new social position of being a children’s community nurse which brings about a sense of order and the

communication that the participants were starting to appropriate the most cherished values of the new group. For van Gennep (1960) an individual could not pass from one social position to another without going through this intermediate stage. An important aspect of the analysis presented here was my developing conceptualisation of an *ideal experience* of transition. This is threaded through each of the findings chapters and considered in more detail in the final discussion.

4.1 Shadowing

In the UK the essence of the system of support for nurses has been the allocation to each newly qualified nurse of an experienced practitioner working in the same setting (preceptor) who would provide support with the transition from student to registered nurse and assist with the development and consolidation of knowledge and skills (UKCC 1993, NMC 2006, DH 2008, DH 2009). This has been identified as essential in ensuring a smooth transition from student to professional practitioner in the world of work. More recently, the DH (2010) Preceptorship Framework for newly registered nurses, midwives and allied health professionals acknowledged shadowing as an aid to professional development during the transition period.

In observance with this guidance, all the participants in this study had been allocated a qualified nurse who acted as a preceptor, supervising them during a period of supernumerary practice at the start of their employment. During this period they spent most of their time on joint visits to children and families' homes with a qualified nurse who was a member of the children's community team, this was usually their preceptor. They termed this 'shadowing' or a time to observe established members of the team and to develop

knowledge, skills and job specific competencies under supervision before going out on visits on their own. This was consistent with the description of ‘shadowing’ discussed in the literature review.

This was a time that was generally seen as beneficial by the participants. As Lee explained in an interview:

“It’s the time period between you being the student nurse and actually becoming independent in your job and doing what you’re meant to be doing. So it’s that sort of period where you’re going from being a student, where you’re coming into your preceptorship period, where you’re being supported, where you’re supernumerary and you’re just watching what’s going on and you’re learning about the job and what they’re doing. It’s sort of that period where you’re still not quite independent and working on your own and from being a student nurse” **Lee.**

Lee explained here that shadowing is experienced by her as a period of movement between being a student and becoming independent or a time of being supported whilst watching and learning. By stating that she had “gone from being a student” Lee acknowledged both “movement” (Meleis *et al.*, 2000) and a “rite of separation” (van Gennep 1960) consistent with the rites of passage that an individual undergoes as they pass from one defined position to another. Chick & Meleis (1986) suggest that such awareness is a universal property of transition and indeed suggested that to be in transition a person must have some awareness of the changes taking place. According to Meleis *et al.* (2000) transitions are actually characterised by such movement and significantly, they follow a time trajectory. Acknowledged as processes that take place over time, transitions have been discussed with reference to newly qualified nurses’ experience as a series of stages (Tryssenaar & Perkins 2001; Dearmun 1997; Newton & McKenna 2007; and Boychuk Duchscher 2007). For these participants, commencing the period of shadowing defined the start of them separating from

their previous identity as a student nurse and symbolised their movement towards becoming a children's community nurse

4.2 Protection versus surveillance

However, this period was not without problems as the participants described a tension between the feelings of protection from facing potentially difficult clinical situations on their own – which they welcomed; compared to the discomfort associated with being watched. Here, Nasim, Tyler and Jesse all acknowledged the physical presence of a preceptor as supportive.

“I think in terms of support from colleagues, I feel as supported as I was as a student, I'm quite lucky really” Jesse.

“We have been supported ... as newly qualified ... a lot and you're always guided ... you're always shadowing a nurse or the nurse is shadowing you” Nasim.

“It was a case ... we were very protected for three months and then we came out of that supernumerary period” Tyler.

Jesse compares this to her time as a student giving some indication of the level of protection she felt, and that she was “lucky” implying that this kind of protection was not available to everyone. The opportunity to undertake joint supervised visits was seen as a distinct advantage, giving an opportunity to build on knowledge in a protected environment which in turn increased their confidence:

“I think having preceptors and being able to do joint visits was an advantage most definitely” Max.

“I think that's helped me to grow in confidence, that experience of being supported has helped me grow and certainly it's helped me build on my knowledge” Jesse.

The benefits of supervised practice during the initial stage of a new post is a very well documented aspect of transition and this type of support has been widely recognised as a

process that helps to ameliorate negative experiences of transition (Kramer 1974, Boychuk Duchscher 2007). Studies by Gerrish (2000); Jackson (2005); Leigh *et al.*, (2005); Beecroft *et al.*, (2006); Maben *et al.*, (2006, 2007); Berridge *et al.*, (2007), and Clark and Holmes (2007) all support the notion that good formal support is highly valued by newly qualified nurses during their experiences of transition since it has a significant impact on their ability to cope with the demands of the job and is thought to lead to perceived stress reduction. Similar findings are also found in studies of midwives, other health care professions and doctors who also value support from senior colleagues during transition. Here, effective support is reported to have a significant impact on the ability to cope with the demands of the job and increase confidence levels where the preceptor helps with assimilation into the new role (Amos 1999; Gerrish, 2000; Brumfitt *et al.*, 2005; Jackson 2005; Beecroft *et al.*, 2006; Maben *et al.*, 2006; Berridge *et al.*, 2007; Clark & Holmes, 2007; Lauder *et al.*, 2008; Thomas *et al.*, 2008; van der Putten, 2008; Morley, 2009; and Brennan *et al.*, 2010). Similarly Godinez *et al.*, (1999) claim that having regular contact with a supervisor for feedback, advice and answering questions helped during the initial transition period, which in turn, leads to a reported increase in confidence in clinical skills (Bick, 2000; Berridge *et al.*, 2007). The findings in this study therefore reflect the findings in the literature which support the notion that the physical presence of a preceptor as a supportive individual helps newly qualified nurses during their transition.

For these participants, one of the benefits of the shadowing period appeared to be related to allaying their anxieties associated with being accountable, described by Max as “a big cloud”:

“As we were coming up towards qualification there was kind of this big cloud stuck up here with the big word accountability written on it and that was quite scary”. But when I did start work because of the induction process and because I was able to go out with more senior members of staff all the time it wasn’t that scary”.

Here, Max described an acute awareness of a perceived increase in accountability associated with qualification and that this provoked a negative emotional response. Anxiety associated with accountability amongst newly qualified nurses has been discussed by Gerrish (2000) and Whitehead (2001). They suggested that newly qualified nurses' perceptions of their transition experiences were strongly linked to the concepts of responsibility and accountability and that perceptions of increased accountability are reported as a stressful aspect of transition. This is because they perceive themselves as not being fully prepared for the change from being a supervised individual with responsibility for their own actions to an individual fully accountable for their own actions. However it is clear from the quote that Max's worries and concerns were not realised at this point which she attributed to the period of shadowing where she enjoyed protection from the stress of accountability through the physical presence of a senior member of the children's community team.

The period of shadowing during the initial stages of transition was therefore a facilitator in the process of transition for these participants and, a number of factors were implicated in this. They felt protected – particularly from the pressure of accountability, gained support from the physical presence of a preceptor or senior member of staff, and were able to benefit from being guided in order to develop their knowledge, skills and confidence. This period therefore appeared to act as a buffer against the detrimental reactions experienced by other newly qualified nurses described by Kramer (1974), Gerrish (2000), Whitehead, (2001), and Boychuk Duchscher (2007).

Significantly, the participants also compared their experiences favourably with their colleagues who were working in acute care settings, as Tyler illustrated:

“From speaking to some of my friends who have been dumped right into the deep end basically and left to it, I’m glad, because I’d rather have somebody there for support and do things right than to be left to my own devices and do something wrong”.

By describing colleagues in the acute clinical setting as “being dumped into the deep end” and “left to it” implies that they received little, if any support. The use of such idioms have been reported repeatedly to describe the feelings of newly qualified nurses during the initial stage of the transition process in acute settings, for example both Dearmun (1997) and Amos (2001) reported that nurses felt as though they were “thrown in at the deep end”. Ellerton and Gregor (2003) described “surviving” and “just holding my head above the water”. In comparison, the participants in this study did not use such expressions, indicating that this was not their experience. Rather, they acknowledged that the model of supervision used in the community served to protect them from over exposure or lack of support in clinical situations which created a safety net in the event of mistakes. The participants saw their supervisors’ presence as a benefit, protecting them from being put in a position beyond their competence. This mirrors Lauder *et al’s.*, (2008) findings that new graduates are aware that they need high levels of support and that newly qualified practitioners working in the community reported greater satisfaction with all the sources of support compared to those working in acute settings. That said, it is difficult to ascertain the optimum amount of time that newly qualified nurses should spend in the physical presence of a preceptor or mentor. It is fair to suggest that for many newly qualified nurses, the preceptorship period may be cut short due to competing work pressures. For example a review by Hancock (2002) found that the 4 week supernumerary period recommendation in a preceptorship programme for

neonatal nurses (NMC, 2006) was not always completed due to lack of availability and time commitments of qualified staff. Furthermore, this is often a cause for disappointment amongst newly qualified staff (Robinson & Griffiths 2009). The findings reported here contest this and they present a significant challenge to established assumptions that community teams, including children's community nursing teams, have insufficient staff and time to adequately supervise newly qualified nurses appointed to posts in the community as first post destinations.

However, the participants did not always find this helpful, and as noted by Tyler the presence of a qualified nurse during the shadowing period was at times unwelcome and perceived as unwanted surveillance;

"But when I first started it was literally there was somebody over your shoulder, observing you, which is good, but it didn't do much for my confidence, I'll be honest. So at first, it was frustrating, because the things that I could do, it was like they were there all the time, looking over my shoulder, but I am glad of it now. Stuff like the asthma where I felt very confident to do, because I was very protected and people were very worried because I was on my own and then I don't work, I'm a lot more relaxed doing stuff on my own, whereas I think if someone's watching over me, I do become a little bit paranoid and I start stammering and doing things wrong because I'm thinking, I become very nervous."

It seems that Tyler understood the benefits of the system but that this also had other implication for her developing confidence. Whilst feeling perfectly capable and confident to undertake some aspects of care on her own, she interpreted the surveillance by other team members as a signal indicating a lack of confidence in her ability. It is possible that this could have disrupted her progress towards moving to the next stage of transition.

Furthermore, whilst some of the participants reported the benefits of spending most of the time with the same preceptor, not all the participants valued the support of just one person

in the shadowing period. For example Chris thought this was a limitation to her development. She thought it could have been of more benefit to spend more time with other members of the team.

“I think you’d get a better picture of just different practice as well and you wouldn’t feel like I said you’re just regurgitating everything”.

Consequently observing *different* styles of practice and how a *variety* of people delivered nursing care was viewed as being helpful in learning to develop their own practice. The participants interpreted their experiences such that they viewed working with different nurses as positive as it gave them a variety of models of practice. They also viewed being restricted to working with a single nurse as a risk. Which they viewed as problematic.

It is clear from the data that the shadowing period was a time during their transition that involved close working with another, more experienced nurse. The participants recognised and described this part of their transition as a period of movement between supported, observed practice, to more independent working. They felt “protected” from over exposure to potentially difficult experiences in clinical practice or positions beyond their competence. However, this was also experienced as unwelcome surveillance, or being “watched” which, although understood to be a necessary part of the process, led to feelings of frustration, evoking a lack of confidence which may have disrupted their transition.

Although the benefits of supervised practice have been well documented, it may be that the fine detail of the experience, that is, the feelings of the participants undergoing this could be explored further.

The analysis had led me to consider the notion of an “ideal” model of supervision for this stage of transition. It could be argued that some aspects of this ideal experience of transition

are already well known, such as the importance of the physical presence of a preceptor, which affords protection, and to be supernumerary to learn about the job before being placed in a position beyond individuals' perceived competence. However there should also be some acknowledgement that this stage may also involve less facilitative factors such as feelings of being watched which may serve to reduce or impact on the development of confidence and inhibit a smooth transition process. This suggests that any ideal experience of transition would need to take account of individual difference, differences in the interpretation of similar experiences and that individuals may move at different time scales. Furthermore, it may be that the ideal experience of transition involves the opportunity to observe more than one qualified nurse during this time as this was perceived as facilitative by the participants in this study. Observing the practice of different children's community nurses delivering care was valued and understood to be an advantage in the development of the practitioners practice as they had seen things from more than one perspective.

4.3 "Starting from Scratch"

A further difficulty experienced by the participants in this initial period was the lack of recognition of their previous experience gained during their undergraduate nurse education by members of the children's community nursing team. As Chris described:

"It's almost like putting down what I have achieved in three years at University to starting from scratch in community and not really being seen as being able to do anything really. I'd say it was more of you're in your third year being a student you're happy, you're confident you're seen as the top level of being a student and then once you've gone into being a nurse you're sort of back at the bottom it tends to be more of a negative thing ... that you're the newly qualified, and it is talked about in like a negative tone. I think as well you've done like a year and a half before you've even qualified of nursing experience. I think a lot of people forget that when you go into your first job depending how much you put into your nurse training depends on how much you know and competence".

Although positive and confident about her skills Chris felt that the team saw her as *just* a newly qualified nurse, failing to recognise her strengths or previous experiences which meant that she had to “start from scratch”. Chris realised that there was a difference between her perceptions of what it meant to be newly qualified and what this meant to others. It seemed to Chris that team members equated being newly qualified with a lack of experience rather than recognising the value of the experience of undergraduate nurse education. In part, Chris had gone through a change in status that involved moving from being at the *top level* as a student to now being perceived to be *back at the bottom* by her colleagues.

She not only recognised the change in status but experienced this change as a negative factor and attributed this to the lack of acknowledgment of her undergraduate community experience by established staff. Boychuk Duchscher (2007) and more recently Farasat (2011) highlighted the importance to newly qualified nurses of being valued by others in the clinical environment and that this can have a positive impact on confidence levels. They suggested that newly qualified nurses anticipate the fulfilment of being recognised for the knowledge and experience they have acquired during their undergraduate nurse education. What Chris illustrates is not only that the experience of starting from scratch disrupted her perceptions of the status that she *thought* she would be afforded at this stage, it illustrated that qualified staff attitudes to this were disrupting her transition.

Chris recognised that she was in a liminal state, which van Gennep (1960) and Turner (1988) describe as being on the threshold or margins. Being in this state during this stage can produce feelings of isolation and disruption to an individual. Indeed the acceptance of

the newly qualified nurse is thought to be a pivotal aspect of their developmental need to assimilate into the existing group (Boychuk Duchscher and Cowin, 2004). The perceived *lack* of acceptance of newly qualified nurses by their new group of colleagues may lead to marginalization (Boychuk Duchscher and Cowin, 2004) with newly qualified nurses on the periphery of the dominant group of seasoned nurses with whom they work. The idea of being placed on the periphery of the dominant group has been explored in the theoretical explanations of transition as marginalization (e.g. Meleis *et al.*, 2000; Boychuk Duchscher 2007) and is thought to be a condition that may inhibit transition. The term *marginal man* was originally coined by Park in 1928 to describe the assimilation of migrants into the dominant culture or as living between two cultures that have asymmetrical power. The concept was expanded in relation to transition to include the process through which persons are placed on the periphery on the basis of identities, associations, experiences and environments (Hall, Stevens & Meleis 1994). Boychuk Duchscher & Cowin (2004) applied the concept to newly qualified nurses and highlighted the perceived lack of acceptance by them into their new group. As van Gennep (1960) suggests, strangers need to be *let into* the group, and this is key for these newly qualified nurses because they desire the acceptance, respect and admiration of colleagues.

One of the main indicators that an individual has completed the transition stage is reformulation of their new identity and status (van Gennep 1960, Meleis *et al.*, 2000). In the case of the participants in this study entering the group and being afforded the status of being a children's community nurses has traditionally depended on being seen as having some post qualifying experience prior to entering the community. Entering the community as a newly qualified nurse troubles this tradition and disrupts the perceptions of the team in

relation to their status, this in turn hindered the participants' development of their identity as children's community nurses. Here, Tyler illustrates how being "newly qualified" was perceived by other members of the children's community nursing team in a fairly negative way:

"But when you are seen as newly qualified not from all of the staff but from some of the staff, well, what some members of staff did say to me is that they didn't agree with newly qualifieds in the community because they hadn't had previous experience".

Being newly qualified in this context was linked by the team to the participants' lack of experience and therefore lack of ability to act independently, which they may have perceived as reducing their value as a team member. In contrast, the participants valued their experience as student nurses not least because they had undertaken several placements within a community setting with health visitors, school health advisors and children's community nursing teams during their undergraduate nurse education. For example during the fieldwork Chris explained that she had undertaken a placement during her third year with the children's community nursing team in which she was eventually employed as a qualified nurse and Harley identified that her final placement had been within the children's community nursing team where she was employed. Jesse had also undergone 13 weeks as a final placement student with a health visitor. However, these experiences were not acknowledged by the established team members. The participants had to deal with the historical non acceptance of newly qualified children's nurses holding their first post in the community. This perceived lack of experience may have been a significant inhibitor to their transition as Boychuk Duchscher (2007) explains, during the initial stages of transition; if

newly qualified nurses engage in validating dialogue about their experience with their colleagues then this has a more positive outcome in terms of self confidence.

It is likely that the views of the qualified nurses reflected the traditional notion that the norm is to recruit nurses to the community only if they had a number of years of previous hospital experience; this was thought to “consolidate” the undergraduate educational experience and reinforced the view that a children’s community nurse was someone who had previous experience. In some ways this reflects Luker *et al*’s., (1996) assertion of the importance of distinguishing between fitness for practice and fitness for purpose. What this finding suggests is that the participants expected that they were fit for practice in some situations; however, the members of the team did not recognise this experience as being fit for purpose and that a period of consolidation was required. It is possible that it was a lack of contact and experience of working with newly qualified nurses in the community that led many experienced staff to assume that they lacked the relevant experience. At the same time the participants were disappointed that they were viewed as “inexperienced” as this seemed to disrupt their transition and subsequent development of their identity as a children’s community nurses.

Still, the participants in this study maintained that they had individual and transferable experience from their undergraduate nurse education that they thought could have been used in this setting to undertake some care activities independently, and that “starting from scratch” was unnecessary and disruptive. Arbon (2004) supports this view, defining experience as an individual, personal and transferable concept across different spheres of practice. In addition Arbon noted that the development of experience was not linear. Ideally, the participants in this study would have benefited from some recognition of their previous

community experience even though it occurred prior to qualification; the lack of recognition of their experience disrupted their transition

4.4 Being “signed off” - assessment of competencies as a key milestone to independent visits

Clearly then, there were differences in participants expectations of themselves and others expectations of them. Interestingly, in the literature this tends to be discussed most often in terms of the tensions between unrealistic expectations placed on newly qualified staff and the need for increased support and opportunities to consolidate skills learnt during undergraduate programmes (Brown & Edelman 2000; Evans 2001; Ross & Clifford 2002; Jackson 2005; Toal-Sullivan 2006; Thomka et al., 2008; Morley 2009a). These studies show that newly qualified practitioners value being given some autonomy to act independently but in the acute setting they are generally expected to *hit the ground running* (Lauder *et al.*, 2008) which reflect the often unrealistic expectations of others (Dearmun 1997, Trysennar & Perkins 2001 and Boychuk Duchscher 2007).

Significantly, this was not the case for the participants in this study. The participants were not expected to hit the ground running, indeed they felt that they were not expected to be able to do *anything* independently prior to being observed and assessed as competent. This meant that whilst the notion of informal observation may have been seen as problematic for some, the more formal process of observation - particularly of clinical skills, was welcomed. Indeed the participants regarded the development and assessment of competence in specific skills as an important part of their transition. More specifically, having their performance observed and being assessed formally as competent by a supervisor was a necessary task or a key milestone prior to working on their own; and was therefore a significant marker of

transition. The participants acknowledged that they were working towards mastery here (as explained by Meleis *et al.*, 2000) because they perceived that being assessed as competent would lead to them working independently as a children's community nurse. The competencies were in the main skills based, related specifically to the area in which they were working and developed from the specification of the job.

"That's basically just trying to give us exposure to as many things as we can.... So we never had to do visits on our own, we were always accompanying somebody. ..We have competencies to do like NG passing, gastrostomies and things. But no, it's really good, really structured."

Yan explained that not visiting on her own during the shadowing period and being given the opportunity to develop competency in certain clinical skills was valued and viewed as a positive aspect of her experience. The participants in this study recognised that being assessed as competent in the job specific competencies gave them the opportunity to develop their professional capability and facilitated their transition. According to Eraut (1998) the purpose of professional education and training (in this case after qualification) is to develop professional capability, which normally includes competence in a specified minimum range of tasks, roles and jobs required of the post.

Eraut *et al.*, 1995 found that frontloading of additional capability at the start of a career may militate against later conversion of that capability into practical use. In this study this was demonstrated and therefore may have improved their ability to demonstrate capability when they moved to working on their own. Several studies suggest the advantages of a bridging period during the initial stages of transition where newly qualified practitioners can gain experience and exposure to the required skills (e.g. Boychuk Duchscher 2007) and it is generally acknowledged that one to one relationships during these periods facilitates competence (Clark & Holmes, 2007; Luhanga *et al.*, 2010). Eraut's (1998) definition of

competence as the ability to perform the tasks and roles required of a particular job to the expected standard is useful here. The participants were exposed to these job specific skills, usually during the shadowing period. They then practised under supervision and were then assessed in terms of their ability to carry out the skill independently, leading to what they termed “signing off” as Jesse described:

“We have got to have observed, been taught and practised so it’s either your preceptor or somebody with experience”.

Achieving competence was something to work towards during the shadowing period, providing a time in which the participants could identify, learn and demonstrate competence in a number of key clinical skills. Similar findings were identified by Miller and Blackman’s (2003) study of 30 newly qualified nurses during their first three years of employment in hospital settings. They found that completing such competencies in the first year of employment seemed to give newly qualified nurses something to work towards and clarified expectations of them at this stage. In this study, having the job specific competencies signed off was a clear expectation where formal assessment of competence facilitated their transition.

4.5 Summary

This chapter has described the experiences of a group of newly qualified children’s nurses during the initial stages of their transition, termed by them and described in some literature as the shadowing period. This was a period where they were supervised by a qualified children’s community nurse and had the opportunity to be supernumerary. The participants

described the benefits and disadvantages associated with this period of transition which mirrored much of the available literature.

However what this study adds is that acknowledgement of their undergraduate community experience was a key issue as it fostered notions of acceptance into the group and facilitated their emerging identity as children's community nurses. Lack of acknowledgement of this experience by established staff impacted on their confidence because potential transferable experience was not accounted for, leading them to perceive themselves as "starting from scratch" which in turn hindered their transition experience. As identified by van Gennepe (1960) acceptance into the established group is an outcome indicator of a successful transition.

At this stage I started to conceptualise what they were telling me as an ideal experience of supervision which involved a balance between protection and surveillance during joint visiting to ease their feelings of trepidation, particularly related to increase in accountability, and being able to observe different styles of practice. They also welcomed formal assessment of their skills as this provided them with something tangible to demonstrate their movement towards working independently.

Chapter 5 Visiting

The previous chapter outlined some of the key factors that were perceived by the participants to facilitate or disrupt their experiences of transition. This was termed the shadowing period, where their day-to-day experience involved accompanying experienced qualified staff when they visited children and families in their homes. This chapter explores their experience of “the visit” in more detail, looking at what a visit entailed, how the movement from shadowing to independent visiting operated, how visits of a complex nature (or otherwise) were allocated and how this influenced the participants’ transition experience. This chapter explores the subthemes of progressing to independent visits, undertaking independent uncomplicated care, the benefits and challenges of having a caseload, continued support and the move to independent decisions.

The key issues to emerge at this time included the importance of exercising choice in terms of the timing of progression to independent visits, and how various allocation thresholds operated - such as moving from undertaking routine to complicated care, and from a restricted to a full caseload. These issues are discussed with reference to how they further added to my developing conceptualisation of an ‘ideal model’ of transition and how in part, this involved them in achieving the tasks of the transition.

5.1 The Visit

To set the context, each time the participants went to the children and families homes to carry out the required care they termed this a visit. The term “visit” was used freely and as shorthand in the day to day dialogue between the staff and the participants for the journey to

and from the children's homes and what they did while there. It was essentially work away from the children's community nursing teams' office.

The children were referred to the teams on their caseload from a range of sources including the local children's ward or the Accident and Emergency department at the local hospital, the main children's hospital in the city, and self referrals by parents or other health care professionals including General Practitioners and Health Visitors. The children's nursing needs were categorised according to either acute nursing needs or children with long term conditions. The working day for the participants usually started in the office, where the visits for the day were discussed and the allocation of visits organised. Visits were then allocated to the participants by the shift leader via the team 'visits book' which listed all the children who had a nursing need and required nursing care during that shift. Their workload consisted of visiting a number of children and families in their homes.

5.2 Progressing to Occasional Independent Visits

Once "signed off" a further significant milestone in the participants' experiences of transition was the undertaking of independent visits, that is, without being accompanied by another member of qualified staff. During and after the shadowing period the participants' working patterns changed. The majority of participants progressed to undertaking visits on their own as a gradual process which was managed informally, acknowledging that it took time to move from intense support to working alone. The participants were able to describe several factors that were facilitative and therefore 'ideal' in this process which included acknowledgement of the complexity of the case by qualified staff, and being given the choice about when the timing related to when they undertook independent visiting.

The complexity of the case

For this group of participants the time frame for the commencement of lone visits varied from a few days to three months, Max for example described undertaking a lone visit which was endorsed by the team, within the first few days:

“I probably went to see a (child with a) circumcision within the first few days because once you’ve seen a couple, what we do is a visit where I’d lead the visit and then the other nurse would stay in the background and once you’ve done that really then you could go on your own”.

Max described the process of being exposed to the experience of caring for children who had circumcisions during the first few days of her employment under the supervision of a qualified nurse, and explained that she had then being given the opportunity to lead the visit whilst still having supervisor support in the background. Max suggested that once this was achieved she could then go out on her own albeit occasionally. This highlights how part of the transition experience depended on the complexity of the case, that is, the clinical circumstances of the child influenced the decision. Here Max implied that the circumcision check was an uncomplicated procedure that required only “a couple” of visits to gain the necessary experience. Jesse also described the move to visiting on her own with uncomplicated care situations with which she felt comfortable;

“Some visits by then I was quite happy to maybe go out on my own and try a couple, you know, if they were just a wheezy episode, something that was quite, it wasn’t a long assessment or something where I needed a lot of knowledge which I didn’t particularly have at that time”.

The participants’ progression to occasional visits on their own was therefore partly guided by their allocation to and ability to cope with uncomplicated care situations – a decision they made jointly with their managers. Jesse described “being happy” to go out on her own

because of the perceived routine nature of the child's condition describing this as "just a wheezy episode" illustrating, as Clark and Holmes (2007) suggest, that experiences of transition that involve gaining experience result in increased confidence. The participants in this study felt confident to visit on their own to perform skills when they perceived they had gained experience and exposure. Clark and Holmes's (2007) also found that confidence increases with exposure to relevant clinical experiences during the initial stage of transition, acknowledging that there are individual differences in confidence levels during the initial stages of transition.

In contrast, some of the participants were reticent to undertake independent visits to care situations which they viewed as beyond their knowledge and skill capabilities. As explained by Nasim:

"We were in a team meeting once and two of the new starters had been going out on visits on their own to assess acute asthma patients, I hadn't done any and some nurses were of the feeling that those nurses shouldn't be out assessing acutely ill patients because acute asthma it's really hard to determine whether they're on the verge or not on the verge. And they were comfortable to do that and so the team leader was like 'Well if they're comfortable, that's their own registration, so they're doing it on their own back'".

When considering the assessment of children with asthma who were acutely ill, Nasim recognised her own limitations and explained that the team did not feel newly qualified nurses were experienced enough at this stage.

Clearly, for the participants in this study there was an individual time related aspect to reaching the milestone of moving to occasional lone visits. Some of the participants had made the choice to undertake these relatively early and others were more reluctant depending on the complexity of the case, supporting the notion that experiences of transition are not regularised or prescriptive (Glaser & Strauss 1971; Boychuk Duchscher 2007).

Choosing independence/when shadowing ends

Of further significance for the participants in this study was the importance of being able to *choose* when the progression to undertaking all visits independently (or the end of shadowing) took place. So for example Nasim had taken the full three months during the preceptorship period that she was allocated to continue on joint visits:

“I said ‘I don’t feel comfortable, I think I want to have my three months preceptorship and after that I’ll see how I do’, and I think if you’ve got that three month leeway, where you can follow someone, you might learn something in those three months of shadowing someone than you would on your own, so I prefer it like that I think”.

For Max, Nasim and Jesse, being allowed to exercise a choice to undertake lone visits at a time to suit their development needs was a facilitative condition of their experiences of transition (Meleis *et al.*, 2000). Max had opted for a more gradual approach and had started to progress to occasional independent visits almost at the start whereas Nasim described the three months almost as an entitlement and perceived this differently and she felt she might learn something. The important point here is that despite making different choices, they are actually able to exercise *some* choice, and valued this opportunity and element of control over the process. This emerged as an important aspect of the ideal experience of transition.

In contrast, one participant was given very little choice on one occasion:

“When I came back from that placement, because I was so nervous, they’ve put me down for visits on my own. I went, ‘I can’t, I can’t do them’, so one of our sisters, she said I’ll come with you so she came with me and I were fine, I just needed somebody with me for that day because I wasn’t feeling sort of the best, I just needed somebody and she said, it’s fine, you’ll be alright” Yan.

In this instance Yan clearly felt rushed and unprepared, describing that she was allocated rather than negotiated with and that she did not have a choice. Although her concerns

prompted a supportive response from the team the experience was disruptive in terms of her transition as it highlighted the difference between her expectations and the expectations of the team in terms of her capability.

However, expectations of undertaking visits on their own “too early” were not the only issue for the participants. Tyler’s account below seemed to suggest that waiting too long to undertake a visit independently can also be problematic. Tyler explained here that she felt that she could have undertaken independent visits earlier but wasn’t given the opportunity, and this inhibited her progress and movement.

“The visits that I felt I could have done a bit sooner, I wouldn’t have liked to have done it straightaway. I didn’t feel that I needed three months supervision really. Personally it wasn’t gradual; there was somebody there and then somebody wasn’t. I would have preferred it to have been eased off slightly. Obviously my friends said that it was the same when they qualified, they went from being a student with somebody there and then they qualified and then that’s it, nobody was there. So I am glad that I had somebody there, for a bit of support for me, but in some ways I felt like I could have done some things a bit sooner on my own”.

Interestingly, Tyler also expressed regret that her move to independent visits was not experienced as a more gradual process similar to the participants who had undertaken occasional independent visits during shadowing. Since she had opted to undertake joint visits for the whole three month period, when she made the move to independent visits this was experienced as a sudden loss of support similar to her colleagues in an acute care setting. Dearmun (1997) reported similar findings in her study of children’s nursing graduates’ perceptions of their first year of practice, where some of her participants reported feeling that their progress was delayed due to being allocated only to children with routine or uncomplicated care situations, whilst others reported caring for a number of children who were seriously ill and who had complex nursing needs after only two weeks and

subsequently felt too rushed. However, Dearmun (1997) did not report that the participants had any choice in this process, and this appears to be a significant facilitator in the transition of the nurses in this study as the following quotes illustrate:

“If I didn’t feel ready then I wasn’t rushed out, I still got to spend more time with different people and I only went out when I felt ready and when everyone else was confident that I was able to do my job. I think the help is the support network you get and with everyone letting you take your time and absorbing the information. Rather than just throwing the information at you and saying there you go, you get to take your time, especially in six weeks, you see a lot in six weeks. You get to go out with all the different teams and see what they do, and it just gives you time to absorb everything and not having to rush and feel rushed either, and panic thinking oh I’ve got three weeks left, I’d better learn this, that, and the other” Lee.

“Yes by the time I got here I was quite nervous but because it was such a gradual process I really felt at ease before I went out on my first visit own, the rest of the team are very supportive” Max.

Significantly, this quote highlights how the shock like reactions experienced by other newly qualified nurses as described by Kramer (1974); Gerrish (2000); Whitehead, (2001); and Boychuk Duchscher (2007) did not occur for the participants in this study. The participants discussed a number of factors that facilitated the process of transition which included spending time with a variety of experienced nurses, exercising a choice about timing of movement between points of progress and not feeling rushed. They also felt supported which developed confidence and averted feelings of panic. These issues all support the notion that the ideal experience of transition potentially counteracted or created the conditions to ameliorate shock like reactions. Aspects of this ideal experience of transition have some similarity to the recommendations made by Kramer (1974) and Boychuk Duchscher (2007) who suggest that the initial shock like reaction would be alleviated by a supernumerary employment period that would facilitate learning and practice skills without being encumbered by the overwhelming weight of responsibility that comes with managing

a full clinical workload. However, the participants' narrative adds detail to the factors that might facilitate transition during this supernumerary period.

5.3 Undertaking independent uncomplicated care

The next milestone in the participants' transition experience was the move from undertaking occasional independent visits to children with uncomplicated care needs, to undertaking all of their visits independently.

When the supernumerary period was completed all of the participants progressed to independent visiting. At this stage the participants' experience remained dependent upon perceived thresholds of capability and they were typically allocated visits to children whose care was thought to be within their level of competence and previous experience gained during the shadowing period. For example their allocations included children with acute nursing needs who required wound assessment and management, removal of sutures and children with chronic nursing needs such as constipation. The participants were therefore in the main situated in familiar practice situations during the initial stages of lone visiting which was dominated by less complicated care which offered them consistency, familiarity and predictability within their level of competence, skill, cognitive ability and experience. Boychuk Duchscher (2007) recommended that newly qualified nurses should be placed in familiar practice situations in keeping with their competence and capability levels in order to alleviate anxiety regarding independent practice. For the participants in this study, categorising the children in this way may have helped the participants' transition as there was nothing unexpected for them to deal with, as Tyler explained:

"You know a lot of our pathways, that we've done like the wound assessment and the eczema and the constipation. They are very quick, so it is literally tick boxes which you can do".

Tyler interpreted the recording of children's routine care on a care pathway as a tick box exercise, where the care pathway contained established pre-planned care, providing a manageable interaction because she could follow the care pathway which had been planned for her by the team. Yan also reported following this routine uncomplicated care by following guidelines and established instructions:

"So I gave the advice per the asthma guidelines that we use, no more than six puffs four hourly".

"Going in and introducing myself, asking what's been going on, are they okay, removing dressings, putting dressings on and assessing wounds when you see them and then redress it".

It was clear that initially some of the participants prepared themselves for a fairly circumscribed interaction that was based on the prescribed care identified in the care plan, encouraging the categorisation of the child in relation to the routine or uncomplicated task they were able to perform. The low allocation threshold at this point in their transition was ideal for them as it allowed them to carry out independent practice despite their relative inexperience because they could identify with a list of tasks and activities required. This included the giving of basic health advice on pre-planned established care as Lee explained:

"I think with things like the bowels and the eczemas that you don't tend to see on the wards, anyone with bowel ... well I never saw on the wards anyway, with constipation, eczema, so things like that where I can advise the parents on creams and medicines and routines and things like that, I've learnt just solely from being on this team".

At this point Lee felt able to give advice, but this advice was predetermined in that she had "learnt it from just solely being on this team" and at this point she was unable to move from the prescribed care. This was also observed during a visit with Lee to a fifteen year old child with constipation. On this occasion the child's mother had expected Lee to tell her the result of her child's blood tests as there was a potential diagnosis of coeliac disease. There was a

letter in the notes to this effect and the type of blood test the child had had, but Lee explained that she didn't know much about it when discussing it with me later in the car. Whilst Lee had read the child's notes she had focused on the care to be carried out in regards to the child's constipation, disregarding the other information that subsequently emerged during the visit. Due to her limited experience and knowledge base she had developed a strategy that included focusing solely on the identified nursing need which meant that the mother's needs related to a different problem were not met in this instance. She did however highlight that the mother would be able to find out the results of the blood test.

This illustrates how there were clear limits to the participants' clinical practice at this stage in their transition. This was possibly recognised by the experienced nurses who operated a threshold when allocating patients to the newly qualified children's nurses. Therefore, whilst they were gaining experience in one aspect of their transition - independent working, it was recognised that they were operating at a fairly low level of clinical complexity which amounted to the completion of set tasks which meant they were allocated to children who required routine, uncomplicated care. The emphasis was on being able to "go it alone". Despite being given the opportunity to undertake unsupervised visits, the focus on task based care rather than holistic care at this stage represented a relatively early stage in their transition; since they were limited in terms of their "mastery".

Performing routine uncomplicated care at this stage in their transition corresponds to Benner's (1984) and Benner, Tanner and Chelsa's work (1996). They identified that clinical situations reveal themselves to advanced beginners as inventories of tasks and skills that are valued and the priority is maintaining the planned schedules. According to Benner (1984)

advanced beginners have to concentrate on the rules of the prior experiences that they have had in practice, which they have been taught and that they operate on general guidelines. The data supports the benefits of this strategy of acting as advanced beginners for these participants. In a longitudinal study of early career professional learning of newly qualified nurses, Eraut (2007) established that they employed strategies to routinise their actions in their mode of cognition to help them cope and deal with the cognitive demands of practice learning. Boychuk Duchscher (2007) also identified that during the *Being* which she described as the second stage of transition, new graduates were comfortable with more common events consisting of stable client presentations to slowly advance their thinking and practice. Therefore it appears that the participants in this study were being allocated visits within their thresholds of capability which meant that they were able to slowly advance their thinking and development. Adding further to my developing conceptualisation of the potential for an ideal experience of transition derived from this work that could assist others during this stage of their transition to children's community nurses.

However, it may also be that the participants' focus on routine task based care is a consequence of the way that children's community nursing is organised. Indeed a study by Randall (2009) on children's perspectives of children's community nursing found that children's community nurses seem to have a task orientated approach. Randall (2009) observed children's community nurses practice and found that nurses seem to arrive at the children's homes, perform the allocated task and then leave. Therefore it may be that the participants were simply emulating the task based care they had observed during the shadowing period and that in this way they simply engaged in the custom and practice ritual

(van Gennepe 1960) in this case of children's community nurses practice which (perversely) may have enhanced their identity as a children's community nurses.

5.4 Undertaking complicated care

Whilst in the main the participants were allocated a contrived workload there were some complex visits to which the participants were allocated. For example they found visits to children and families with child protection or safeguarding concerns challenging as illustrated by Jesse:

“Well, it was a baby with suspected HIV, mum had HIV and she'd stopped taking her medicine whilst pregnant, so the baby was on some medication which we had to give twice a day for quite a while. And I went in and did the first visit, and mum had mental health issues, there was lots of concerns about mum and the family, grandpa was a drinker, and I went in and it was just all really quite daunting. I went to the hospital to meet them, and mum was really strange in the way she was. I was asked if I was alright to do it, and I was on the late shift, and I did feel a little bit obliged to say yeah, I'm fine, don't worry. And I think it just all ... when I went in ... because I was worrying as well about the baby, was the other child okay ... we were told that there was possibly another child in the house that they weren't aware of, so I was asking about that, and I think it was just a bit too much really for ..it was after about six or seven months, so it was quite a while, and I'd been going out ... But that was like the first referral I'd had that had that many concerns, there was quite a few, the main one being mum's mental state really and possible drug use ... it was just all a bit daunting”.

Here Jesse had been asked to go on a first visit which was not usually the case for newly qualified nurses and the complexity of the visit and the safety concerns about this child and family led to the realisation that even though she was six to seven months into visiting on her own her knowledge and skill capability was being tested. She perceived that she was being placed in a situation beyond her current capability at this stage of her transition. She had reassured the nurse who had allocated her to the visit that she was able to cope with this and had felt obliged to do the visit which illustrated that her colleagues had confidence in

her abilities. Whilst this increased her confidence it also intensified the pressure on her. Dearmun (1997) highlighted a similar finding, reporting that at nine months into the new post the participants in her study, whilst wanting to be stretched to develop their practice, were reluctant to volunteer to look after children who were critically ill questioning whether they had the capabilities and that those situations were daunting. Tyler explained that she had been supported by not being allocated patients with complex needs during the period of shadowing:

“and I have had a lot of support and I wasn’t given complex needs, so chronic patients until I did come out of my supernumerary period this year, so that did help, but it was a very daunting experience. I think just the thought and all the stories that you hear about in the newspaper as well, about the child protection issues and you think, “Oh I’m going to be out there on my own and if I don’t pick up on these”, it is very daunting, but that’s how it is.... And you can and do doubt yourself sometimes”.

She explained that had this had helped to ease her through to the next stage of working on her own. However now she was working alone she identified that she had apprehensions about her practice and being on her own and about missing areas of concern.

The added responsibility of child protection cases was particularly daunting for the participants when they were working on their own. For example Nasim told me during the fieldwork about a child who had been living with his father and his father had been abusing him. His mother did not want parental responsibility so he was now living with his aunty. Nasim had had to contact the social worker for information to do with this visit. She told me however that this issue was not her focus, her focus was the dressing. Although Nasim was aware that there were “*parental responsibility issues*” the focus of the interaction with him was the care of his wound regardless of the other needs that he may have had. This approach was also observed during a visit with Yan who asked a child’s grandfather where his wife

was and he told her she was in hospital having had a hip replacement. He tried to talk to Yan of his concerns about where she would sleep when she returned home and although Yan listened, she did not engage with this problem in any meaningful way, but focused solely on caring for the child.

This highlights that following the period of shadowing, during visits the participants sometimes found themselves in situations where they lacked experience. They expressed feelings of self doubt and lack of confidence in their ability and expressed that they had not had enough exposure and experience to be confident in these areas of practice. The two examples here illustrate the participants' tendency to focus on the routine and what they know about the care of the child even in complex situations. They focused on the expected and known part of the visit and although they were beginning to view the child in the context of the family they maintained their focus on the task.

However whilst these situations tested their current stage of development they recognised the importance of being exposed to experiences that they would be faced with as a children's community nurse as illustrated by Max:

“The emergency situations that you find yourself in, like finding that boy home alone that then allowed me to have exposure to social services and child protection. I did refer on to social services and the child protection nurse knew all about it so that exposed me to kind of another whole group of professionals. Going to children's houses and finding them poorly and having to phone 999 sharpens your skills it makes you think on your feet and gives you its good exposure”.

Max had found the child at home alone which had been challenging but she valued the experience as this had provided her with the opportunity to develop her skills in working independently. Therefore, being allocated visits based on their previous experience and

capability level was seen by the participants in this study as a facilitator and ideal as it assisted them to cope during their transition to becoming children's community nurses.

5.5 The benefits and challenges of having a case load

A further key milestone for the participants when they were undertaking independent visiting was being allocated their own caseload. In this context the term caseload referred to the workload allocation of children to individual nurses on the team and was an established role for members of the children's community nursing team. For the participants this included children that had long term or acute illness needs or chronic nursing needs, and those that were visited on a regular basis by the children's community nursing team, rather than short term visits to children with acute illness needs. Their caseloads were initially an allocation of children whose care was uncomplicated, and in fewer numbers than the established nurses on the team. The participants commented on the fact that at this stage they were not expecting or given the same number of children on their caseload as the other team members and compared their allocated workload favourably to the workload of their colleagues in a hospital setting:

“Yeah, it's a more laid-back environment where you can ... not ease yourself into it but you're not rushed into it like on a ward ... if you've got fifteen kids between three of you to look after”.

Here, Lee perceived that being allocated a lesser workload was helpful, alluding to an ideal of being “eased in” and again identifying with a community rather than acute care setting.

Alongside a reduced caseload (in terms of number and complexity) there were also children and families that the participants as newly qualified nurses were not allocated to and would not be able to visit independently as Max described:

“When the complex or long term children come out that are discharged from hospital and like the neonates that are on oxygen, it tends to be the band 6 that will go to the multidisciplinary team meeting but they’ll always take a band 5 with them. It tends to be a band 6 that does a first visit when they first come home but usually they take a band 5 with them. So they tend to lead the visits on the long term children that come home”.

The participants did not question this allocation to the more experienced nurses and regarded this as an accepted part of the way that the children’s community nursing teams worked.

The Benefits

All the participants apart from Max began to be allocated their own caseload at the time of the data collection. Their experience of having a caseload was viewed in a positive light.

“But we don’t have our own case loads anyway it’s a shared case load but it’s just nice to you know when you go and see that patient more than other people it’s nice to follow it through on your own” **Max.**

“Good experiences, in terms of your visits and the patients that you see, seeing them from start to finish and being able to discharge them off the caseload, and receiving good feedback from parents and patients” **Harley.**

In acute care settings it is well documented that newly qualified health care practitioners find managing care and workload challenging (Dearmun 1997; Bick 1999; Charnley 1999; Brown & Edelmann 2000; Amos 2001; Whitehead 2001; Ellerton & Gregor 2003; Boychuk Duchscher 2007; Clark & Holmes 2007; and Farasat 2011;), it has also been acknowledged as an issue for children’s community nurses (Carter & Coad 2009). It is also acknowledged that in midwifery and nursing, the idealism of the new graduates is often tempered by the reality of the workplace (Trysenaar and Perkins, 2001; Maben, Latter and MacLeod Clark, 2006; van der Putten, 2008; and Mooney, 2007a, 2007b) where newly qualified health care professionals had ideals to organize their work with a patient centred focus, but found in

reality that the management of care that they were required to provide was ritualistic and bureaucratic. Boychuk Duchscher (2007) commented that this dissonance manifests itself as disconcerting doubt about an emerging professional identity. Furthermore, according to Maben, Latter and Macleod Clark (2006) in hospital settings there is evidence that nursing workload has intensified so much in the last three decades that staff with heavy workloads were no longer able to commit fully to supporting newly qualified staff. Indeed one of Boychuk Duchscher's (2007) recommendations to ease the difficulties associated with stress during the initial stages of transition was to allocate a reduced workload.

In contrast there have been few reports about newly qualified nurses been given a reduced workload or having their workload allocation managed in the same way that the participants in this study described. Being allocated a case load and having to manage this independently was undoubtedly a new experience for them, and they discussed some challenges but ultimately they recognised that they were in a better position than their colleagues in a hospital setting and acknowledged the benefits of an initial reduced caseload. Any barriers to a smooth transition that might arise with the pressure of a caseload were therefore ameliorated by careful management.

Significantly as Max and Harley indicated, there were definite benefits to having a caseload. For example their ability to work independently meant they felt valued by their colleagues, which then contributed to them fitting in to the established group and aided their transition which was found to be significant in achieving incorporation (van Genneep 1960). Although studies of transition experiences of children's nurses (e.g. Dearmun 1997; Jackson 2005 and Farasat 2011) report that dealing with children and families is a challenging area of practice for newly qualified children's nurses, the nurses in this study valued working independently

because it provided opportunities to develop relationships with the children and families, leading to feelings of professional fulfillment as Yan, Tyler, Chris and Lee state:

“Good ones are when you can help families, when you’re doing an eczema visit and I suggest like a different type of emollient or trying something else and we send all the prescriptions through to the doctors for them to issue it and then we go back in a week or two and it’s working and it’s helping and it’s making the child feel better and the mum feel better” Yan.

“I’ve had lots of good experiences, I think it’s always a good experience when you see patients, whether they are acute or chronic, that you actually have done something positive for them” Tyler.

“Good experiences, difficult patients where you’ve just come through and you really feel like you’ve taken on board and mastered something. A couple of special needs constipation children have been really difficult and then families have just been so appreciative when you’ve got to that point you’ve persevered with them and then you get to that point where they’ve cracked it and you can just see the relief in their faces and you feel like you’ve done a good job” Chris.

“You know you’re making a bit of difference ... even a child sleeping through the night with eczema, it’s making a difference to parents” Lee .

Here, the participants reported being involved in the care, making treatment suggestions, doing something positive and making a difference to the children and their families. The positive outcomes they observed and the positive feedback they received from children and families helped them to establish themselves as children’s community nurses. Doing a good job, getting it right and making a difference contributed to the development of their identity. For these participants a satisfactory part of the role was providing direct care and making a difference to children and families, perhaps reflecting Jackson’s (2005) assertion that professional fulfillment is the main reason why nurses come into nursing and as Boychuk Duchscher (2007) suggested what newly qualified nurses strive for. In contrast to research findings reported in chapter 2, there were no reports of ideological dissonance for these

participants; they did not report being unable to implement their ideals into professional practice.

5.6 Continued Support

The participants continued to receive support from their colleagues even when they had begun to visit on their own and were carrying out care for children and families independently.

“and even when that six weeks was up I’d see a child that had been on the caseload for a while and I’d go through it with someone before I left the office so I knew what I was doing” Lee

At this time, Lee expressed a lack of confidence to commence this particular visit without seeking support, guidance and additional information from other nurses in the team. This mirrors Boychuk Duchscher’s (2007) work which also highlighted that participants’ during the Being stage had a lack of self trust and sought validation for their decision making and clinical judgment from senior colleagues whose level of practice they admired and respected.

There were also numerous examples during the fieldwork where the participants understood and were aware of the treatment options yet they checked information with their colleagues and sought confirmation of their own knowledge. For example Nasim explained here how she drew on qualified staff with specialist experience:

“I think just today, when you’re going out to see a child with a burn, and I know I’ve not specialised in burns and I’m going in with leaflets and education, background education, which is verbal and through pictures, but it’s totally different when you’re seeing it in real life. But I think if there’s someone specialising in the team, knowing to go and seek advice and help, even if it’s just to console yourself have I done the right thing and I think that’s one of the good things”.

Nasim’s use of the term “console yourself” is interesting in that it indicated a realisation that she needed advice and help at this stage of her transition experience. She displayed a lack of

self confidence in her ability at this stage and sought guidance to affirm her knowledge. However Nasim's quote also highlights how she viewed the ability to draw on others experience in a positive light. This use of the knowledge and experience of others resonates with transition theory as Meleis *et al.*, (2000) stressed that the support of others is a condition that can facilitate an individual's transition. At this stage the participants continued to value support and developed a strategy of interacting and drawing on the experience of the children's community team and senior colleagues to ease the process. Meleis *et al.*, (2000) states that there is a pattern to the way individuals develop confidence in their own ability during their transition indicating that those involved develop strategies that include seeking support from others, to manage the roles, responsibilities and routines accompanying the change in status. Maben, Latter and Macleod Clark (2007) and Roxburgh *et al.*, (2010) highlight the centrality of a supportive environment with both colleagues and workplace support to ensuring a smooth transition. However other studies have highlighted that support diminishes after the first few months of transition for newly qualified nurses in acute care settings. Farasat (2011) identified that the participants in her study required ongoing support when coping with challenges however despite this the support diminished rapidly during this period; a finding supported by studies by Dearmun (1997) and Boychuk Duchscher (2007). This was not the case in this study as the participants highlighted the organisation and their colleagues supported them.

Interestingly, the established children's community nursing team also identified the participants' inexperience and sometimes subtly intervened to enhance their care. During their fieldwork observation the asthma nurse specialist had picked up on something that Nasim did not know. Nasim explained this to me in the interview:

“Even with asthma, one of the nurses just eavesdrops. So it's just working together to get a bigger picture, basically, because there's things that might have been missed that she's picked up on and, like she said, it's the saturations study, that's something that I wouldn't have thought of, only because of being a newly qualified, but now that I've seen that I've dealt with it I know that if I get another one who is similar situation, that would always be at the back of my head. So it's just that”.

They had an impromptu conversation instigated by the asthma nurse specialist who had “eavesdropped” and then advised Nasim. Nasim acknowledged that there were issues that she had not considered and accepted the input of the nurse specialist, which she interpreted as working together. The nurse specialist acknowledged Nasim’s lack of experience, realised the potential consequences for the child and family and subtly intervened to help Nasim to see the bigger picture which she then internalised for future reference. This scenario supports the work of Benner, Tanner and Chesla (1996) who state that expert nurses are attuned to the skill level of other nurses and intervene when necessary. According to Benner Tanner and Chesla (1996) the safety of patients is actually protected by the advanced beginners’ awareness of their partial grasp of clinical situations and their respect and reliance on the judgment of expert nurses around them.

The ability to obtain help in this way and the acceptance of the interventions of senior nurses further supports the notion an ideal transition experience which includes continued support whilst undertaking independent visits. The task of transition (van Gennep 1960) would be to continue to seek support from colleagues during this intermediate stage, whilst experienced colleagues facilitate the transition by validating or supplementing the newly qualified nurses’ knowledge, and intervening if necessary.

5.7 The move to independent decisions

During the transition period there were also times when the participants demonstrated their ability to work independently without seeking advice and support from senior members of the team. Here they demonstrated the ability to gather information, undertake nursing assessments, use observation and questioning skills to ascertain more detailed information about children's conditions, suggest treatment options and refer to other health care professionals. Both Benner (1984) and Dearmun (1997) recognise this in their studies when new practitioners begin to trust their own knowledge which was observed in this study. Indeed Dearmun (1997) and Gerrish (2000) suggest that this happens within approximately six months of qualifying, since the nurses in their studies reported that they were able to integrate the knowledge they had from their course with practical skills they had developed since qualifying at this point.

I observed that the participants were able to interact and communicated effectively with children and families during the visits. These examples indicated that the participants were able to use strategies to manage situations based on previous experience where they had acquired knowledge and skills. The ability to make independent unsupported decisions was illustrated by Yan during a telephone consultation:

"I rang one parent and her child was suffering with pyrexia on this case and it just wasn't stopping, it was just hitting 40s all the time. She'd been to hospital and they'd sort of said, paracetamol and keep him cool. I followed that through but I had a gut feeling that there was something else because it had been for days and he kept going rigoury and I followed it through, I rang her back later to check on him, he was still the same and I sent her back to A&E I said, 'have they done a wee sample, urine sample?' she said 'no' so I sent her back to A&E and I said, 'tell them you want a wee sample doing, that you'd spoken to us' and he had a urine infection. Just from my judgement I knew he wasn't settling, and it had been going on for days, so obviously something was going on. That was a good one and he got the antibiotics and he was okay".

Yan referred to her gut feeling here and indicated that she made the decision independently to phone the mother and suggest that the child have a urine sample collected. She had identified from her own clinical judgment that something was wrong. It could be argued that the participants were displaying some aspects of becoming competent which Benner (1984) and Benner Tanner and Chelsa, (1996) suggest is a stage that nurses enter after two years of practice. Competent practitioners differ from the advanced beginner by their increased clinical understanding and management of the patient's condition and develop competence in handling familiar situations.

The participants also began to consider holistic assessment and care rather than the routine uncomplicated care needs of the child and family and in these instances did not view the outcomes of their care as a task to be completed. For example here Harley identified that she had moved beyond the narrow based clinical understanding which was partial and focused on routine pre-planned task to using her own judgement and knowing the reasons why she was undertaking the wound care and the rationale underpinning her decision:

"I suppose as well just my own personal development, of which I now feel competent in say, for example, the wound cares that we go and see ... the difference between being able to go and change a wound and now knowing why you're making those changes rather than just physically doing it ... and being able to make those decisions if you need a change of a dressing and what that particular dressing would do for that wound in terms of stimulating the skin growth and what not. So probably just my personal development and being able to make those decisions on my own"

Joint discussion and decision making was also observed between the participants and the children and families and they recognised the importance of children and families' observations as well as their own in order to build up a picture of the child's current illness and management. Smithbattle Diekemper and Leander (2004) report similar findings in their study of the development of public health nurses in the USA. They also identified that

nurses move from a task focused approach to a more holistic approach during their development and begin to focus on what they call “the bigger picture”.

This aspect of their transition experience included having the confidence to question the decisions of other team members. Chris for example identified that on one occasion she no longer simply accepted the word of another member of staff but explained that she wanted to visit the child to make sure that she was happy to make the decision to discharge the child:

“I got handover from A (name) about a patient I wanted to make sure that I was happy with a patient before I discharged them than take her word for it I think that as well I'm a bit more developed”.

These examples were observed and discussed at different stages for individual practitioners. Harley and Nasim reported these situations at the three month period, Yan at five months and Chris at eight months. What was significant about these findings is that they support the suggestion that from three to four months to six months of newly graduates’ experiences of transition the stage was marked by being able to integrate the knowledge developed during their undergraduate programme with practical skills they developed since qualifying (Dearmun 1997; Tryssenaar & Perkins 2001; Newton & McKenna 2007; and Boychuk Duchscher 2007) and more recently the work of Andersson and Edberg (2010) who identified that after a couple of months nurses slowly acquire the ability to work independently.

5.8 Summary

This chapter has identified the participants’ milestone of progressing to independent visiting during their experiences of transition. The meaning of this and the factors were that helpful and those that hindered or disrupted their transition have been explored. The majority of the

participants highlighted that the ideal progression to independent visits was a gradual process, with the most significant aspects being the ability to choose to visit alone with the support of their supervisors. The decision to move to independent visits was not a prescriptive or time specific situation and differed between individuals. However the choice included feeling comfortable and having the confidence in themselves and their competence to make the transition. The support of the children's community teams and being given the time to develop the necessary knowledge and skills under supervision eased their feelings of panic and nervousness. The milestone of moving to lone visits was experienced by the participants as a stage where their knowledge and skill capabilities increased. They recognised this as a period where they were eased into working alone and as a significantly better experience than their colleagues in acute care settings. At times during this period they categorised and cared for children based on a series of tasks to be completed. This strategy enabled them to work alone by carrying out care that was predetermined. The focus on routine task based care might be necessary for the participants at this stage of their transition since they prepared themselves for a fairly circumscribed interaction based on the child's current care situation. The participants as new nurses were open to information provided by colleagues.

There were however instances where they demonstrated the ability to work independently. This confirmed that they had moved from a narrow task based clinical understanding to demonstrating the ability to use their own judgment and ability to make decisions and see the bigger picture. During this interim stage a task of transition was to seek support and guidance from their colleagues and children and families. This was to confirm and validate their own knowledge as this was a period where they displayed a lack of self trust. Their

colleagues intervened at times and recognised the participants' limitations by providing support and guidance and to ensure their interactions with children and families were more holistic. The majority of the independent visits were allocated based on the participants' knowledge and skill capability. There were some visits that the participants and their colleagues were reluctant about, and these visits were based on skills that the participants and their colleagues viewed as higher level skills. When some of the participants were exposed to patient care situation that were perceived to be challenging they expressed feelings of self doubt in their knowledge and skills capabilities. This was a period where the participants' continued to learn and develop their knowledge and skills and it was perceived by them and others that the participants required more experience of independent working before undertaking some interactions. There was some individual difference in this reticence and this appeared to be dependent on the participants self confidence in being able to cope with the increase in responsibility and accountability.

In summary from the participants' descriptions and interpretation of the transition change to lone visits I was able to further conceptualise an ideal experience of transition which involved "having a choice" and "feeling ready" to undertake them. The ideal experience of transition also involved individual choice about when to undertake lone visits, increasing their control over this process. Therefore taking a gradual approach to commencing lone visits when individual nurses felt ready, being given sufficient time to develop job specific knowledge and skills, and being able to exercise choice in progressing to independent visits were factors that were helpful in their transition. When the participants changed to undertaking all their visits on their own the allocation of children within their threshold of

capability to develop their knowledge, skill and experience enhanced their experience and facilitated their development as children's community nurses. Being able to work independently, being recognised as being valued by colleagues and being able to develop autonomy and responsibility were also indicators of an ideal experience of transition. Being allocated visits based on their previous experience and capability level, not being placed in complex situations without help and support and given a reduced caseload was seen as ideal during the move to independent visiting and assisting them to cope during this period of their transition.

Chapter 6 The challenges of working in a community setting

This chapter explores the issues that arose for the participants that related to the community as a workplace and considers how this influenced their perceptions of transition. Importantly, the community was described as “a different world” by the participants. This was discussed in terms of contextual differences such as time spent in the car, or navigating around the geographical location but also in terms of the raised awareness of “being on your own”. Adjusting to these differences was a significant aspect of their transition where the discussion of the differences served to strengthen their emerging new identity as children’s community nurses. The situation specific nature of these matters has meant that they have remained largely unexplored in terms of transition in the literature since the majority of research to date has focused on acute care settings.

6.1 The community as “a different world”

The community was described as “a different world” by Chris and Max in comparison to the hospital setting and this reflected the perception of most of the participants.

“I think community is so much different to the ward” **Max.**

“It’s a lot different; it’s a different world in community” **Chris.**

6.2 The car

In the main, this “different world” was reinforced by issues in the community that were not likely to arise for their peers working in acute care settings and highlighting these differences helped them to begin the process of developing their own identity and therefore begin their transition to children’s community nurses. One of the most tangible issues related to having a car which was a prerequisite to being able to undertake the job as a newly qualified children’s nurse in the community. The necessity of travelling to and from

the child's home was a significant issue that involved new skills in navigating the area, and developing new knowledge of the local geography and streets. The participants relied heavily on their car not only to get them to their workplace but also to transport them between the office and the children's homes, and in this way their cars were described as an extension of the workplace.

However, whilst considered a necessity, the car was also discussed as a sometimes unpredictable and financially draining resource for their daily work and during the fieldwork observations some of the participants experienced problems with their vehicles. For example although both Max and Nasim owned their own cars they both discussed how they had recently had to rely on other family members because their cars needed to be repaired. Therefore their necessity for a car also impacted on their families. This highlights a unique aspect of the transition experience for nurses working in a community setting since although partners and parents are a recognised source of emotional support for newly qualified nurses during transition in acute care settings (Brown & Edelmann, 2000) as had been found in this study, in the community it may be that they are required to be a source of much more practical support. The reliance on a car for their daily work also had a tangible financial impact, for example a puncture was a source of real distress for Jesse who was already paying off a car loan and had no money to pay for repairing the car.

The car was a place where the participants spent a significant amount of time during their working day and for some this was much more than they had anticipated:

“I think days of utter stress... times when I've spent like a whole day in my car. I've not had hardly any patient contact and I just think ... give me a ward any day”

Chris.

With the statement “give me the ward any day” Chris is clearly expressing an unfavourable comparison between community and previous ward work which she perceived as providing more opportunities for patient contact. However, this is not necessarily disruptive to the transition experience since Meleis *et al.*, (2000) suggest that individuals’ comparisons between their new location and their previous location, whether favourable or not is important to most transition experiences. This is because it involves justification of how the location has changed and how it differs from their previous understanding. So whilst this may have disrupted her perception of the benefits of the new job and her acceptance of the new location, it also reinforced her role as children’s community nurse because her colleagues in acute care settings did not spend significant parts of the working day in the car.

6.3 Navigating

A further issue that impacted on the transition experience in both positive and negative ways involved navigation of the local streets. During the fieldwork observations, it became clear that finding the way around the local community was a challenging area for the participants. For example Tyler got lost on two occasions and at both times was embarrassed, emphasising that she knew how to get to some patients’ houses if she had been before. Geographical navigation has been highlighted as a challenge for newly qualified nurses and nurses new to community by Drennan, Goodman and Leyshon (2005) and more recently by Maxwell *et al.*, (2011) whose UK study regarding the challenges facing newly qualified community nurses highlighted travelling to unfamiliar areas as demanding. For the

participants in this study competent navigation was a rather taken for granted aspect of their new role and their colleagues may have assumed that this would not be an area of concern since it did not appear to feature in their orientation programme. Therefore, during the observation the participants demonstrated how they had developed strategies to develop their knowledge of local geography such as seeking help from colleagues who were already familiar with the streets in the community or asking the members of families that were due to visit. Some of the participants relied heavily on their satellite navigation system whilst others, such as Chris, preferred to use an A to Z (a street and map directory) suggesting that she was “*learning the streets*” in a similar way to taxi drivers (Girardin & Blat, 2010). It may be that memorising the streets reinforces a sense of place and belonging for Chris and therefore facilitates the transition process.

The participants’ socialization into the community as a different world involved a further task of transition which was navigating the streets. It could be argued that at the time of the fieldwork observation some of the participants continued to be in the liminal stage (van Gennep 1960). This was highlighted because during the observation it was apparent that they had not yet mastered the knowledge and skills to be competent in this skill. As noted earlier, mastery is an outcome of transition indicated when an individual has demonstrated competence and skilled performance.

6.4 Being on your own

“Being on your own” was discussed in two main ways by the participants. Firstly, they discussed it in terms of personal safety – related to being alone in the office or being alone

in the family home, and secondly in terms of increased expectations related to professional decision making.

Transition to the community for these participants meant an increased awareness of their vulnerability in the work environment related to being away from a large institutional setting. At times they were alone in the office and the children's homes and felt intimidated as Tyler explained:

“ it was like that pokey office at night, the light was broken and you were locking up on your own, whereas here, during the week, you have people who lock up so you don't have to worry about that, so that's a load off your mind and, it's a big office and it's well, you have your own private area, whereas everything is locked, so at the weekend when we are in, there is only this bit that is literally open, we take off the alarm and we put it back on, so it's only our bit that's open, so you are a lot more safe, but like you need fobs to get in everywhere, whereas before you didn't, anyone could walk in and out, I mean if you are on your own at eight o'clock at night and its pitch black during the winter, it was intimidating”.

Jesse also had significant concerns about being alone in the office because of the location of the health centre. This was a particular issue on weekends and late shifts when the number of nurses working was reduced.

A question raised in relation to the application of Meleis *et al's* (2000) work to this study was how the workplace location impacts on the participants' transition. In Imle's (1990) study of the transition experiences of expectant parents, the environment was conceptualised as an external facilitative resource, or as resources external to the individual that can be perceived as facilitators in the transition experience. Being, on their own in the office environment, was a significant factor for these participants and again, differentiated them from colleagues in acute care settings. How the environment is perceived and evaluated is important and in this case it was marked by feelings of vulnerability. For Tyler, the change

in environment was facilitative as she expressed ease in feelings of vulnerability that occurred as a result.

During each fieldwork observation Jesse described safety related incidents such as when cleaners had left the office doors open or that when building contractors arrived without prior notification it had threatened her personal safety. That said, the participants were also able to highlight strategies they and the organisation had developed to minimise the risks. For example Jesse responded by completing a critical incident form and informing management of the untoward occurrences. This example highlighted that participants used their agency and internal resources to overcome challenges they faced in the community setting during their transition. Jesse had followed the relevant policy however she had perceived the risk and responded with the necessary skills to manage the situation. As Meleis *et al.*, (2000) suggest during the transition process individuals become more confident to use available resources and develop strategies for managing and coping with challenging situations.

Being “on your own” was also discussed by the participants in terms of the challenges of lone working. In chapter 5 the contrived nature of initial independent visits was described, highlighting how it served as an informal mechanism to advance progression from the shadowing experience and how this progression formed part of my conceptualisation of an ideal model. Decisions about independent visits were loosely based on capability thresholds that were arrived at informally by their managers. The notion of “being on your own” was

significant for the participants because the lack of immediate access to other health professionals increased feelings of increased responsibility and autonomy:

“I suppose the main change is the responsibility you have, going out on your own”

Jesse.

“Yeah, you’re on your own, you haven’t got any other nurses around you, they’re at the other end of the phone if they’re available, but you are solely on your own so you’ve got to be aware of that fact” **Lee.**

The other members of the team were described as a distant or remote support mechanism and this was perceived as very different to “immediate” back up:

“I think the thing that sticks out most is the autonomy of community nursing you don’t have a doctor down the corridor” **Max.**

“Obviously as I am qualified I’m now accountable for everything I do to the Nursing and Midwifery Council, that’s obviously the biggie that you’re aware of when you qualify. Also, the difference from my acute placements to now being in community. I now obviously spend a lot of time on my own on visits, which is different without the backup immediately there but then obviously you’ve got your work mobile if you need any support” **Harley.**

“But in the community I think it’s responsibility over a patient and you’ve not got someone else there with you, so the only thing you can do is come back to the office and clarify with other nurses like I’ve been doing anyway” **Nasim .**

As discussed in Chapter 4 the period of shadowing had provided protection from the stress of accountability because of the physical presence of a senior member of the children’s community team. These data extracts suggest that a significant milestone in the participants’ transition was the move to being on their own during all visits which became entwined for the participants with their ideas about autonomy, responsibility and accountability. Similar findings were identified by Drennan, Goodman and Leyshon (2005) who examined the key knowledge and support required by experienced hospital nurses moving into community matron roles. They also found that autonomy was a word used to capture what was different

about working in the community and this was related to making decisions without reference to another authority.

The necessity of being alone in this setting was seen as something that increased confidence as Nasim explains:

“I think I've grown in confidence, only because as a student you have someone there with you all the time and so you're always thinking 'am I saying the right thing', but now that you're autonomous and you're going out to people's homes I think you increase in confidence, and especially to increase in confidence you need the knowledge behind it and you can only gain knowledge through experience and going out to people's homes”.

However, whilst the remote nature of the support increased their perceptions of personal responsibility, it also highlighted awareness of their vulnerability as Lee describes:

“You're on your own more so your knowledge has to be up to date, and because you're on your own more your competencies and your accountability as well, what you say ... you're telling them to follow this regime so obviously it comes solely on you, what you're saying, and just making sure that you back everything up and you support everything that you're saying and you're not leaving yourself vuln ... you're not giving any sort of wrong information, like making the patients vulnerable or anything like that”.

Here both Nasim and Lee connect lone working to the pressure of relaying correct information, or “saying the right thing” to children and families, and the lack of proximity to colleagues who might otherwise be on hand to give advice or support and that this presented a new challenge. This challenge was perceived as something that staff in acute care settings did not experience, but was something specific to the community setting and this differentiation helps the development of a community specific identity.

However, the participants perceptions of better support in acute care settings may have been misguided since there have been many reports about the lack of support for such newly qualified nurses during their transition period despite the physical presence of colleagues

(Bick 1999, Gerrish 2000; Thomka 2001; Ross & Clifford 2002; Jackson 2005; Beecroft, *et al.*, 2006 Runcapadiachy *et al.*, 2006; Clark & Holmes 2007; Thomas *et al.*, 2008). Boychuk Duchscher (2007) suggests that this raises levels of stress in new graduates. Of most significance perhaps is Lee's acknowledgement of the personal vulnerability attached to this situation, implying that if anything should go wrong, there was nobody with whom to share the blame.

The notion of lone working was therefore partly facilitative and partly disruptive to their transition. In relation to the meaning of an ideal experience of transition for these participants moving to working on their own was a significant marker in their developing identity as a children's community nurse. This was perceived as enabling confidence development and the ability to gain knowledge through experience. However it was not without challenge and the tasks of transition involved coping with being on their own without the immediate proximity of colleagues and managing risks.

Being Watched

The notion of being "on your own" clearly increased feelings of pressure for the participants and not only did they have to deal with a more remote kind of professional support from colleagues, they also recognised a shift in the power relationships when visiting children and families in their own homes in comparison to the acute care setting, as Tyler describes:

"Because I think when you are in the hospital setting, it's very much your environment and I think the health care professionals have a lot of power and input over the patient's care. Whereas when you are in someone's home, obviously you want to empower the patients and the parents, you can't let them intimidate you and at first I was a little bit intimidated by the fact that I had to go in people's houses and tell them how, or advise them how they should be looking after the child for a certain medical condition or illness".

It is significant that it is the hospital setting that is seen as “very much your environment” for the health professional, where they have “a lot of power”. In contrast, giving advice and being watched during their interactions with children in the home was described as intimidating and challenging because the power dynamic has changed. Tyler recognised that although it was important to empower children and families to care for themselves, relinquishing the power associated with being in your “own environment” was initially uncomfortable; indeed she described how parents may be in a position to intimidate her, which was perceived as something to be avoided.

The vulnerability the participants described was exemplified in the notion of “being watched” by the family and it is interesting to note that the descriptions often involved the use of theatrical metaphors:

“I don’t know, I suppose with the parents as well and the family as a whole, being able to interact with them, because you’re not going in just to see that one person, it’s everyone, and more often than not you’ll find that they’ll all sit round ‘cos they want to watch, so you have everyone to entertain” **Harley.**

“Sometimes if you go into somebody’s house to pass an NG tube or remove stitches or you know change a dressing for whatever reason and there’ll be a whole line of relatives all wanting to watch and see what you’re doing so you’re used to performing in front of an audience if you like” **Max.**

Here, the family were described as an audience, with Harley referred to as “entertaining” everyone whilst Max raised the issue of having to perform. The use of such theatrical metaphors highlights the perceived vulnerable position of the participants whose actions they feel are being scrutinised in a somewhat intimate environment.

The notion of parents exercising a greater degree of power in the home as compared to the hospital environment has been noted by Kirk (2001) in a study exploring parents' experiences of caring for a technology-dependent child in the home and by Liaschenko (1994) whose study with home care nurses identified that those who had previously worked in acute care settings were acutely aware of the shift in power relations. As Wright (2005) indicated nurses working in the community have to adapt to this shift in power relations and have to empower patients. This was something that the participants were beginning to recognise and come to terms with. Hughes and Horsburgh (2004) also identified the difference in the role of the children's community nurse as markedly different from that of a nurse in an acute care setting as enabling the family to manage the care of their child and share their skills with the family to empower the family to make decisions. The participants in this study recognised this difference and at this point in their transition it was challenging to them. These findings also resonate with research about more experienced nurses making the transition into community from acute care settings. For example Drennan, Goodman and Leyshon, (2005) identified the challenges associated with giving care and advice and negotiation between the nurse, the patient and their family and suggested that this was one of the main reasons that nurses who move from a hospital environment to the community irrespective of expertise feel that they became novice practitioners again. This led them to conclude that all nurses entering community settings are faced with this challenge.

'Risky' visits

In a study of the impact of the one-year development programme for newly registered nurses and midwives in the UK, Lauder *et al.*, (2008) reported that the transition period was the time when nurses learned to manage many aspects of their practice – including

managing the safety demands of the job. In addition to feeling the scrutiny of the parents in this changed power dynamic, the participants also had to consider the patients home as a safety risk. So for example some families were considered to live in “risky” areas as Lee explained:

“Some patients we have, where we have a two worker policy going on as well. And some areas as well, you think I’m not really comfortable round here, and if you’re not comfortable then don’t go. And we have areas that are no-go areas after certain times just for safety reasons ”.

The participants also recognised that the presence of pets was a safety concern for themselves at times but also for the children for whom they cared. Nasim for example said that she found it strange that she was going into a child’s house to do a dressing of a dog bite and the dog was present so she asked for it to be taken out. Chris and Yan both relayed instances when a cat walked across the sterile field when they were undertaking a dressing change and both had to ask family members to remove the cat. Clearly these incidents are unique to a community setting, and reinforce the notion of the community as a different world.

For the participants in this study, although the lone working environment was perceived as intimidating in relation to their risk and personal safety, strategies were put in place at both an individual and organisation level to minimise the risk. For example the participants had to inform a senior nurse when they had completed their visits in the evening. Tyler explained that remote contact with members of the team eased the concerns and risks about safety but also draw attention to the fact that there may be failings in this system if no one was in the office to help:

“Obviously, the other issues that you have to think about are safety issues, obviously being on your own, but we do have a works mobile and on speed dial is the office

number so that, if there are any problems you give them a ring and there should be someone in the office. Yeah, if no-ones in the office you are pretty screwed, but and we do have a lone worker who we text as well, so if we are going out on visits, I've done it where I've gone out and I've been out on visits right until eight o'clock and you just text whoever is on the late shift who is more senior will be the lone worker and everyone will text them when they have finished''.

This excerpt from the data further illustrates that being alone in a community setting is challenging. The participants were able to overcome some of the challenges using their agency, and the organisation also had strategies in place. Reinforcing as Meleis *et al.*, (2000) indicate that both personal and community resources come into play as facilitators in the experiences of transition.

Managing the risks associated with being in the community is a further example of the differences of the experiences of transition into a community setting. This is not only an issue for newly qualified nurses however. Drennan, Goodman and Leyshon (2005) also highlight this issue and suggest that supporting any transition into the community should address the important dimensions of assessing and reducing risks in community environments.

6.5 Summary

This chapter outlines the situation specific transition of children's nurses into a community setting which they perceived as a 'different world', a world of navigating streets and transport which their colleagues in acute care settings did not have to consider. These issues helped the process of identity reformulation as a children's community nurse as they embraced the difference between themselves and their colleagues in acute care settings.

One of the main differences experienced by these participants was the notion of being alone because although support was available to them from the members of the children's community team and the organisation, this support was not in the immediate vicinity. This

resulted in a perceived increase in autonomy, responsibility and accountability which they found challenging particularly in areas such as giving advice to children and families and in the power shift they experienced by visiting children and families in their own homes. Being alone in the community also posed safety concerns for these participants which were particularly noticeable during weekends and evenings when less staff were on duty or when they were visiting 'risky' areas or homes which led to feelings of vulnerability.

Throughout the chapter I have highlighted that the participants used their agency and internal resources to overcome challenges they faced in the community setting during their transition. Strategies were put in place at both an individual and organisational level to minimise these challenges

In the previous chapters I have argued that I had started to conceptualise an ideal experience of transition for newly qualified children's nurses into the world of work as a children's community nurse. The findings in this chapter also support this notion. Working on their own was part of the ideal experience of transition as it assisted in their developing identity as a children's community nurse. This was perceived as enabling confidence development and the ability to gain knowledge through experience. However it was not without challenge and the tasks of transition involved coping with being on their own without the immediate proximity of colleagues and managing risks.

Chapter 7 Emerging Identity as a Children's Community Nurse.

The previous chapters have detailed how the participants had interpreted their experiences during their first months working in children's community nursing teams. These had been viewed as both positive and disruptive to their transition. However, some factors were particularly implicated in their emerging identity as community children's nurses. This chapter presents the findings related to this, not least the participants' agency and how this contributed to them differentiating between themselves and peers in acute care posts. Environmental integration and having a place, being seen as experienced, being part of the team, making mistakes, the identification of the visible signifiers of identity, "The IVs" - the final competence and themselves and others as arbiters of their professional identity are all implicated in this. My analysis established that the participants paid attention to, emulated and appropriated the perceived existing values, expectations, norms, and interaction styles of the established children's community nurses. Despite some considerable challenges the participants began to develop strategies to achieve significant milestones in the development of their identity.

7.1 Environmental Integration - Having a place

As noted in chapter 1, children's health services had undergone radical change. The ramifications of these were notable during and just after field work observations. One ramification related to the increasing numbers of staff employed by the teams. This meant that some offices had insufficient space to accommodate everyone that had been employed.

Most the teams for which the participants worked changed were relocated. However, I witnessed the impact of insufficient desk space and how this was interpreted by the participants. When desk space was at a premium, it was the senior nurses and original team members had been allocated to a desk. As new additions to the team the participants were not and this held significance for them. For example on return to the office following a visit to a child's home, Yan sat in an unoccupied desk. The desk had a label stating it belonged to a senior nurse. Chris had previously commented on how she interpreted not having a desk:

“I ended up bringing it up causing a rift such as specific desks for staff when I said we are all working in this team it should be a hot desk system you shouldn't have specific desks so then that changed, they recognize now that it should be like a hot desk thing which is something petty and small but it just had to be dealt with and I just think it's been hard for the people who had to come out of their comfort zone and to take in these new people and it's the first time they had had a newly qualified nurse in the role”.

For Chris the allocation of desks to some but not all members of the team was interpreted by her as the established members having difficulty incorporating new staff, not least newly qualified nurses for the first time. Stating that “we are all working in this team” suggests that she was actively seeking recognition as a team member. The lack of parity in terms of the desks was interpreted as a symbolic gesture that signified that she was not being recognised as a team member. This mattered because part of the identity of a children's community nurse was that they had their own desk in the office. In this way the desk was a symbol of their status. Failing to allocate desks to the new starters was interpreted as a being treated differently, or being on the margins. This could disrupt their perceived status as equal to the other children's community nurses. Established team members and the organisation are implicated in this. It seems that they were acting as arbiters of the participants' emerging identity as children's community nurses. However the participants

were not passive in their responses. Chris' response was to establish the status quo by suggested that they introduce a desk system.

In an analysis of the impact of providing placements for student nurses in community settings, Kenyon and Peckover (2008) noted the importance given to having a place to sit.

Affording status to newly qualified nurses forms the basis of the degree to which they are assimilated into and accepted by professional equals (Boychuk, Duchscher & Cowin 2004).

In this case allocating desks to the more established members of the team was interpreted as differentiating between the status of established nurses and those new to the team. This was interpreted almost as a symbolic gesture in keeping with the notion of a seat of hierarchical power (Hall, Stevens & Meleis 1994). As noted by Meleis *et al.*, (2000) the environmental context of a transition is important. Resources in the environment can be factors that either help or adversely disrupt the individual's transition. In this case the lack of resources in the office environment and how these were allocated had a negative impact on the participants' experiences of transition. In particular was not being allocated a desk or place to sit that they could, like other members of the team, call their own.

7.2 Being seen as experienced

The presentation of findings in Chapter 4 highlighted the importance of being seen as "experienced" and in particular the acknowledgement of the participants' undergraduate experience. The perception that others thought they lacked experience persisted for some time as noted by Tyler, 7 months into employment.

"Even now, we still get called newly qualified nurses even though we've been qualified now nearly seven months".

Although she identified that other team members still referred to her as a newly qualified nurse, she also started to discern that a different label was being applied to her:

“So I do think at the moment, you can see people starting to get more, seen more as ... you know ... rather than the newly qualified. There are actual members of staff who are training obviously they acknowledge that I wouldn't know everything, but, they do acknowledge that I have been here for seven months now”.

No longer being seen as newly qualified or lacking in experience was important as it signaled movement to becoming a full member of the team. Their position as someone who was training, or in an interim period of their transition was interpreted as a shift in status, confirmed by others. As discussed in Chapter 2, the second stage of transition is about individuals fitting in, learning the rules and their position in the hierarchy (Trysennaar & Perkins 2001; Boychuk Duchscher 2007). Still, it seemed that the established members of the team perceived them differently to how they perceived themselves. A factor that helped Tyler come to terms with this was a realisation that this could be the case with any new starter. Since the teams had been recently reconfigured, newly qualified nurses were not the only new recruits to the team; other nurses had been recruited that did not have experience in a community setting. Tyler noticed that they also had some difficulties. This reinforced that it was not only newly qualified nurses that experienced difficulties in transition into the community setting, and this was a comfort:

“Because a lot of the nurses here are, like I said more qualified nurses who have come from different areas, it was kind of comforting to know that somebody who had been qualified six or seven years still was learning stuff, so I didn't feel thick, you know, “Oh here she comes, here comes the newly qualified who knows nothing”

Similar findings have been reported by Drennan, Goodman and Leyshon (2004), Rosser and King (2003) and Simpson *et al.*, (2006). All noted that making the transition to a different

area was a challenge that engendered feelings of doubt in ability, and that this could be imposed by self or others.

A strategy used by the participants to actively promote the development of their identity as community children's nurses was to recount what had happened on visits when they returned to the office. This was witnessed during field work, and at times I was involved in this as I journeyed with the participants in their cars during field work. It seemed that this strategy was important, not only in helping them to integrate as members of the group but also to demonstrate that they shared common experiences with the group. By doing this they were emulating more established nurses. The stories that they recalled highlighted situations that they may not have encountered previously. As such, they provided verbal testimony, and anecdotal evidence in an informal context. By doing so they helped to build a bank of stories that signified their identity as 'experienced'. It has been suggested by Street (1992) that nurses learn to value their culture by retelling their experiences. According to Berger and Luckmann (1967) this is described as identification of the individual with the socially assigned typifications of their identity. Snow and Anderson (1987) add that a component of the social construction of identity entails narrative construction of particular identities. Tradewell (1996) reinforces this point and emphasises that an oral culture plays an integral role in transition in nursing. The participants in this study were constructing their identity as children's community nurses, and convincing others of this by recalling and reflecting on their experiences in the job. This knowledge could contribute to an ideal experience of transition in practice by informing strategies, such as providing time for storytelling, during the initial stages of employment.

7.3 Being Part of the Team

A further illustration of the participants' agency and attempts to integrate and develop an identity as a children's community nurse was by viewing themselves as part of the team. They perceived that working as a team member was a key component of the identity of children's community nurses. They recognised that becoming part of the team was an important in establishing their professional identity, as Chris noted:

"You just go through that stage of you're entering a new team, you're just going into a different team you've got to gel into you've got to adapt yourself to fit into there and conform to their ways and the way they do things whilst trying to learn the role".

Chris's description highlighted the issues of having to *gel*, *adapt*, *fit in* and *conform* to the ways of the team. These strategies were an attempt to overcome the challenge of herself within the team. Still, they recognised that at this stage they were not yet part of the team but that they were required to be actively involved in achieving this, as Jesse noted:

"I know as a student you are a member of a team, but obviously when you're qualified you are a team member, that's your job".

The difference between being a member of a team and being a team member was important for Jesse. For her there was a difference between integrating into teams as she had as a student and integrating into the community nurses team as a permanent member. Other researchers have reported similar findings commenting on the importance of integrating into a team. For example Jackson's (2005) study regarding the roles and responsibilities of children's nurses found that working as a team member reinforced the nurses' perceptions of their changing status.

Overtime the participants began to reformulate their identity and regard themselves as part of the team. This was signified by the use of the collective pronoun "we" which appeared to

underline their integration into teams and their emerging identity as a community children's nurses. The following illustrates this:

"Some patients we have". (Lee)

This signified that she had embodied a shift in identity. Tyler reinforced this point. In one instance when leaving the shift she described that she had felt guilty that she had left her colleagues with too much to do:

"Feeling guilty because you have seen how busy it is on the late thinking "my God, I've left her to write up all these notes for the patients", I thought "I've left her to write up all these notes now which I could have helped her with. Then I'm thinking she won't have had a break and she's got all these other visits".

Being empathic with someone else's predicament indicated that she positioned herself as an established member of the team.

It seemed to me that the participants recognised that to develop an identity as a children's community nurse they needed to integrate into the team. Once they assimilated into the team they were able to empathise with other members. These findings relate to the concepts of transition and identity. According to van Gennep (1960) and Snow and Anderson (1987) the way individuals integrate into groups plays an important part in how they identify themselves with the group. In keeping with Holmes (2001) the participants legitimately carried out their performance (providing nursing care) by conforming to the set of identities (those associated with children's community nurses) appropriate to the situation (working in children's community teams). For these participants this was achieved by fitting in to the team.

Another discernible shift in the participants emerging identity as children's community nurses was that they began to differentiate and distinguish between themselves and their

peers employed in acute care settings. Throughout the study I have described examples of the differences they perceived between themselves and their colleagues in acute care settings. For example during the initial stages of transition they perceived that the support they had received was more favourable than that offered to their peers in acute care settings. They also perceived that the allocation of their workload compared favourably to that of their peers employed elsewhere. The participants' descriptions of themselves as "different" to nurses in acute care settings served to reinforce their identity as children's community nurses and allowed them to separate themselves from their colleagues. Max reinforced this point:

"I think our patient care is really good and we do our best it's difficult sometimes liaising with nurses on the ward because they're very busy. I think they kind of think we sit around drinking cups of tea all day really ... they don't really appreciate that we can be really busy as well. It makes things difficult sometimes because there's been instances that have been involved in when patient care have suffered because the ward staff aren't listening or there's a breakdown in communication between us and them or vice versa".

Max highlighted that there was at times a lack of understanding of each others' workload and she described that communication with nurses on the ward was sometimes difficult. According to Snow and Anderson (1987) this is a strategy known as associative distancing which entails individuals comparing and distinguishing themselves from other groups. They argue that this is central to the development of an emerging identity.

7.4 Making mistakes

Some of the participants had told me about the mistakes they had made since being employed as community children's nurses and the subsequent upset that these had caused. The mistakes included a medication error, miscommunication of advice during a telephone call with a parent, a needlestick injury and a failure to record repeat visits in the visits book.

The issue of making mistakes has been previously reported as the *fear of making mistakes*. Gerrish (2000) for example reported that newly qualified nurses feared making mistakes when they became accountable practitioners. Dearmun (1997) considered that the fear of making mistakes was a natural apprehension associated with becoming a newly qualified nurse because they believe they have to be seen as omniscient and infallible.

However, spending time in the field meant that I was able to explore in more depth, not only the fear of making mistakes, but how the participants' interpreted contextual factors when mistakes were made. It was clear that a factor that helped the participants deal with the challenge of making a mistake was gaining support from their colleagues. As Jesse and Tyler described:

"I felt really well supported. I felt they dealt with it really well because I was devastated, and I felt that I've been able to get my confidence back and ... not forget about it, but it's not this huge thing now, I can kind of ... I was able to reflect and I think in turn just get on with it really and not let it get me down too much, because at first it was really getting me down" **Jesse.**

"That feeling was one of the worst feelings I've ever experienced to be honest but my preceptor was really, really supportive. The team did everything right" **Tyler.**

The feeling of utter devastation arising from making a mistake was ameliorated by the support of the team that followed. In turn this was important in helping them to deal with their emotional responses. The participants were able to cope and develop their confidence as a result of their colleagues support. Benner, Tanner and Chelsa (1996) reported that how nurses coped with their emotional responses to making mistakes was crucial in clinical learning.

The importance of this support was underlined by Chris following an incident following which she felt unsupported.

“There been a couple of times everyone does it but like I’ve been pulled up cos like missed I’ve come back from a visit for one reason or the other I’ve been distracted I’ve had a phone call or discussion and I’ve not put the next visit in the diary and then it’s been pulled up on because usually it’s the one time I’ve gone out and done three visits and I’ve not put them in the diary cos I’ve been called away a couple of times I’ve been pulled up on that and I think because I’m the newly qualified one its I don’t know I get a bit more stick whereas everyone else it’s like ohhhh OK erm but I think it more like a little bit more vigilant about picking up negative things from me rather than identifying what I have achieved as a new nurse”.

Chris perceived that she was not only being treated differently to others in the team that also made mistakes but that she was not supported by the team when mistakes were made. This lack of support was interpreted as disruptive in to her emerging identity.

The participants in this study had made mistakes and this had threatened their emerging identity which manifest as self doubt and a lack of confidence. According to Schumacher and Meleis (1994) fear of failure is a notable emotion experienced by individuals undergoing transition and when experienced, fear of failure manifests itself in self doubt and lack of mastery. What this study adds is the importance of support and being treated the same as other members of the team would be in similar circumstances. This is an important message for those working with newly qualified nurses in community children’s teams as Benner, Tanner and Chelsa (1996) have noted, experience in nursing practice is laden with failure, and experiencing comes from increasing involvement and agency in practice. However, and somewhat perversely, when the participants in this study made mistakes this challenged their perceptions of qualified nurses being infallible, thus forcing their engagement with the realities of nursing practice.

7.5 Visible signifiers of identity

Spradley and Francis (2006) indicated that the uniform the nurse wears is a powerful symbol and that wearing a uniform creates an impression that has correlations with status and identity. Wearing a uniform outwardly creates the impression of competence and signifies a professional status and that a person is a member of a group and has a place. Wearing a uniform for these participants was part of establishing their identity and this in turn was important factor in transition. The wearing of a visible symbol created an impression of them to others and themselves (Goffman 1959). According to van Gennep (1960) a change in uniform is a significant rite of passage towards being incorporated into the group. All of the participants in the study wore a uniform. For example in one team all the qualified nurses wore navy blue trousers and tunics. They also had a bag containing equipment such as wound dressings that they took with them on visits. The physical change to wearing a uniform and carrying a nurse's bag were symbols that the participants used to as identifiers that they had changed their status and identity to that of a children's community nurse. For Jesse, it was important that everyone wore the same uniform:

*“We all wear the same uniform so there is no sense of hierarchy whether band 5 6
or 7”*

Godinez *et al.*, (1999) found that changing from a student nurse's uniform to a qualified nurse's uniform assisted in transition. The notion of the place in a hierarchy is also implicated in Jesse's account. According to Allen (2001) hierarchy has assumed a central place in the organisation and management of nurses' work. In her study into the division of labour in nurses' work she highlighted the intra-occupational division of labour between the senior and junior nurses. For Jesse, the wearing of the same uniform enabled her to feel like

the others in relation to her physical appearance. A facilitator in the transition journey of the participants was therefore embracing the visible identity as a children's community nurse.

7.6 “The IVs” - the final competence

Chapter 4 highlighted how being assessed as competent in specific skills was an important part of the participants' experiences of transition. Being assessed formally as competent by a supervisor or having practice skills validated by a senior person had meant that they could go on visits where these skills may be needed alone. Of note amongst all of these skills was achieving competence in the administration of intravenous medications (IVs). This was perceived differently by the participants and the other members of the children's community nursing team. Five of the participants talked to me about the administration of intravenous medication during the fieldwork observation and interviews. They told me that specific training was undertaken for this competence and that they had gained exposure to doing this and experience under supervision. However they had not been, what they termed, as *signed off* for this competence. This was different to the achievement of many other competencies as explained by Jesse:

“But yeah, my preceptorship, I’ve just been signed off. The only thing I need to get signed off is on my IVs, formally signed off on those, but everything else, all my other competencies that they require me to have I’ve been signed off on”

The fact that the participants had not been signed off had implications for them caring for children that required intravenous medication at this stage of their transition. This type of visit would be allocated to more senior members of the team who had achieved this

competence. The participants and their preceptors appeared more cautious about carrying out this skill and the preceptors advised a period of time before undertaking this skill independently as Tyler indicated:

“I was talking with my preceptor actually, at my last personal development planning meeting about when to start IV training. They said, obviously because I didn’t want to start it straightaway, I wanted a good couple of months when I was doing the role on my own, whereas she said advised me not to do it until September time, after I had been qualified a year”.

She and others perceived that this was a higher level skill and should be treated with caution. Some of the participants were at the end of the first year of qualifying, and had undertaken the IV training, but were still not have thought to have reached the stage at which this competency could be signed off. Still others were advised to wait until they had been qualified for a year. Jesse explained this:

“Some of them you can’t achieve, like IV antibiotics because that’s something way down the line, they’re way down the line”.

The fact that this competence had not been achieved and was seen as something that was *way down the line* had implications for the participants’ transition and subsequent development of their identity as a children’s community nurse. A significant factor was that their preceptors acted as gatekeepers in the achievement of this skill. In a concept analysis of identity and its relation to competence, Holmes (2001) identified that graduates have to engage with those who are the gatekeepers to opportunities. It appeared that the preceptors were not affording the participants the opportunity to be formally assessed as competent in this skill. This is important as, according to Holmes (2006) it is not only the individual who affirms their identity but also gatekeepers. Remaining unable to administer intravenous medication meant that the participants were not afforded the same status as the established

children's community nurses. In turn this disrupted their developing identity as children's community nurses.

According to the Royal College of Nursing (2010) the administration of intravenous medication to children is an important skill for nurses caring for children and young people to develop and maintain. However they do not stipulate whether this skill should be developed during undergraduate programmes or on qualifying. The literature review highlighted similar findings; that newly qualified nurses have initial deficits in clinical and practical skills see for instance, Gerrish, (2000); Whitehead (2001); and Clark & Holmes, (2007). Clark and Holmes (2007) highlighted that newly qualified nurses were keen to learn about the administration of intravenous medication as this seemed to help them to be accepted by the team. However, nurses have reported that they were able to integrate the knowledge developed during their undergraduate programme with practical skills they had developed since qualifying (Dearmun 1997). Clark and Holmes (2007) also argue that any initial deficits are remedied after a few months post qualification experience. In relation to this particular skill the participants in this study were not able to influence when this skill was achieved despite it being a significant marker in their transition. I contend that this was rite of passage in itself – the final competency; the arbiters of this were the established members of the team. It was not something not to be undertaken by newly qualified nurses.

7.7 The arbiters of their own identity

Throughout the first year of their transition the participants began to perceive themselves differently and no longer identified themselves as newly qualified. That said, towards the end of the first year they were still not at a stage where they saw themselves as the same as

the others in the team or as children's community nurses. The following excerpt from Jesse illustrated this point:

"I do still feel quite ... I think because I'm the only (band) 5, I do feel a bit outnumbered. And the new (band) 5 that's starting has got loads of experience anyway ... I think in terms of experience I'm quite outnumbered with who I work with. I don't feel like I'm newly-qualified though, I just feel like a slightly less-experienced Band 5. I just don't have anything ... like they go on about past jobs and stuff and I can't do that really, I've got nothing to compare other than experience as a student, but I don't feel newly-qualified any more" .

Pay banding was introduced within the National Health Service as a result of Agenda for Change (DH 2004). In the UK nursing staff are paid in pay bands on the basis of the knowledge, responsibility and skills needed for the job (DH 2004). Other nurses in the team were allocated to higher pay bands and therefore an explanation for Jesse's perceptions could be that it was inevitable that she would feel less experienced given the band to which she was allocated. This was a further indication that experience continued to be perceived as a significant factor in their integration and the fact that they had less experience than the senior nurses; this was implicated in their reluctance to identify themselves as a children's community nurse. Nonetheless, this was considered by me to be a key milestone in their transition. For Max there was difference between being a qualified staff nurse and being a qualified children's community nurse:

"I am waiting for this moment when I stop calling myself a staff nurse and start sometimes when I'm on the phone I'll describe myself as a children's community nurse but when I'm writing my notes I always sign it staff nurse so I'm waiting for the defining moment when I stop writing staff nurse and write children's community nurse instead but it hasn't happened yet I'm not sure it will".

At the time of these disclosures, Jesse and Max had been in their post for 10-12 months. It remains uncertain when, if ever, they would perceive themselves to have achieved the identity of a children's community nurse.

For van Gennep's (1960) work the post liminal stage of transition is characterised by the individual taking up their new status and identity. As reported in the literature studies identified that towards the end of the first year new graduates are able to demonstrate capability, although there is some debate as to whether there is a full incorporation (van Gennep 1960) or mastery (Meleis *et al.*, 2000) at this stage. The findings of this study are consistent with those of Farasat (2011) for example who found that the participants at 12 to 14 months still experienced feelings of uncertainty and still felt new in relation to their emerging identity. However, what this study adds is the role that others play in this and that both newly qualified nurses, and those with whom they work are implicated as arbiters of a new professional identity.

7.8 Summary

This chapter has identified that the participants in this study had developed an emerging identity as a children's community nurse. According to Meleis *et al.*, (2000) an outcome of transition is reappraisal of identity. The participants began to reformulate an identity as a children's community nurse when they experienced a change in their own and others' perceptions of their identity. This reappraisal fluctuated as suggested by Meleis *et al.*, (2000) and certain factors were implicated in this. There were circumstances that facilitated the development of their identity and in part knowledge of these is useful in informing strategies to influence an ideal experience of transition. These included wearing the same uniform as other established of the team and gaining support from their colleagues when

they made mistakes. However there were situations that disrupted the emergence of their new identity. Both individuals and organisational structures were implicated in this and included being treated differently to other members of the team, having no desk, being viewed as nurses in training and remaining unable to administer intravenous medication.

The participants were active in developing strategies to overcome these challenges and this is a new finding. This included the suggestion of a hot desk system to overcome the feeling of being marginalised, viewing themselves as part of the team and attempting to integrate into the team, recalling stories of their experiences to emulate others in the team.

Essentially, the participants were both active in developing their identity but also arbiters, along with others, in the final recognition that the new identity had been achieved.

Chapter 8 Discussion and Conclusions

In this chapter I draw together and set out the findings, highlighting what this study adds and pointing out the implications of this work for education, practice and future research.

I also present the limitations in this work.

The purpose of this research was to answer the research question

How do newly qualified children's nurses describe and interpret their experiences of entering the work-world of children's community nursing teams as first post destinations?

The research question was further broken down into 4 research objectives.

1. To identify, explore and describe the meanings that newly qualified children's nurses attribute to their experiences during their transition into children's community nursing teams?
2. To identify and explore those factors, if any, that the participants perceive as facilitating, helpful or necessary to assist in their transition
3. To identify and explore those factors, if any, that the participants perceive as disrupting or impacting adversely on their transition?
4. To make recommendations for practice, education and research regarding the transition of newly qualified children's nurses entering the world of work in children's community teams that are grounded in the experiences of the participants.

This final chapter demonstrates that these objectives were met and reiterates the key messages from this work. What is presented here represents the knowledge and insights that I derived, through a robust analysis of the data. A key strength of this work is that it is firmly grounded in the unique perspective of the participants concerning their transition from student nurse to becoming a qualified children's community nurse. The participants articulated those factors they perceived as facilitating and helpful to their transition and those factors that they perceived as hindering or disruptive to their transition. The key findings add to the empirical body of research in two ways.

First, the work presents insights into the experiences of newly qualified children's nurses as they entered the world of work of community children's nursing teams. Although the transition of newly qualified nurses has been reported, less attention has been paid by researchers to the experience of children's nurses, and no research could be found that focused exclusively on the experiences of newly qualified children's nurses employed by children's community teams as first post destinations.

The second contribution that this work makes is the discovery of the subjective knowledge and interpreted insights of those experiencing transition. I contend that field work observations were central to this as they enabled inductive reasoning. This led to the notion of a potential ideal experience of transition that is grounded in the experiences of those undergoing transition. Aspects of this ideal experience of transition have been identified throughout the study. This ideal experience of transition could be used to inform strategies to ease the transition of newly qualified children's nurses into children's nursing community

teams. This is especially important as there is a dearth of knowledge regarding this yet an increase in the recruitment of newly qualified nurses to children's community nursing posts.

8.1 Summary of the key findings

The thesis concludes that the participants in this study benefited from having a supernumerary period at the start of their transition experience which included being allocated an extended period of time shadowing an experienced practitioner or a preceptor. This was aligned with recommendations made in previous studies in acute care settings that suggest incorporating an extended supernumerary period would be beneficial. This period enabled the participants to practice job specific skills and develop knowledge and confidence in the clinical practice context. This stage of transition was viewed by the participants in a positive light as it eased their feelings of trepidation related to their perception of an increase in accountability. Additionally, ensuring that newly qualified nurses working in children's community teams are not placed in situations beyond their confidence and competence levels without the necessary support and experience is important. This period appeared to act as a buffer against some of the detrimental reactions experienced by other newly qualified nurses previously reported in the literature in acute care settings (Kramer (1974), Gerrish (2000), Whitehead, (2001), and Boychuk Duchscher (2007). This study adds that being supernumerary for a period of time which allows newly qualified nurses to practice and develop knowledge, skills, experience and confidence in job specific competencies in the physical presence of a supporting member of the existing team was viewed as ideal for these participants and achievable in community settings.

It is also important to acknowledge the initial tasks to accomplish during this period. These include learning the roles and responsibilities of a children's community nurse, inherent in this is the development of knowledge, skills and job specific competencies under supervision. This study adds that assessment of job specific competencies by their preceptor is experienced as an important milestone in this process and marks readiness to the move to working on their own.

However a less positive aspect of the extended period of supervision were situations that were perceived as disruptive. These included not having their previous undergraduate nursing education experience recognised and the lack of others' perceived confidence in their ability to undertake any care activities independently. This is a new finding and extends those reported in the literature review. Getting the balance right between protection and surveillance is not easy. Getting the balance wrong could diminish feelings of confidence. This matters as confidence has been reported as a key factor in the transition process (Lauder *et al.*, 2008).

This work has also identified factors that facilitated or disrupted the participants' experiences and movement to working on their own; a key part of any community nursing post. The ideal progression to working on their own was viewed as having further benefits including the fact that they were they were able to make a choice regarding their progression to occasional independent visits. They had some control over this process in terms of the time frame. A positive aspect to moving from the shadowing period to undertaking independent visits was being able to decide when they felt ready. Therefore it

was perceived as ideal for the individual in discussion with their preceptor to make the choice when to undertake visits on their own. This involved enabling an individual to progress at their own pace and waiting until they felt ready, ensuring they were not rushed. The decision included that the visit was dependent on the complexity of the case and that the care needed was within their perceived knowledge and skill capability. The task for individual newly qualified nurses to achieve the milestone of progressing to independent visits was that they made the choice when this should happen.

A noteworthy finding was being allocated children whose care was within their thresholds of capability as this enabled them to work independently. Employing strategies to routinise their actions helped them to cope and deal with the cognitive demands of practice. The participants undertook lone visits and demonstrated examples of working independently. They were able to use learned knowledge and skills to interact and communicate with children and families which in turn enabled them to carry out care on an independent visit. The participants were able to use strategies to manage situations based on previous experience where they had acquired knowledge and skills.

The next milestone in the participants' journey was being allocated a caseload albeit contrived and controlled. This was perceived as a positive change and part of their developing identity as a children's community nurse. The positive outcomes they observed and the positive feedback they received from children and families helped them and aided their transition in the way that they are establishing themselves and their position as a children's community nurse. Being given the opportunity to work independently and

develop their autonomy and responsibility was significant and enhanced their confidence. This is a new finding and has not been reported elsewhere. However when the participants began to visit children and their families on their own they remained reliant on the children's community nursing team for support. Their sense of self trust was tenuous and many sought validation for their decision making and clinical judgements from senior co-workers whose level of practice they admired and respected. This was particularly significant when they were placed in patient care situations that were perceived to be challenging and daunting which included visiting children with child protection or safeguarding concerns. Again this has not been reported elsewhere.

Despite reaching the milestone of undertaking visits independently they continued to seek support from their colleagues indicating that this support was crucial and important. This signaled that they were able to work independently as a children's community nurse showing advancement in knowledge, skill and experience but that they were still reliant at times on the support of others. The evolution of the "ideal" model of transition when visiting alone would therefore include allocation limits and contrived caseloads such that what was needed by children fell within an individual's threshold of capability to develop autonomy, knowledge, skills, experience and relationships with children and families. It seems that at this stage, it would be ideal to continue to have experienced colleagues available for support in order to have knowledge validated and to provide help and guidance.

I commenced this research knowing that there was a gap in the literature in relation to newly qualified nurses working in a community setting. This was supported in a systematic review of experiences and perceptions of newly qualified nurses in the UK undertaken by Higgins, Spence and Kane (2009). The situation specific nature of these matters has meant that they have remained largely unexplored in terms of transition in the literature since the majority of research to date has focused on acute care settings. Importantly, for these participants and as reported in chapter 6 of this work, the community was described as “a different world” in terms of their experiences. This was discussed in terms of contextual differences and challenges such as time spent in the car, or navigating around the geographical location but also in terms of the raised awareness of “being on your own”. Throughout the study the participants compared their experiences with those of colleagues in acute care settings and in the main these comparisons were favourable. Learning how to manage the differences in the community and separate themselves from colleagues in acute care settings is interpreted as a further task of their transition. Adjusting to these differences served to strengthen their emerging new identity as children’s community nurses. The situation specific tasks included the recognition of the shift in power relationships in the home and being able to give advice to parents and children. The ideal was being given the autonomy to work independently, to gain confidence through experience, and being able to face challenges using their agency alongside the help of the organisation and more experienced colleagues.

It is known that one of the main indicators that an individual has completed the transition stage is reformulation of their new identity; this indicates that a key task of transition is

identity reformulation. What emerged from this study, and as reported in chapter 7, were internal and external factors that both facilitated and hindered the development of their identity as children's community nurses. The challenges that adversely impacted on the participants' emerging identity included not being afforded the status of a children's community nurse by not being allocated a desk, making mistakes, being viewed as less experienced than established colleagues and not being assessed as competent in the administration of intravenous medications.

The participants employed their agency to overcome some of these inhibitors. This included developing relationships with children and families and colleagues to gain professional fulfilment, having good experiences, and doing the job well created a sense of achievement and perceived well being. They were able to validate their identity by gathering experience and thereby becoming part of the team.

It was clear that the children's community teams and the organisations in which they were located were very supportive and implemented strategies to integrate the newly qualified children's nurses into the team. However the teams and to some extent the organisations, acted as gatekeepers and sometimes disrupted the participants' transition and their subsequent emerging identity. In these instances the participants felt they occupied a marginal position and that a hierarchy was evident. It would be ideal therefore if these factors were taken into account to avoid marginalisation as this seemed at odds with the participants' subjective interpretations of their developing identity as children's community nurses.

A significant finding of this work was that the participants had still not fully internalised the identity of a children's community nurse concluding that their emerging identity was fluid, not static, and situation and circumstance dependent.

8.2 Limitations of the study

The possible challenges associated with the research design have been discussed in chapter 3. This section of the study offers some final reflections on the implementation of the method in practice. The strengths of this study relate to the application of methods that discovered the subjective knowledge of newly qualified children's nurses during their transition into children's community nursing teams.

In retrospect the qualitative descriptive approach described by Sandelowski (2000) served well to guide my thoughts and actions in data collection, analysis, and interpretation. My purpose for choosing this approach was to establish whether this situation specific experience of transition confirmed or added to the current body of knowledge. As described by Blumer (1969), I began this study with anticipatory suppositions from the literature regarding the concept of transition. However, I was able to use the participant's understandings and experiences to develop, advance and contest what was known regarding the original concept of transition and how this had been applied and translated to derive meaning for nurses.

The participants' willingness to let me share in their day-to-day work by working in the field with them to explore their subjective interpretations enhanced my understanding. The participants provided vivid, informative and insightful accounts. The data collection methods were informed by ethnographic methods and by spending time in the field I was

able to observe, question, participate, listen and communicate with the participants as suggested by Mason (2002). Spending time in the field was extremely useful as it enabled me to elicit the nurses' views, generating rich data to engage in inductive reasoning to gain an in-depth understanding of their perceptions.

As discussed in chapter 3 I wanted to spend time in the field with the participants because I thought this would help me to understand more fully why they acted and behaved in the way they did during their transition. I found this to be the case as discussed and, in keeping with Long and Johnson (2000) spending a significant length of time in the field enhanced validity because it allowed me to gain a more in-depth understanding of the meanings the participants constructed regarding their transition. Further benefits of spending time in the field included gathering information about the context of the environment and some elements of the findings were uncovered that would not have been elicited in interview alone. During the field-work I was constantly aware of my role as a researcher and the importance that this may have had on the process of gathering data. I was acutely aware that the participants may view my presence as intimidating. The majority of the participants had known me before in my capacity as a lecturer. However in reality this proved beneficial in developing a rapport with them. Spending time with them in the field enabled me to develop relationships with the participants which then enhanced their willingness to talk to me. Issues were raised throughout the day during our in-car conversations for example that could be clarified and expanded upon in the interviews. Darbyshire (1994) also highlights the benefits of this time of observation when he familiarised himself with the participants and the research setting.

It also allowed me to generate more data as they discussed issues related to their transition with me throughout the day. It also enabled me to ask questions and refer to incidents in the interviews that would not have occurred to me. It also allowed me to draw on personal knowledge during the interpretation stage of the analysis of the field as Patton (2002) suggests. The benefit of undertaking the interviews after a period of observation was that I had already developed a rapport with the participants.

In order to eradicate my own biases as Bryman (2004) suggests it was important to ensure that I did not allow personal values or theoretical inclinations to unduly sway the conduct of the research. However it is important that I acknowledge the possibility that my presence in the field, acting as a sounding board and helper and engaging in reflective conversation with the participants may have changed in some way their experiences of transition. Again this is inevitable and I contend that the richness and insights gained from fieldwork observation outweigh this. That said it is important that I acknowledge this. Great care was taken to institute rigorous data analysis and interpretive procedures that could serve as checks to the accuracy of the description. Data analysis posed the greatest challenge particularly during the writing up phase. The use of the step by step approach helped me to develop a clear and analytical description of the participants' experiences so that I could tell their story. Throughout the writing up phase I continued to refer to the data on a regular basis to ensure I did not misrepresent their accounts with my interpretations. I kept a detailed account of my analytical decisions with the use of diagrams and a research diary. Discussion and verification throughout with my two supervisors as experts in the research process to confirm and interpret the findings greatly facilitated this progress. My description and

interpretation was challenged and discussed until consensus was reached. The use of reflection on the method in the research diary also allowed me to challenge my assumptions and any subsequent misrepresentations of the data.

Whilst the study had some limitations stemming largely from the focus on a small sample of newly qualified children's nurses in the UK this was inevitable. According to Sandelowski and Barroso (2002) all qualitative research studies are vulnerable to the very elements that provide them with their rich thematic insights. The findings of this study are not generalisable but this was never the intention of this work, the aim was to tell the participants' story of their experiences of transition. However I have attempted to develop new understandings and added to the debate regarding the employment of newly qualified children's nurses in a community setting. The study may have some significance to other newly qualified nurses working in a community setting or seeking to gain employment in a community setting.

Finally, this work focused on the perceptions, insights and interpretations of the participants, newly qualified children's nurses. As such I did not explore the perceptions or experiences of the staff with whom they worked, or, and perhaps more importantly, the children and their families for whom they worked. The recommendations for future research that follow take account of this. Therefore, what has been presented may be considered a partial insight. That said, and as noted previously, there is a dearth of work in this area, this study was attempted to start the process of finding out.

Chapter 9 Recommendations

This final brief chapter sets out the recommendations for practice, education and research.

9.1 Practice

There seems to have been considerable resistance to the employment of newly qualified nurses into children's community nursing teams. In part this reluctance has been fuelled by the assumption that established nurses in children's community teams have insufficient time to effectively supervise these new recruits. The findings from this study contest this. **It is a recommendation that children's community nursing teams are a suitable first post destination for newly qualified children's community nurses.** However, it may be necessary to restrict the number of recruits at any one time to ensure that effective support is achieved during the first twelve months of employment.

This study has made tentative suggestions regarding the components of an ideal experience of transition that could be used to assist those employing newly qualified children's nurses to develop appropriate strategies to ensure successful transition from student nurse to qualified children's community nurse. **It is a recommendation that the components of this ideal model, discovered and grounded in the experience of newly qualified children's nurses entering the work world of children's community nursing teams be used to develop effective strategies to support other newly qualified children's nurses when they are employed in first post destinations in children's community nursing teams.**

As noted in this work it was difficult to ascertain which children's community teams had employed newly qualified nurses. Indications suggest that more newly qualified nurses may be employed by these teams in the future. **It is recommendations of this study that those that do, record the numbers of those recruited and the duration and progress of their employment to establish if those recruited are retained.**

9.2 Education

This study has discovered a number of factors interpreted by the participants as facilitative and disruptive to their transition. **It is a recommendation of this work that those charged with preparing children's nurses in higher education institutions incorporate evidence-based sessions that focus on the experiences, facilitators and disruptive factors for transition, alongside tasks to be completed by newly qualified nurses during their transition into first post destinations.**

A significant factor in ensuring that on completion of their programme of study, children's nurses are ready to join children's community teams, relies on their exposure to the real world of community children's nursing. This would also help established community nurses to gain a better insight into the knowledge, skills and competencies gained by students on undergraduate programmes of nursing. **It is a recommendation of this study, that as many students as possible are allocated to children's community teams and that they experience a contrived case load under close supervision whilst there.**

9.3 Research

This study has highlighted that there is a dearth of evidence to support strategies to ensure that newly qualified children's nurses experience a smooth transition into children's

community teams. Based on the findings presented here, **a recommendation of this study is that programme of research is established to:**

1. Refine, implement and test the tentative ideal model, and the associated components of this proposed in this work to validate the usefulness and outcomes derived from it.
2. To examine, from a national perspective, the transition experiences of newly qualified nurses in community settings in other geographical locations. This could be extended to include other nurses, such as adult and mental health nurses and include the experiences of midwives and other health care professionals.
3. Examine the feasibility, and acceptability of the employment of newly qualified nurses from other health professional and educational perspectives.
4. Examine the cost/benefit of employing newly qualified children's nurses in children's community nursing teams. This could be extended to include other nurses and health professionals.
5. Establish the acceptability to and examine the impact and outcomes on children and their families that follow the employment of newly qualified nurses by children's community nursing teams.

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Appendix 1 – data evaluation sheet

Author, date of publication and country	Title	Study aim and research questions	Methods	Data Collection	Sample	Data analysis	Results
Amos, D (2001) UK	An evaluation of staff nurse role transition	<p>To consider whether Project 2000 courses are producing nurses who are analytical and skilled in critical thinking.</p> <p>To highlight areas of weakness in nurse education that requires change and adaptation.</p> <p>To identify strategies that support and promote role transition from a newly qualified staff nurse to a fully functioning staff nurse.</p>	Exploratory evaluative study	Interviews and focus group	<p>Purposeful Sampling</p> <p>10 Project 2000 nurses qualified during the nine months preceding data collection</p> <p>5 newly qualified working in gynaecological areas in hospital settings (semi structured interviews)</p> <p>5 newly qualified working in non gynaecological areas in hospital settings (focus group)</p>	Content analysis	<p>Responsibility, accountability and autonomy 'the double edged sword'</p> <p>Confidence</p> <p>Support and preceptorship</p> <p>Clinical environment 'thrown in at the deep end'</p> <p>Relationships with medical staff and healthcare assistants</p> <p>The effectiveness of Project 2000</p>

Andersson, N Cederfjäll, C & Klang, B (2005) Sweden	The novice general nurse's view of working in a paediatric setting: a Swedish experience	To describe the experiences and perceptions about the role transition in newly qualified general nurses at a paediatric hospital in Sweden. What do new graduates describe as the content of their nursing practice with regard to responsibility, management of daily and rapidly changing situations and reflection?	Qualitative study	Self report technique written accounts using central themes from orientation programme	18 newly graduated nurses qualified for "about a month" attending a orientation programme at a Children's University hospital	Content analysis	Responsibility Moral issues (advocacy) Knowledge in and management of others Reflection (to understand and think)
Andersson, P.L.& Edberg, A. (2010) Sweden	The transition from rookie to genuine nurse: narratives from Swedish nurses 1 year after graduation	To describe the experiences of newly qualified Swedish nurses during their first year in their new professional role.	Qualitative study	Interview 1 year after graduation	Eight nurses working in acute care settings	Qualitative content analysis	Being a rookie – striving for acceptance, striving for respect Becoming a genuine nurse – being able to shoulder responsibility, being able to convey confidence, being able to prioritise tasks Satisfaction Support Socialization
Beecroft, P. Santner, S. Lacy, M.L. Kunzman, L. & Dorey, F. 2006 USA	New graduate nurses' perceptions of mentoring: six year programme evaluation.	To determine whether mentoring was successful and if new graduates: Were satisfactorily matched with a mentor Received guidance and support Attained socialization into the nursing profession Benefitted from having a role model	Evaluation study Educational decision model	Survey - open and closed questions quantitative and qualitative data One year after qualifying	new nurse graduates 318 working at a Children's hospital	Descriptive statistics SPSS Content analysis	

		for acquisition of professional behaviours Maintained contact with mentor throughout the programme Were satisfied with the mentorship					
Berridge, E.J. Freeth, D. Sharpe, J Roberts, M. (2007) UK	Bridging the gap: supporting the transition from medical student to practising doctor – a two week preparation programme after graduation	The effect of a preparation for practice programme on the confidence and skills of new graduates commencing their first clinical post	Programme evaluation	Questionnaires first day of course final day of course one month into first post Focus group interviews on the same day as questionnaires completed	50 new graduate doctors	Thematic analysis (focus groups) SPSS 12 for Questionnaires	New graduate concerns – taking responsibility, preparedness, clinical skills, clinical decision making. Perceived value of the course – increasing confidence. shadowing (variable) Perceived value of the course after clinical duties – social introductions and socialization gaining confidence in clinical skills, anxious about responsibility Variations in experiences of preceptorship Support varied Lack of time for preceptorship skills deficits reported more responsibility critiques by colleagues Paper 1 Transition shock Paper 2 The stages of professional role transition Paper 3 heroes of their own story: new
Bick, C (1999) UK	Please help! I'm newly qualified	To assess newly qualified nurses' personal experience of induction and preceptorship	Survey	Questionnaire containing both qualitative and quantitative responses Audit	Fifteen project 2000 nurses six months after qualifying Post changes thirty one nurses	Not identified	
Boychuk Duchscher, J. (2007) Canada	Professional role transition into acute care by newly graduated baccalaureate female nurses	What is the experience of the first 12 months of professional practice for the new graduate RN in an acute care setting	Grounded theory	Interviews Reflective journaling Focus groups Undertaken over a period of twelve months	14 female graduates working in adult and paediatric acute care settings	Constant comparative analysis	

		Using previous research and study of initial transition experiences of NG as a guide to the process of discovery what particular aspect can be elucidated to motivate and mediate the experiences of professional role transition in this context		Interviews at 1,3,6,9,12,18 months Focus groups			graduates in acute care
Brennan, N. Corrigan, O. Allard, J. Archer, J. Barnes, R. Bleakly, A. Collette, T. & Regan de Beer, S. (2010) UK	The transition from medical student to junior doctor: today's experiences of Tomorrow's Doctors	To explore the experiences of junior doctors during their first year of clinical practice. How are medical graduates experiencing transition How well prepare do they perceive themselves to be How well supported are they	Qualitative methods	Semi structured interviews AT 3-4 MONTHS and 3 – 4 months after the end of the first year Audio diaries throughout the year	Purposive sampling 31 of 186 newly qualified doctor self-selected. 31 participants were interviewed once and 17 were interviewed twice. Ten of the participants also kept audio diaries.	Thematic analysis	The stress of transition – responsibility, dealing with uncertainty, valued prior experience, preparedness Support Lack of support with dying patients Only learn with experience
Brown, H. & Edelmann, R. (2000) UK	Project 2000: a study of expected and experienced stressors and support reported by students and qualified nurses	To examine stressors and sources of support longitudinally in relation to Project 2000 students and newly qualified adult branch nurses To examine anticipated sources of stress and coping strategies subsequently reported as having been actually	Longitudinal study	Questionnaires containing both qualitative and quantitative responses Phase 2 6 months after qualifying	3 groups of Project 2000 adult branch student nurses 73 students 1st year 20 2nd year 16 completed Follow up Phase 2 Setting not specified	Grounded theory approach	Phase 2 - Less difficulties than expected - expectations of the role feeling part of peer group Difficulties with finances Variable support – some from parents

Brumfitt, S. M. Enderby, P.M. & Hoben, K. (2005) UK	The transition to work of newly qualified speech and language therapists; implications for the curriculum	experienced To ascertain the extent to which the experiences gained on university speech and language courses sufficiently equips the new therapists for the realities of the work context	Mixed methods	Questionnaires Interviews (managers) Focus groups During one year	13 managers 31 new qualified speech and language therapists	Not mentioned for questionnaires Thematic analysis for qualitative data	Newly qualified – level of support varies Preparedness Reported confidence in clinical skills Concerns on starting work managers – start generalists and learn when qualified improvement in clinical skills needed support was important Preparedness improved differences across medical schools 59% well prepared in 2005 36 % in 2000/1 50% 2003 Due to curriculum changes
Cave, J. Gold acre, M. Lambert, T. Woolf, K. Jones, A & Dare, J. (2007) UK	Newly qualified doctors' views about whether their medical school had trained them well: questionnaire surveys	To report the views of newly qualified doctors in 2003 and 2005, compared with those in 2000/2001, about their preparation for clinical work	Survey	Questionnaires 9 months after graduation	2001 5330 67% response rate 2003 4257 65% response rate 2005 4784 43% response rate	Statistical analysis	The reality of practice - managing care Developing clinical Judgment – gaining confidence and experience Developing professional relationships – responsibility and accountability
Charnley, E (1999) UK	Occupational stress in the newly qualified staff nurse	To explore the perceived occupational stresses experienced by Project 2000 trained staff nurses during their first six months as qualified practitioners	Qualitative study	Semi structured interviews Graduated in the previous six months	18 project 2000 newly qualified staff nurses one manager Acute care settings	Grounded theory approach	Ready for practice A question of confidence Different models of staff development Staff nurse development programme
Clark, T & Holmes, S (2007) UK	Fit for practice? An exploration of the development of newly qualified nurses using focus groups	To gain an understanding of the way that competence develops amongst nurses themselves and how this is seen	Qualitative exploratory study	Focus groups Interviews	Purposive sample 105 in total 50 newly qualified nurses qualifying on UKCC (1999) curriculum 55 experienced	Content analysis	

		by managers and those working with them			nurses 11 practice development managers 5 ward managers		Core and specialist skills Competence versus competencies The role of the preceptor the Initiation stage (developing confidence and acceptance learning the ropes) The consolidation stage – integration of knowledge and skills Outgrowing the role Promotion vs. stagnation, confusion and uncertainty Learning the job - challenges to competent practice approaches to the challenges of work (support)
Dearmun, A. (1997)	Paediatric nursing graduates' perceptions of their first year of professional practice.	To explore the perceptions of newly qualified children's nursing graduates during their first year of professional practice	Qualitative approach	Interviews significant events in diaries Pictorial narrative 4 interviews at 3 monthly intervals (3, 6, 9, 12 months)	10 Newly qualified project 2000 children's nurses Acute care settings	Grounded theory	
Ellerton, M. & Gregor, F. (2003) Canada	A study of transition: the new nurse graduate at 3 months	To explore the adequacy of preparation for the role of hospital staff nurse provided by contemporary baccalaureate nursing programmes	Interpretive social science approach	semi structured interviews Within 3 months of first employment	11 nurses All acute care 8 employed in children's hospital Convenience sample	thematic analysis	
Evans, K (2001) UK	Expectations of newly qualified nurses	To examine the concerns and expectations of newly qualified staff at the beginning of their career	Qualitative approach	Focus group	9 child health nurses immediately qualified convenience sample	Content analysis	Role acquisition separation from student status transition to staff nurse status Integration into the profession Developmental aspects of role transition Areas of difficulty in role transition Role mastery
Farasat, H,C. (2011) UK	The invisibility of a new nurse: the experience of transition from student to	What is the experience of making the transition from student to RN (child)	A phenomenological interpretive design	Qualitative interviews at three stages: Mid final year, 3-4 months and	Six children's nurses Setting not specified	Descriptive (Colazzi) and interpretive approaches	Personal and professional identity Primacy of practice Working with people Managing newness

Gerrish, K (2000) UK	registered children's nurse Still fumbling along? A comparative study of newly qualified nurse's perception of the transition from student to qualified nurse	like To examine newly qualified nurses perceptions of the transition from student to qualified nurse and to compare these perceptions with those of nurses in 1985	Grounded theory approach	12-14 months post employment Individual interviews	Initially study 10 staff nurses qualified between 3 and 6 months 25 project 2000 adult branch nurses who had qualified between 4 and 10 months	Constant comparative analysis	Stressful aspects of the role – accountability Managerial responsibilities Clinical skills Clinical decision making Preparedness Learning the ropes
Gould, D. Carr, G & Kelly, D (2006) UK	Seconding healthcare assistants to a pre registration nursing course – role transition to qualified practitioner	To explore the role transition of newly qualified nurses who have previously been employed as HCAs and who have been seconded onto a University course	Qualitative study	Semi structured Interviews 3 months after qualifying	4 newly qualified nurses who had been HCA's ward managers preceptors clinical practice facilitators	Qualitative data analysis	Reflections on the pre-registration programme Feelings about returning to the seconding ward Transition from student to registered nurse new skills Working with the multidisciplinary team Working with unqualified staff Views on preceptorship Fear of failure Real nurse work Guidance Transitional processes Institutional context Interpersonal dynamics Self image and changing status Support and expectations Doing the job
Godinez, G Schweiger, G Gruver, J & Ryan, P (1999) USA	Role transition from graduate the staff nurse: a qualitative analysis	To describe the initial steps in the role transition of graduate nurse to staff nurse	Qualitative study	Feedback sheets during first three weeks	27 newly qualified nurses of an orientation programme in acute care hospital six Newly qualified Children's nurses hospital based undertaking a rotational programme	Content analysis	
Jackson, K (2005) UK	The roles and responsibilities of newly qualified children's nurses	To gain an insight into the meaning of being a newly qualified children's nurse in contemporary health care To identify and	Phenomenology	Unstructured interviews qualified ten to twelve months		No mention	

Lauder W, Roxburgh M, Holland K, Johnson, M, Watson, R, Porter, M, Topping, K & Behr, A (2008) UK	Nursing and Midwifery in Scotland: Being Fit for Practice. The Report of the Evaluation of Fitness for Practice Pre-registration Nursing and Midwifery Curricula Project.	explore factors which facilitated or inhibited the transition from student to register nurse Identifying the extent of and perceived impact of increased flexibility, achieving fitness for practice and partnership working on the skills and competence of newly qualified nurses and midwives Evaluating the one year development programme for practitioners qualifying from September 2005 Further constructing an evidence base and research platform on which to build and develop appropriate nurse and midwife education programmes which reflect and meet modern health care needs	Large comprehensive 3 phase evaluation.	A systematic review Survey OSCEs and paper-and-pencil test In-depth face-to-face and telephone interviews with practitioners and educators Analysis of curriculum documents Focus groups Four stakeholder events Written feedback Postal survey of Flying Start ©	Stratified random sample students n=2011. Student competency n=99 11 HEI & NHS partnerships Stakeholders n=311 Cross sectional survey n=97	Phase 1 Statistical analysis Phase 2 Thematic analysis Phase 3 Statistical analysis	Students consider themselves to be fit for practice A sense of career development and competency progression was reported Flying Start NHS was well regarded. A portfolio of practice experience (often assessed) serves as evidence of fitness for practice
Lempp, H. Cochrane, M & Rees, J (2005) UK	A qualitative study of the perceptions and experiences of pre-registration house officers on teamwork and support	To explore the experiences of the transition of two cohorts in relation to team work support and shared responsibility How well the undergraduate programme prepared PRHOs for	Qualitative study	Semi structured interviews First three months following graduation	33 PRHOs 16 from one cohort 17 from the other convenience sample and quota sampling	Content analysis	Supportive environment Educational environment Organisational changes

Maben, J. Latter, S & Macleod Clark, J (2006) UK	The theory-practice gap: impact of professional-bureaucratic work conflict on newly- qualified nurses	their new posts To examine the extent to which the ideals and values of the pre-registration nursing course are adopted by individual, newly educated registered nurses The extent to which they are able to implement them in practice Whether the so-called theory practice gap remains	Longitudinal study using naturalistic enquiry	Phase 1 Questionnaires with final year project 2000 adult branch students Phase 2 interviews 4-6 months post qualifying Phase 3 Interviews 11-15 months post qualifying	Purposive sample Phase 1 n=72 Phase 2 in-depth interviews 4-6 months post qualification n=26 Phase 3 interview 2 11-15 months post qualification n=26	Questionnaires – content analysis Interviews – constant comparative analysis	Phase 1 Patient centred holistic care Quality care Nursing knowledge and research based care Phase 2 & 3 Professional sabotage – obeying covert rules lack of support poor nursing role models Organisational sabotage – time pressures, role constraints staff shortages and work overload
Maxwell, C. Bingham, L. Logan, J & Smith, A. (2011) UK.	Challenges facing newly qualified community nurses: a qualitative study	To explore the challenges facing recently qualified nurses working in community and intermediate healthcare settings, and their perceptions of role and professional identity, and then to propose effective support structures	Qualitative evaluation study	In-depth individual interviews 8-18 months post qualifying	10 qualified nurses 7 working as community nurses 3 as staff nurses in intermediate care	Thematic and narrative analysis	Transition work New learning Support and supervision Identity and integration
Mooney, M (2007a) Ireland	Professional socialization: the key to survival as a newly qualified nurse	To ascertain newly qualified nurses perceptions of becoming newly qualified nurses	Grounded theory	In depth interviews	12 newly qualified nurses qualified between 6 and 10 months Acute care setting	Grounded theory methods	Old habits die hard - Set in stone Without a voice
Mooney, M (2007b)	Facing registration: The expectations and the unexpected	To ascertain how newly qualified nurses perceived the transition from being a supernumerary nursing student to becoming a registered nurse	Grounded theory approach	In depth semi structured interviews	12 registered nurses Theoretical sampling Acute care setting	Grounded theory approach	An unexpected reality - Great expectations - No time for nursing Facing the trepidations

Morley, M (2009a) UK	An evaluation of a preceptorship programme for newly qualified occupational therapists	To evaluate a preceptorship programme for newly qualified occupational therapists	Qualitative part of a mixed methods study	Semi structured interviews 6 and 12 months into the programme	Convenience sample 4 newly qualified occupational therapists and their preceptors working for less than thirteen weeks Within 12 months of qualifying	Template analysis	Feeling motivated to engage in preceptorship Feeling supported to engage in preceptorship Agreeing expectations Engaging in effective supervision Being confident to engage in observed practice Using preceptorship to improve practitioners' skills
Morley, M (2009 b) UK	Contextual factors that have an impact on the transitional experience of newly qualified occupational therapists	To explore the impact the preceptorship programme had on the transition experience of NQOTs and to identify the contextual factors that would sustain the programmes positive effects	Qualitative part of a mixed methods study	Semi structured interviews 6 and 12 months into the programme	Convenience sample 4 newly qualified occupational therapists and their preceptors working for less than thirteen weeks	Template analysis	Job design Realities of practice Team working Professional identity Development strategies
Newton, J.M. & McKenna, L. (2007) Australia	The transition journey through the graduate year: a focus group study	To examine how graduate nurses develop their knowledge and skills during their graduate programmes and immediately after and to identify factors assisting and hindering knowledge and skill acquisition	Qualitative approach	3 Focus groups interviews 4-6 months into graduate programme 11-12 months into graduate programme 4-6 months after completion of graduate programme monthly short stories for 16 months Findings reported from focus group interviews of first 12 months	25 new graduate nurses undertaking a graduate nursing programme working in hospitals	Colaizzi analysis	Phases - Gliding through Surviving Beginning to understand Knowing how to We've come a long way

O'Malley Floyd, B. Kretschmann, S & Young, H (2005) USA	Facilitating role transition for new graduate RNs in a semi-rural healthcare setting	To describe and evaluate a structured orientation program Six month programme classes and preceptorship	Evaluation Study	Evaluation Questionnaire after four months Open and closed ended questions	31 newly qualified nurses 9 clinical managers 30 preceptors Acute care settings	Descriptive statistics Thematic analysis	Challenges included lack of confidence, knowledge and experience Envisioned becoming more confident and competent over the year Learning experiences facilitated by preceptors and clinical educators
O'Shea, M & Kelly, B (2007) UK	The lived experience of newly qualified nurses on clinical placement during the first six months followings registration in the Republic of Ireland	To explore newly qualified staff nurses' experiences of being on clinical placement in the Republic of Ireland and the meanings that this experience held for them	Phenomenology	in-depth interviews more than six months and no more the seven months	Purposive sample 10 newly qualified staff nurses Acute care settings	Colaizzi approach for phenomenological studies	Challenges –lack of confidence, knowledge and experience support and preceptorship Topics found useful The experience of being qualified highs and lows Stressful aspects of the role - organisational /managerial skills deficits clinical skills deficits The allocation of students Dealing with new experiences Post qualifying - Becoming familiar and being supported Support varied Preparation Previous experience on ward as student
Ross, H & Clifford, K. (2002) UK	Research as a catalyst for change: the transition from student to registered nurse	To examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified nurse To identify areas for discussion and development both in education and service settings	Mixed methods	Pre – qualifying questionnaire 3 months prior to qualifying Pre-qualifying interviews Post qualifying questionnaire 4 months after qualifying Qualitative findings only presented	Convenience sample 19 project 2000 nurses pre qualifying questionnaire 4 interviewed 13 post qualifying Questionnaire Acute care settings	No framework identified Categories generated	

Runcapadiachy, D.M Madill, A. & Gough, B (2006) UK	How newly qualified mental health nurses perceive their role	How is the role of the mental health nurse perceived after mental health student nurses have made to transition to mental health nurse	Based on grounded theory	Semi structured interviews six months post qualifying	11 Mental health nurses Various settings	Grounded theory	Transition Role ambiguity Lack of support Theory practice gap
Smith, R.A & Pilling, S. (2007) Australia	Allied health graduate program – supporting the transition from student to professional in an interdisciplinary program	Report on graduate and facilitator experience of a programme to support the transition from student to allied health professional	Programme evaluation	Questions of the week feedback Process evaluation feedback after sessions 1,3,7,12 Qualified from four days to three months	14 graduates occupational therapy, physical education physiotherapy, podiatry social work, speech pathology	Thematic analysis	Interdisciplinary orientation Facilitate transition Develop team skills Develop professional attributes and knowledge Build commitment to research EBP and learning Critical thinking and reflective skills Skills in managing Team building and networking across campus
Tryssenaar, J & Perkins, J (2001) USA	From student to therapist: exploring the first year of practice	To explore the lived experience of rehabilitation students during their final placement and their first year of practice	Phenomenological approach	Reflective journals Submitted monthly Final placement and first year of practice	6 participants 3 physical therapists 3 occupational therapists	Thematic analysis	stages - Transition Euphoria and angst Reality of practice Adaptation Themes – Great expectations Competence Shock Politics Education Strategies
Thomas, H Hicks, J. Martin, G. & Cressey, G (2008) UK	Induction and transition in the National Health Service for four professional groups	To examine current practice on induction and role preparation in the NHS in the context of a diversity of needs differing practice among professional groups and new NHS workforce developmental policies	Qualitative study	Documentary analysis Interviews	21 participants 1 human resource manager 5 senior managers 5 pharmacists 6 paediatric nurses 2 radiographers 2 community dentists	Thematic analysis	Contexts and cultures Initial training Induction and transition programmes CPD and appraisal

Toal- Sullivan, D (2006) Canada	New graduates' experiences of learning to practise occupational therapy	What is the experience of transition from student to practising OT What are the challenges faced by OTs in their entry to practice How do the beginning OTs learn in a practice context What is the role of mentoring in supporting beginning OTs learning	Qualitative study using phenomenological approach	Interviews Journals First interview – 3 to 5 months Journal for one month Second interview 8 to 10 months	Nurses and radiographers newly qualified Acute and one in primary care setting Purposive six newly qualified occupational therapists	Thematic analysis	Knowledge and skills Expectations of practice Professional identity Learning in clinical practice
van der Putten, D. (2008) Ireland	The lived experience of newly qualified midwives: a qualitative study	To explore newly qualified midwives lived experience of clinical practice with a view to gaining a deeper understanding of their individual experiences as a result to highlight and inform the practice issues which need to be addressed by midwifery education What are newly qualified staff nurses' perceptions of the role transition from student nurse to qualified nurse	Qualitative study using Phenomenology	Interviews	Purposive sample 6 newly qualified midwives who had been qualified for six months	Colaizzi analysis framework	Reality shock Feeling prepared Living up to expectation Theory practice gap Clinical support and mentorship Continuous professional education
Whitehead, J. (2001) UK	Newly qualified staff nurses' perceptions of role transition	What are newly qualified staff nurses' perceptions of the role transition from student nurse to qualified nurse	Qualitative exploratory design	Semi structured interviews nurses average time qualified 8.9 months	Convenience sample 6 Newly qualified Acute care setting	Colaizzi framework	Uncertainty Responsibility and accountability Support Preparation and training Knowledge and confidence Management

Appendix 2 - Participant information sheet

Role transition to qualified nurse: experiences of children's' community nurses

Newly qualified nurses information sheet

I would like to invite you to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to describe and analyse the experiences of newly qualified children's nurses who are making the role transition into children's community nursing teams (in the Greater Manchester area). I am undertaking this study to fulfil the requirements of a PhD qualification at the University of Salford.

Why have I been invited?

You are invited to be a participant as you are employed as a newly qualified children's community nurse in the Greater Manchester, East Cheshire and High Peak Primary Care Trusts.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide. If you decide not to take part this will not affect your career in any way.

What will happen to me if I take part?

As this study is about role transition. The data collection involves a combination of observations and interviews. To take part you would be required to consent to being observed and interviewed on two occasions. The two observations will be for the duration of one shift. The interviews will last a maximum of one hour and would be audio taped with your consent.

What are the possible benefits of taking part?

The possible benefits of taking part in this study may be that you will have the opportunity to give voice to your own views, and understandings of the transition experience. Also there is hope that this information may help other newly qualified nurses undergoing transition.

What are the possible disadvantages and risks of taking part?

Taking part in this study is unlikely to cause you any harm. A possible harm is that you may suffer emotional distress by divulging personal information and your loss of privacy. If you have any worries about this I can discuss this with you prior to the start of the data collection.

It may be that during the observations I encounter nursing practice or unacceptable behaviour that I would consider to be detrimental to the welfare of the child. As a registered nurse I have professional responsibilities to the Nursing and Midwifery Council (NMC 2008) and as such have a moral obligation to intervene to act in the best interests of the child and family. Also I have a responsibility to report the incident to the senior manager of the service and the Institute of Health and Social Care Director at the University of Salford. Where poor practice is witnessed which does not cause immediate concern for the child's welfare this will be discussed with you and reported to your manager.

Will my taking part in the study be kept confidential?

Yes. All information, which is collected, about you during the course of the research will be kept strictly confidential. Maintaining your confidence means ensuring that you as an individual cannot be linked to the data you provide. All the data, which could identify you, will be anonymised. Personal information such as identifiable information, consent forms, audio data will be kept physical separate from anonymised data.

All data will be kept in secure locked store at the University of Salford.

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

You may withdraw from the study at any time. If you withdraw from the study, after any of the stages you will be asked to give your consent for any previous data collected to be used. If you do not want this then any data will be destroyed and not used in the analysis or final report.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Salford's Complaints procedure. Accessible via the University's website <http://www.salford.ac.uk/>

What will happen to the results of the research study?

The results will be published as a PhD thesis and within articles in nursing journals. Results may also be shared with interested parties e.g. The Children and Young Peoples Forum network.

Prior to this the results of the data analysis will be checked with you to ensure they represent your views.

Who is organising and funding the research?

The sponsor for this research is the University of Salford. I am a postgraduate research student within the Institute for Health and Social Care Research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by the Tameside and Glossop Research Ethics Committee.

What happens next?

If you are willing to take part I will contact you to obtain your informed consent.

Please ask me if there is anything that is not clear or if you would like more information.

You will be given a copy of this information sheet and a signed consent form to keep.

Contact details

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Appendix 3 – Children’s community nurses information sheet

Role transition to qualified nurse: experiences of children’s community nurses

I would like to inform you about this research study. Before you decide about your involvement you need to understand why the research is being done and what it would involve for you. Please take time to read the following information carefully. Talk to others about the study if you wish.

Please ask me if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part.

What is the purpose of the study?

This study aims to describe and analyse the experiences of newly qualified children’s nurses who are making the role transition into children’s community nursing teams (in the Greater Manchester area). I am undertaking this study to fulfil the requirements of a PhD qualification at the University of Salford.

Why am I involved?

You may be involved as you are employed as a children’s community nurse in Greater Manchester, East Cheshire and High Peak Primary Care Trusts. The newly qualified nurses within your team are the focus of the study.

Do I have to take part?

Taking part in the research is entirely voluntary. It is up to you to decide. The decision not to take part will not affect your career in any way.

What will happen to me if I take part?

You would be required to consent to being observed if you are in the company of the newly qualified nurse who is the focus of the observation. Each nurse will be observed for the duration of two shifts.

What are the possible benefits of taking part?

It may be that you do not experience any benefits from participating in this study however the information gained from this study will help improve the understanding of role transition experiences.

What are the possible disadvantages and risks of taking part?

Taking part in this study is unlikely to cause you any harm. A possible harm is that you may suffer emotional distress by divulging personal information and your loss of privacy (Long 2007). If you have any worries about this I can discuss this with you prior to the start of the data collection.

It may be that during the observations I encounter nursing practice or unacceptable behaviour that I would consider to be detrimental to the welfare of the child. As a registered nurse I have professional responsibilities to the Nursing and Midwifery Council (NMC 2008) and as such have a moral obligation to intervene to act in the best interests of the child and family. Also I have a responsibility to report the incident to the senior manager of the service and the Institute of Health and Social Care Director at the University of Salford. Where poor practice is witnessed which does not cause immediate concern for the child’s welfare this will be discussed with you and reported to your manager.

Will my taking part in the study be kept confidential?

Yes. All information, which is collected, about you during the course of the research will be kept strictly confidential. Maintaining your confidence means ensuring that you as an individual cannot be linked to the data you provide. All the data, which could identify you, will be anonymised. Personal information will be kept physical separate from anonymised data.

All data will be kept in secure locked storage at the University of Salford.

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

You may withdraw from the study at any time. If you withdraw from the study, after any of the stages you will be asked to give your consent for any previous data collected to be used. If you do not want this then any data will be destroyed and not used in the analysis or final report.

What if there is a problem?

If you have a concern about any aspect of this study, you should ask to speak the researcher who will do their best to answer your questions. If you remain unhappy and wish to complain formally, you can do this through the University of Salford's Complaints procedure. Accessible via the University's website <http://www.salford.ac.uk/>

What will happen to the results of the research study?

The results will be published as a PhD study and within nursing journals.

Results may also be shared with interested parties e.g. Children and Young Peoples Forum network, nurses and lecturers to make sure they are aware of the findings of the study. If you wish I will also write to you and let you know the findings.

Who is organising and funding the research?

The sponsor for this Research is the University of Salford. I am a postgraduate research student within the Institute for Health and Social Care Research.

Who has reviewed the study?

All research in the NHS is looked at by independent group of people, called a Research Ethics Committee to protect your safety, rights, wellbeing and dignity. This study has been reviewed and given favourable opinion by Tameside and Glossop Research Ethics Committee.

What happens next?

If you are willing to take part I will contact you to obtain your informed consent.

Please ask me if there is anything that is not clear or if you would like more information.

You will be given a copy of this information sheet and a signed consent form to keep.

Contact details

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Appendix 4 - Information sheet for children and young people aged 5 and under

Changing from being a student nurse to a trained nurse: experiences of children's community nurses

This information should be read to the child by their parent or carer.

Who is the person doing the project?

I am Angela Darvill. I am a teacher of student nurses at the University of Salford.

What is this project about?

This project is about nurses changing from being a student nurse to being a trained nurse.

Why have I been asked to take part?

You have been asked to take part because the nurse who is part of the study is your nurse.

What will happen during the project?

I will be watching what your nurse does whilst visiting you in your home.

Do I have to take part?

No not if you don't want to. It is up to you. You can take time to decide. Please take your time to decide, if you want to ask your parent or the researcher please do. If you do not want to take part this will not change your care.

Will joining in help me?

I cannot promise the study will help you but it might help other new nurses.

Will facts about me be kept private?

Yes, I will not use your name or address

What happens next?

If you want to take part please tell your family.

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Appendix 5 - Information sheet for children and young people aged 6 to 10 years

Changing from being a student nurse to a trained nurse: experiences of children's nurses

Please read or ask someone to read you this information to you.

Who is the person doing the project?

My name is Angela Darvill. I am a teacher of student nurses at the University of Salford.

What is this project about?

This project is about nurses who are changing from being a student nurse to being a trained nurse.

Why have I been asked to take part?

You have been asked to take part because the nurse who is part of the study is your nurse.

What will happen during the project?

I will be watching what your nurse does whilst visiting you in your home.

Do I have to take part?

No, not if you don't want to. It is up to you. You might want to ask your family for help. If you do not want to take part this will not change your care.

Will joining in help me?

I cannot promise the study will help you but it might help other new nurses.

What if something goes wrong or I become upset?

The project should not upset you, if it does please ask me to stop.

I am a nurse and if I watch anything that your nurse is doing that is not correct I have to do what is best for you. I will explain to her the reason I think it is not correct and I will tell you and your family why I have done this.

Will my details be kept private if I take part?

Any information about you will be kept private.

What happens next?

If you want to take part please tell the nurse who will then contact me to start the project.

Thank you for reading this. Please ask me if you have any questions

Contact details

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Salford M6 6PU 0161 295 2752 a.darvill@salford.ac.uk

Appendix 6 - Information sheet for children and young people aged 11 to 15 years

Changing from being a student nurse to a qualified nurse: experiences of children's community nurses

Before you decide if you want to join in it's important to understand why the research is being done and what it will involve for you. So please consider this information sheet carefully. Talk about it with your family, friends, or nurse if you want to.

Who is the researcher?

My name is Angela Darvill. I work as a teacher of nurses at the University of Salford. I am currently undertaking research to find out newly qualified nurses experiences of changing from being a student nurse to a newly qualified children's nurse working in children and young people's homes.

What is this research about?

This study aims to describe and analyse the experiences of newly qualified children's nurses who are changing from being a student nurse to being a qualified nurse.

What will happen during the research?

During the time the nurse is carrying out your care I (the researcher) will be observing what the nurse does whilst visiting you in your home.

Why are you observing the nurse?

By observing the nurse undertaking your nursing care I want to find out what situations ease or delay this change.

Why have I been invited to take part?

You have been invited to take part as you are a patient who is being cared for by a newly qualified nurse who is the focus of this study. You were chosen because the nurse is visiting you during their shift where I will be observing their work.

Do I have to take part?

No, not if you do not want to. It is up to you. No pressure will be put on you to take part. If you do not wish to take part this will in no way affect your care, treatment or legal rights in the future. I will ask you to sign a form giving your consent. You are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care you receive.

What are the possible benefits of taking part?

I cannot promise the study will help you but the information I get might help other newly qualified nurses to settle into their job.

What if there is a problem or something goes wrong?

It may be that during your care I observe some care that I think is not correct. If this were so I would point this out to your nurse and explain to them why I think it is not correct. I am a registered nurse and have professional responsibilities to the Nursing and Midwifery Council and have a duty to act in your best interests. I will explain to you and your family why I have done this and I will report the incident to the senior nurse manager. I will also report this to my research director.

Will my information be kept confidential?

Yes at no time will I record your name, address or any personal details about you. Information on forms will be kept separate in a secure locked cupboard at the University of Salford.

What will happen to the results of the study?

The results will be published as a PhD study and within nursing magazines.

I may give presentations to nurses and nurse teachers to make sure they are aware of the findings of the study. If you wish I will also write to you and let you know what I have found out.

What happens next?

If you are willing to take part please tell the nurse who will then contact me to undertake the observation.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee.

They make sure that the research is fair. This project has been checked by the

Tameside and Glossop Research Ethics Committee.

Thank you for taking time to read this information sheet – please ask me any questions if you need to.

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Appendix 7 - Information sheet for parents and carers

Changing from being a student to a qualified nurse: experiences of children's community nurses

I would like to invite you and your child to take part in a research study. Before you decide you need to understand why the research is being done and what it would involve for you and your child. Please take time to read the following information carefully. Talk to others about the study if you wish. Take time to decide whether or not you wish to take part.

Who am I?

My name is Angela Darvill. I work as a senior lecturer in the School of Nursing at the University of Salford. I am currently undertaking research to find out newly qualified nurses experiences of changing from being a student nurse to a newly qualified children's community nurse.

What is this research about?

This study aims to describe and analyse the experiences of newly qualified children's nurses who are working as newly qualified children's community nurses (in the Greater Manchester area).

What will happen?

During the time the nurse is carrying out your child's care I (the researcher) will be observing what the nurse does whilst visiting you in your home.

Why are you observing the nurse?

By observing the nurse undertaking the nursing care of your child I want to find out what circumstances ease or delay this change.

Why has my child been invited to take part?

Your child has been invited to take part because the nurse carrying out their care will be observed.

Does my child have to take part?

No, it is up to you and your child. No pressure will be put on you or them to take part. If they choose not to take part this will in no way affect their care, treatment or legal rights in the future. You or your child are free to stop taking part at any time during the research without giving a reason. If you decide to stop, this will not affect the care they receive.

What are the possible benefits of taking part?

I cannot promise the study will help you or your child but the information obtained might help other newly qualified nurses with the change from student to qualified nurse.

Will my child's information be kept confidential?

Yes at no time will I record your child's name address or any personal details about them. Personal information such as information on consent forms will be kept separate in a secure locked store at the University of Salford.

What if there is a problem or something goes wrong?

Although unlikely it may be that during the observation I observe some care that I think is not correct. If this happened I would point this out to the nurse and explain to them why I think it is not correct. I am a registered nurse and have professional responsibilities to the Nursing and Midwifery Council (NMC 2008) and as such have a duty to intervene to act in your child's best interests. I will explain to the nurse and you and your child why I have done this and I will report the incident to the senior manager of the children's community team. I will also report this to my research director.

What will happen to the results of the research study?

The results will be published as a PhD study and within nursing journals. I may give presentations to nurses and nurse lecturers to make sure they are aware of the findings of the study. If you wish I will also write to you and let you know what I have found out.

Who is organising and funding the research?

The sponsor for this research is the University of Salford.

What happens next?

If your child and you are willing to take part please tell the nurse who will then contact me to undertake the observation.

Who has reviewed the study?

Before any research goes ahead it has to be checked by a Research Ethics Committee.

To make sure that the research is fair. This project has been checked by the

_____ Research Ethics Committee.

Thank you for taking time to read this information sheet – please ask any questions if you need to.

Contact details

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Appendix 8 - Consent form for Participants

Participant Identification Number for this study:

Title of Project: Role transition to qualified nurse: experiences of children's' community nurses

Name of Researcher: Angela Darvill

1. I confirm that I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason and without my legal rights being affected.
3. I understand that the research supervisors from the University of Salford may look at relevant sections of my anonymised data collected during the study. I give permission for these individuals to have access to this data.
4. I understand that direct quotes of my data may be used with the agreement that my identity is kept confidential.
5. I understand that if during the observations bad practice is observed that this will have to be disclosed.
6. I agree to take part in the above study.

Name of Participant

Date

Signature

Name of Person
taking consent

Date

Signature

Appendix 9 - Consent form for Children

Identification Number for this study:

(to be completed by the child and if required their parent/guardian)

Changing from student nurse to trained nurse: experiences of children's community nurses

Child /young person to circle all they agree with:

Have you read (or had read to you) about this project?	Yes/No
Has somebody else explained this project to you?	Yes/No
Do you understand what this project is about?	Yes/No
Have you asked all the questions you want?	Yes/No
Have you had your questions answered in a way you understand?	Yes/No
Do you understand it's OK to stop taking part at any time?	Yes/No
Are you happy to take part?	Yes/No
If any answers are 'no' or you don't want to take part, don't sign your name!	

If you do want to take part, you can write your name below

Your name _____

Date _____

The researcher who explained this project to you needs to sign too:

Print Name _____

Sign _____

Date _____

Thank you for your help.

Appendix 10 - Consent form for parent

Identification Number for this study:

Title of Project: Role transition to qualified nurse: experiences of children's' community nurses

Name of Researcher: Angela Darvill

1. I confirm that I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to
consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without
giving any reason, without my medical care or legal rights being affected.
3. I understand that relevant sections of the data collected during the study, may be looked at by
individuals from the University of Salford where it is relevant to my taking part in this research. I
give permission for these individuals to have access to my data.
4. I agree to take part in the above study.

_____ Name of parent and child	_____ Date	_____ Signature
_____ Name of person taking consent	_____ Date	_____ Signature

Appendix 11 -Consent form for children’s community nursing team

Identification Number for this study:

Title of Project: Role transition to qualified nurse: experiences of children’s' community nurses

Name of Researcher: Angela Darvill

1. I confirm that I have read and understand the information sheet dated.....
(version.....) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily.
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my medical care or legal rights being affected.
3. I understand that individuals from the University of Salford may look at relevant sections of the data collected during the study where it is relevant to my taking part in this research. I give permission for these individuals to have access to my data.
4. I agree to take part in the above study.

Name of community nurse

Date

Signature

Name of Person
taking consent

Date

Signature

Appendix 12 Interview Topic Guide

1. “To start with then, I’d like you to talk about your experiences of changing from being a student nurse to being a newly qualified children’s community nurse. What changes have you noticed in your role since you qualified?”
2. “Can you tell me about your good experiences and experiences that caused feelings of discomfort?”
3. Are any of the issues you have raised that are about working in the community? Or would you have expected these issues to arise in any working environment?
4. “What do you understand by the term role transition?” “So when you mentioned X would you say that you were talking about role transition?”
5. What would you say have been the things that have helped or hindered your role transition?
6. Can you think of any activities/events either positive or negative that have been significant in your transition experience?
7. Finally I have been observing you today during your shift. Can you think of examples from today’s shift that highlight your experiences of role transition?

Appendix 13 - template for data analysis of fieldwork observations

Use basic questions about the studied phenomena

- 1. What is the setting of action? When and how does action take place?** Describe the setting e.g. health centre and links to the hospital, the sequence of the action, where they are going

The workplace is the setting for the children's community nursing team. This workplace has several locations. For example the office, the homes of children and families, the car, the hospital ward.

The office where it is situated which patients they service

The car S has own car. S drives the car from setting to setting.

In children and families' homes on visits.

The **hospital ward** was also a setting

when organisation of shifts, shift patterns, date, time and day of the shift I go on

How Observation 1

Observation 2

allocation, types of patients, job description, structure of visits e.g. furthest away location first telephone calls action takes place in children's homes where e.g. bathroom, front room, bedroom.

- 2. What is going on? What is the overall activity being studied, the relatively long term behaviour about which participants organise themselves? What specific acts comprise this activity?**

Look at the overall activity of the team first – type of case load, type of visit and then the specifics of the observations

Divide into observations and settings

Acts – conversations with team, handover, reading notes, making phone calls, going on visits, interacting with children and families, social interactions with other nurses, lunchtime activities, desk location, the car – sat nav and a to z is behaviour different in different settings and what is going on in this setting with these activities and the behaviour during these activities

Observation 1

Observation 2

- 3. What is the distribution of participants over space and time in these locales?**

Space – the office their comments on this, the car and feelings, travel to the office in some cases, the house where the activities take place, on visits some families leave some stay, personal space

Time how long the visits take (I don't record this or do they) morning visits, lunchtime, afternoon visits

Some people not being in busy days and not busy days

Personal space in houses

- 4. How are the actors organised? What organizations effect, oversees, regulate or promote this activity?**

Workload, Networks, Lorenzo, Referrals, organisation and reorganisation of visits, preceptors, training, when worked on their own, shifts and team working, manager employing newly qualified nurses, appraisal,

- 5. How are members stratified? Who is ostensibly in charge? Does being in charge vary by activity?**

How is membership achieved and maintained?

Workforce, Manager, team structure, model of working, lone working with support of colleagues, team people leaving expanding, familiarity experience etc, how long has the participant been qualified, preceptor and training, working with students

- 6. What do actors pay attention to? What is important, preoccupying, critical?**

Visits, referrals, children and families, patients on their caseload, urgent telephone calls, deadlines, outcomes, specific issues e.g. travel expenses with A, relationships with colleagues or children and families, food having lunch, how to get to the settings, environment of office, safety of office, safety of areas where visits are taking place pets in homes and sterile fields e.g achieving a sterile field

7. What do they pointedly ignore that others might pay attention to?

Specific issues e.g. Lorenzo, interactions with children and families, my perception of what they ignore?
Appearance, homes, hand washing, time wasting, hospitality, drink, appearance in houses

8. What symbols do actors invoke to understand their worlds, the participants and processes within them and the objects and events they encounter? What names do they attach to objects, events, persons, roles, settings, equipment?

Is this related to illness or the episode of care structured around the visit? Other objects are car, equipment, diary, phone, sat nav or A to Z, staff nurse or newly qualified, names of child and mum, if they know them or not, events are visits, liaison with health visitors ward team doctors etc phoning for prescriptions, care plans, comments on participant by other members, abbreviations, slang, uniform, resources, bags, equipment, stores, prescriptions, mobile phones, patients notes, referral forms.

9. What practices, skills, stratagems, methods of operation do the actors employ?

All care episodes could be listed linked to the visits, any shortcuts also note writing and when taking notes in car, preceptorship and training – specifics how they learn

10. Which theories, motives, excuses, justifications or other explanations do actors use in their accounting for their participation? How do they explain to each other, not to outside investigators, what they do and why they do it?

Handover, assessment and the nursing process? Education, explaining what they do in the car specific conversations, notes, parents, children and families, previous placements on community. Also previous experience of being in hospital preparation and jobs applied for, where they trained.

11. What goals do actors seek? When, from their perspective, is an act well or poorly done? How do the judge their action – by what standards, developed and applied by whom?

POLICIES AND procedures, feedback, their own examples of good and poor practice training examples not linked to the community, preceptor goals

12. What rewards do various actors gain from their participation?

Training courses relationships with children and families feedback on performance, monetary goals, personal satisfaction, team

Appendix 14 - example of fieldwork data

2. What is going on? What is the overall activity being studied, the relatively long term behaviour about which participants organise themselves? What specific acts comprise this activity?

Observation 1 – I arrive on the shift Yan is in the office with the team leader and another staff nurse Yan is allocated four visits this am. There are 3 nurses on the late shift.

Visit 1

5-year-old child who had trapped her finger in a door at school. Had been having previous visits by the team. Yan had previously referred the child to the plastics SHO as the finger nail was not coming off. This had then been treated. A dressing was now required. Mother sat the child close to her. Yan sat on the floor with the dressing pack on what was a coffee table. I helped out. At one point Yan dropped the dressing. Uses aquasol hand wash before opening the pack and then again after the dirty section. She checks her bag for supplies and dressings. Yan took the dressing off carefully. She talks to the child and the mother. The nail is now growing but there is also a scab. This is carrying out a wound assessment she talks out loud about this so she gives information to the mother as she is undertaking the activity. Mother is also involved in this assessment and commenting. Yan tells me in the car that she wants to keep visiting until this has improved. She cleans the wound with water she has a wound assessment sheet with her which she completes. She puts on a mepolex border light dressing. She makes this decision because she says it will be easier to take off and it is like two dressings in one. The child has hearing aids. Yan books a follow up visit with the mother. She also asked about if she was due to go back to the hospital.

Visit 2

Baby with haemangioma. Needs blood pressure check. Yan noted that during the previous visit the BP had been high from reading the notes she also that there are no parameters from the consultant and that it should not be high but low as the child is on propranolol. Yan assesses which BP cuff will be the best fit for the baby. She has a BP machine with her. She talks to mum and dad and the baby. Yan has notes that the BP machine had not been on charge in the office she charged it when she came on shift at 8am but is concerned that it will run out of charge. Yan attempts to take the BP throughout the baby cries and therefore the BP does not register. Then mum and dad introduce distraction with a toy mobile and Yan attempts again. Then she tries again but it does not work. She decided it is the battery but also does not want to attempt again as child is upset so book to call again the next day. In the notes it also points out an ulcerated haemangioma I ask Yan why she didn't discuss this in fact she asked the parents where it was so she did not know.

Visit 3

A 10-year-old boy who has a dressing to his right shoulder. He had an abscess and drainage. We got slightly lost on the way so we had to turn around. Mum & brother were present. He has been in the shower and is waiting with a bare chest for the dressing to be redone. Yan does a wound assessment and she comments on this to the child and mum it looks much better again this is she also verbalises the type of dressing treatment the one he was having previously is no longer useful as the wound is not deep and just needs topical cream a different one to encourage less scarring. The dressing is then applied. She decided to clean it although the previous nurse has suggested a shower and remove the dressing. Mum said she had not cleaned the wound as such. Arranged the next visit after school before leaving.

The fourth visit was to a child who is on Yan's case load Katie (pseudonym). Yan had visited yesterday and she was visiting today as mum had rung saying she was worried about her. She was concerned that she was not taking her Nystatin not drinking and she may be dehydrated. Yan had been visiting the children ward for a prescription and she had seen this mum when Katie was in hospital so this is a slightly different referral than normal. Prior to this Yan had not visited the house for a while. I note that this is a completely different type of visit it is not just about a wound but the total care of the child. Present are mum, father, two boys and a girl comes into room later. We are in the front room of the house. Yan begins with undertaking a total assessment of the child, this includes look listen and measure clues as she is gaining information from mum by discussion as well as carrying out assessment of breathing, heart rate and temperature and oxygen saturation. The

temperature pulse rate and breathing are elevated but the pulse oximetry is normal in fact may even be slightly higher as mum says than normal. Yan goes to the car to get a tempadot and gives some to mum as she says she has been using a thermometer but it is not working. She then talks to Yan about dry nappies mum is very knowledgeable. She has kept the overnight nappy but the one that is being taken off is wet. As mum is changing the nappy she has diarrhoea and there was some discussion about whether it could be D & V or the antibiotics causing it as she is on antibiotics. She has had a viral illness but the doctors want her to be on antibiotics. Some discussion about the fact as she is not drinking and has been vomiting she is not getting her antibiotics. Yan is able to listen to the mum and advise. Father says something about the nurse and mum jokes with Yan about this that they will call her the nurse in future when mum clearly knows her name and feels she should call her that. She decides together that she needs a medical opinion as Yan cannot listen to her chest. They talk about whether this should be at the hospital where mum has free access or GP. Mum rings GP whilst Yan is there and books an appointment for 5pm. Yan says this may be better than going on the ward and having to see the doctor. Yan also advises mum to ring the team if she wants and Yan will ring tomorrow to check on her. Katie is also on inhalers and this is also discussed Yan gave advice previously because she had been prescribed something different than community policy but this had to be changed Yan wrote the notes in the car but not directly outside the house she drove down the road and then wrote them. Yan told me in the car that she had also assessed her colour and she was paler than the last time she had seen her. Yan took over the care of this child on her case load in November before she was out of her preceptorship period. She did have guidance though for her preceptor this is a child with complex needs a discussion follows about what mum has read on the internet about children with down's syndrome refusing to eat – she does not think it's a severe as this but she may have some of the symptoms she also asks our opinion on applying baby shampoo to sticky eyes we both don't think this is a good idea and mum says she has had mixed reactions to this – on return to the office Yan looks at the evidence base behind this and it is mentioned but no evidence as such? Yan tells me that she didn't see Katie and her mum as she went to train on the NMGH for a month and the other members of the team took over her care.

Appendix 15 - Key themes of study

Key theme	Shadowing	Visiting	The challenges of working in a community setting	Emerging identity as a children's community nurse
	Protection versus surveillance	Progressing to occasional independent visits	The car	Environmental Integration (Being out of place)
Sub themes	Starting from scratch	Undertaking independent uncomplicated care	Navigating	The Primacy of being seen as experienced
	Being signed off - assessment of competencies as a key milestone to lone visits	Undertaking complicated care	Being on your own	Team Working
		Benefits\and challenges of having a caseload		Making mistakes
				Visible signifiers of identity
				The IVs – the final competence
				The arbiters of their own identity
Key messages The Ideal experience of transition	Separate time period at the start to learn and develop job specific skills Physical presence of a supporting individual Observe different styles of practice Have previous experience recognised	Having the confidence and competence to choose to commence lone visits Being allocated visits based on their previous experience and capability level Feeling valued by being allocated a case load Support of colleagues continues with allocation thresholds opportunities to develop their knowledge, skills and experiences Develop relationships with children and families Make a choice when to move to independent visits Continue to access support from colleagues Develop capability by focusing on routine care Develop knowledge skills and experience through interaction with children and families Move from task based care to a more holistic approach to see the bigger picture	Being given the autonomy to work independently to gain confidence through experience. Being able to face challenges using their own agency but also with the organisation and colleagues support.	Being given a place or hot desks Being recognised as experienced Become part of a team Support of colleagues if make mistakes Perceived lack of hierarchy
Tasks of transition	Assessment of competence in job specific skills prior to working independently		Navigate the streets Recognise the shift in power relationships in the home and be able to give advice to parents and children Learn to manage the differences in community	Validate identity by gathering experience Integrate into the team Recognise that not infallible and mistakes are made

The transition experiences of children's community nurses

