The Experiences of Newly Graduated Nurses in Saudi Arabia: A Qualitative Case Study Examining Social, Cultural, and Contextual Challenges

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DEDICATION

By the grace and mercy of Allah,

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ABBREVIATIONS

ANCC: American Nurses’ Credentialing Centre

HN: Head Nurses

ICU: Intensive Care Unit

MoH: Ministry of Health

MoHE: Ministry of Higher Education

NGNs: New Graduated Nurse

NMC: Nursing and Midwifery Council

PIS: Participant Information Sheet

UK: The United Kingdom

UKCC: United Kingdom Central Council for Nursing, and Health Visiting

USA: The United States of America

SA: Saudi Arabia

UoS: University of Salford

GLOSSARY

Transition: In this study, this concept refers to the shift from the role of a student nurse to the role of registered nurse.

Foreign Nurse: International Nurses

New Graduate Nurses: Registered nurses with less than 12 months of experience in their first post destination worked at hospitals.

Preceptors: Clinical nurses responsible for supervising, training and teaching new graduate nurses.

Orientation Programme: A structured program designed for gradate nurses, usually lasting fewer than three months, to orient graduate nurses to the healthcare organisation.

Saudisation policy: Saudisation policy, which is intended to allow Saudi citizens with suitable qualifications to replace foreign workers.

Magnet Hospitals: Hospitals known by their characters for being great places for nurses to work revealed from notes that hospitals that were successful in bringing and hiring qualified nurses.

ABSTRACT

Background: The literature indicates that newly graduated nurses (NGNs) tend to feel inadequate during their first year of employment, due to a series of challenges they encounter with whilst transitioning into the role of qualified nurse. Although there is much research on the experiences of NGNs in a western context, far less attention has been paid to the experiences of NGNs in the eastern context, where the social, cultural and contextual climate is largely different.

Aim: To explore, describe and interpret the experiences of NGNs at a hospital in Saudi Arabia during their first year of employment, emphasising how culture and social attitudes affect the NGNs' transition process, and how NGNs rationalise such experiences.

Method: Qualitative case study informed by an ethnographic approach, to provide rich data into the context and meaning-making.

Data collection: Data was collected via fieldwork observations and semi-structured interviews with nine NGNs and four Head nurses.

Data Analysis: Data was analysed using thematic analysis, as described by Braun and Clarke (2006), to enable the synthesis of different data elements to produce a cohesive account of the case.

Findings: The Saudi NGN transition process shares multiple features with the transition process described in international literature. However, the Saudi transition process is also shaped by unique cultural and social challenges not present in other countries, that influence experiences in a culturally distinct manner. These factors include nursing's lesser status in Saudi society, cultural views on women's labour force participation, the presence of foreign nurses, Saudi culture's lack of familiarity with nursing, sex-segregation, night shifts, and transportation challenges. Due to these challenges, NGNs struggle with self-confidence, emotional distress, low job-satisfaction, asymmetric relationships with senior nurses and doctors, and an intention to leave. These findings inform a set of recommendations for government, policy-makers, and educators, that help to improve Saudi NGNs' transition process.

CHAPTER ONE: THE NURSING PROFESSION IN SAUDI ARABIA

1.1 Introduction

Saudi Arabia (SA) only became a state comparatively recently following the unification of its regions in 1932 under King Abdulaziz Al Saud (Mufti, 2000). The Kingdom is a wholly Muslim country and one of the biggest states in the Middle East region. It is located at the edge of the Asian landmass, covering an area of approximately 2,218,000 km^2 (Ministry of Economy and Planning MOEP, 2013a). SA includes 13 separate administration areas, with multiple emirates and governorates (Ministry of Economy and Planning MOEP, 2013), as shown in Figure 2 (map of SA).

The 2012 census showed that SA has more than 29 million inhabitants, with a 55%- 45% male-female gender split (Ministry of Economy and Planning MOEP, 2013b). Furthermore, the country's eight million residents are not Saudi citizens (Ministry of Economy and Planning MOEP, 2013a; SA Information Resource, 2013). In 2010, the population increased by approximately 2.3% (Ministry of Economy and Planning MOEP, 2013).

Figure 1.1: Country Map of SA and Neighbouring States

The economic environment in SA has been shaped by a highly formalised system of planning (Cordesman, 2003). Meanwhile the main basis of the economy is oil, and in recent years

intense efforts have been made to increase diversification in a bid to make the economy less dependent on natural assets (Ministry of Economy and Planning MOEP, 2013a; Saudi Arabia Information Resource, 2013). The discovery of oil in Saudi Arabia was made by a US firm in 1938, and this has since driven Saudi economic development and political influence. The country is the strongest Middle Eastern and Arab nation in economic terms and is the world's biggest oil exporter (Ministry of Economy and Planning MOEP, 2013a; SA Information Resource, 2013). It has 20% of the world's known remaining oil resources, and 90% of the country's income and available expenditure are derived from oil (Aldossary, While, & Barriball, 2008). The development of oil resources has enabled SA to develop both its economy and living standards (Mufti, 2000).

1.2 Saudisation

In order to address the issue of unemployment, the government of SA formulated a *Saudisation* policy in 1992. This allows companies to replace foreign workers with Saudi citizens with suitable qualifications (Alhosis et al., 2012). However, annual targets for the number of Saudi citizens filling positions have repeatedly not been met by the healthcare industry, which is the biggest employer covered by the policy. As nurses comprise the single biggest group of healthcare workers, the Ministry of Health's policy has focused particularly on Saudisation among this group (Al-Homayan, Shamsudin, Subramaniam, & Islam, 2013).

The principal barrier to Saudisation in nursing is the negative perceptions of this profession amongst both Saudi nurses and the wider community (Al-Homayan et al., 2013; Al-Mahmoud, Mullen, & Spurgeon, 2012). Studies in this area connect the perceptions of nursing held by Saudi nurses to religious, social and cultural beliefs and attitudes, a difficult working environment, limited flexibility to achieve an effective work-life balance, and the poor image of the profession (Al-Mahmoud et al., 2012; Miller-Rosser, 2006). On the other hand, while there are barriers to the Saudisation process as applied to nurses, increasing financial pressures are leading more women in SA to seek employment in this role (AlYami & Watson, 2014).

1.3 Nursing and the Saudi Healthcare System

A rapidly implemented programme aims to enhance the Saudi system of healthcare as a result of the rising demand for health services among the population, which is experiencing a changed way of life (Aldossary et al., 2008). This involved massive investment on the part of the government, developing healthcare provision that is free at the point of use for both Saudi citizens and others employed by public sector organisations. Meanwhile, privately employed workers generally receive sponsorship for their health costs from their employers. The budget for the Saudi health service comes from governmental budgets, based largely on income generated by the oil and gas sector (Al Yousuf, Akerele, & Al Mazrou, 2002); 2010, this accounted for 6.5% of the country's gross domestic product (Almalki, FitzGerald, & Clark, 2011a). Healthcare services are provided by the Ministry of Health to the government and public institutions, such as the Ministry of Defence, Ministry of the Interior, university teaching hospitals and the National Guard (Al Yousuf et al., 2002). It is estimated that the Ministry of Health (MOH) provides approximately 60% of all healthcare, with the remainder provided through either private or different government organisations. More specifically, primary care facilities and hospitals are generally managed by private or other governmental providers, while the Ministry of Health has overall responsibility for services. These include prevention and curative treatment and rehabilitation, with healthcare offered via primary care facilities spread across the country (Aldossary et al., 2008).

1.4 The Nursing Profession in the Saudi Context

A range of factors influence the state of professional nursing within SA; the situation is currently dynamic and undergoing rapid development. These influences include the country's rapid economic rise, changing society and rapidly increasing numbers of Saudi nurses. In comparison with the West, the nursing profession is a recent innovation in Saudi society (Tumulty, 2001). From the time when healthcare services were first offered in the country, non-Saudi nurses from a wide range of countries have made up a significant proportion of this profession (Aboul-Enein, 2002). Furthermore, there was no published work on nursing in SA before the 1960s, and very little published before 1980 (Aboul-Enein, 2002; Mufti, 2000; Tumulty, 2001).

Mufti (2000) describes the healthcare offered in the country up to 1960 as reliant on primarily traditional approaches, with no Saudi nurses, and no medical or nursing educational institutes (Mufti, 2000). Formal nursing education began with the founding of a nursing college in Riyadh in 1959 (Tumulty, 2001). Since then, however, despite the development of both healthcare and nursing education in the country, a large proportion of nurses working in SA continue to be from other nations, with varied cultures (Almalki et al., 2011a).

Currently, nurses in SA come from approximately 40 nations (Abu-Zinadah, 2006). The diversity of the profile of the professional nursing group, in terms of culture, religious affiliation, ethnicity and education, has led to complexities in nurse identity and the quality of care offered, thus making it harder for Saudi nurses to enter the professional setting. Furthermore, professional nursing practice in SA has had a western identity from its inception, based not only on the composition of its workforce, but also on its structure and regulation (Tumulty, 2001). This did not start to change until moves were initiated to expand the Saudi influence on directing, running and legislating for the profession.

1.5 Saudi Nursing Education

Saudi education was established with various country-specific features, such as gender separation, which has been in place since the country's formation in 1932. Thus, all female educational institutions in SA have female-only employees and all-male institutions are male-only, including medical education, nursing instruction, public health, and health sciences (Miller-Rosser, 2006).

Nursing education in SA has evolved through various stages. The first year-long course introduced by the Ministry of Health in 1960 was for males only (Tumulty, 2001), and was later extended to a three-year course open to both genders. This was run by an institute of health (Miller-Rosser, 2006), the first of its type, with small numbers enrolling and graduating. During the course, strict gender segregation was practised. On completion of the course, students gained a Diploma in Nursing, analogous to the USA's licensed practical nurse award (Miller-Rosser, 2006).

In what was a socially and economically developing country, the Saudi government identified a mismatch between the requirement for nursing care and the numbers of Saudi

nursing staff, which led to the creation through the MoH of the pioneering Health College in 1972. This was followed four years later by the creation of two female-only nurse education colleges at Jeddah's King Abdul-Aziz University and Riyadh's King Saud University. These were established by the Higher Education Ministry and courses were provided first at undergraduate level (Tumulty, 2001), and from 1987 onwards at postgraduate level (Tumulty, 2001). However, the first PhD-level course was introduced in 1995 through a programme which involved a UK university, in which small numbers of nurses already holding a Master's degree were able to enrol (Abu-Zinadah, 2006).

The Higher Education Ministry (MOH) acted on behalf of the government to reform the state's higher education system in 2006, with the creation of a further 18 Saudi universities spread across the country, bringing the total number to 25 (MOH, 2014). All the universities were equipped with health sciences and/or nursing schools. A further step was taken to address shortages in terms of course places and fill skills gaps in the form of the King Abdullah Overseas Scholarship Programme. This has led to a situation where the government provides support to large numbers of Saudi citizens to study abroad, with over 150,000 doing so across 25 countries in 2014 (Ministry of Higher Education, 2014).

1.6 Saudisation in the Nursing Profession

Healthcare providers in SA have encountered challenges attracting and retaining nursing professionals, and evidence shows that most young Saudi women perceive nursing to be a socially unsuitable profession (Al-Mahmoud, 2013; Gazzaz, 2009; Hamdi & Al-Hyder, 1995; Mebrouk, 2008). Furthermore, parents are also likely to have reservations about their child choosing to study to enter the profession (Al-Johari, 2001; Gazzaz, 2009). Meanwhile, male nursing professionals in the country face difficulties countering the stereotypical view of nurses, and most apply for nursing administration roles (Luna, 1998).

The low levels of interest in taking up nursing as a career, as well as significant staff turnover, have been blamed on the lack of status attributed to the role of nursing, as well as its poor public image. Furthermore, a shortfall in nurses during the 1991 Gulf War was cited by Aboul-Enein (2002) as leading the government to formulate a Saudisation approach. This shortfall was mainly a result of the fact that 7 out of 10 nurses in SA were

expatriates, and when they returned to their home countries, the nursing profession was severely affected (Al-Mahmoud et al., 2012).

Several research projects have considered possible approaches to attracting and retaining Saudi nurses in greater numbers, in line with the drive towards Saudisation. The main recommendations involve improving access to nursing education, raising salaries, and creating better workplace conditions (Al-Mahmoud, 2013; Alghamdi, 2014; El Gilany & Al Wehady, 2001). An additional proposal involves dedicating entire hospitals to either males or females as a strategy to attract a large Saudi workforce (Jackson & Gary, 1991).

1.7 Saudi Culture and Society

Arab lifestyles and Islam's ethical values and norms are enshrined in SA's society and culture (Hamdan, 2005). The belief that Allah, or God, is responsible for one's wellbeing, any ailments, and ultimately death, as upheld by much of the Saudi population, reflecting the beliefs of other Muslims. Lifestyle, health, education, the economy, and politics are examples of the varied aspects of society that are shaped by Islam in SA. One example is the halal principles relating to food, which stipulate that *Sharia* rules for the killing of all birds, camels, sheep and cattle must be adhered to, thus influencing the Saudi Muslim population's food and drink customs. There are no rules on the consumption of fish, although as Kayed & Hassan (2010) stress, drinking alcohol or consuming blood from deceased animals and any pork or pork-derived goods are prohibited. Further relevant rules relating to food and drink concern how people should be seated and use their right hand to hold what they ingest or imbibe, according to the Prophet Mohammed (PBUH)[1] and under Islam.

A crucial foundation of Saudi society is the family. Mebrouk (2008) described how family bonds are regulated by principles of conduct, as well as ethical norms such as benevolence, integrity, obedience, reverence, sympathy, compassion, loyalty and honesty. A visit to grandparents and other elders within the extended family at least once a week, typically on a Friday, is often considered requisite. Elderly people are usually helped by younger relatives, with significant respect shown.

[1] Peace be upon him. A Phrase Muslim use to refer to Prophet Mohammed.

As Rawas, Yates, Windsor, & Clark (2012) have explained, care provision and homemaking are crucial societal roles that have traditionally been assigned to Saudi females, thus often consigned women to the home. Nevertheless, women are assuming an increasingly essential role in wider Saudi society, afforded the same employment rights as males and working in professional roles in numerous sectors, such as banking, the media, higher education, schools and medical facilities.

International education scholarships for countries such as the USA, Canada, the UK and Australia are open and available to both males and females, despite the continuing presence of sex segregation in all levels of education. In recent years women's rights have been expanded, giving them a foothold in areas where males traditionally had an advantage. As reported by Arab News (2011), Saudi females were given the right to vote, run for municipal elections and stand for the Shoura Council in September 2011. In 2018, women were given permission to drive, although when this study was conducted, this right had not yet been established. Before 2018, women were required to travel to school and places of employment accompanied by a male guardian.

1.7.1 Religion and Culture in SA

The Saudi population has fundamentally shaped SA's culture and religion. In order to effectively comprehend the environment for nursing in SA, the country's culture and religion are described in detail in this section. Given the closed nature of Saudi society, there are numerous ways in which the culture of the country and Islam in general have been poorly understood.

1.7.1.1 Islam

Nasr and Religionsphilosoph (2003) described how almost 1,500 years ago, the Prophet Mohammed (PBUH) received the revelations of the religion of Islam. Submission to Allah and acquiescence to the law that Allah has laid down are the central obligations of every Muslim. Nasr & Religionsphilosoph (2003) explain that the revelations of Abraham, Moses and Jesus (PBUT) were finalised through the message of Prophet Mohammed (PBUH). Prophet Mohammed's (PBUH) message was the final one from Allah, and is compiled into the Qur'an. In the Qur'an (12/3), Allah declares, "Verily, we have sent it

down as an Arabic Qur'an in order that you may understand". [2] All understanding in Islam is derived foremost from the Qur'an, with the bonds between Allah and mankind being the fundamental subject of the Holy Book. The Archangel Gabriel revealed the message of Allah in Arabic to Prophet Mohammed (PBUH), which was later set down in the Qur'an. Islamic law or *Shariah* includes the Hadith or Sunnah as a secondary knowledge foundation, with the Hadith deemed to comprise obligatory rubrics based on Prophet Mohammed's (PBUH) sayings (Rehman, 2007). The Hadith form the basis of additional rules known as the Sunnah. Rehman (2007) explained these as comprising a set of norms based on Mohammed's (PBUH) own actions and maxims, or those to which he implicitly assented.

Law, relationships, worship, norms, understanding and every other component of human activity are governed by aims under Islam. The means of introducing a just economic infrastructure, fair human activity and an equitable society are all outlined in depth and strategized according to Islam's teachings. A path of innocence and another of peril shape Muslims' lives, with a definite final end point in the form of Heaven (Rehman, 2007). Throughout the life of a Muslim, taking the path guided by Islam is considered to chart one's journey to Paradise, thus avoiding Hell. Access to heaven is considered to be a Muslim's overall goal. Acts that are *haram* will take a Muslim further from Heaven, while *halal* acts will move them nearer.

Ultimately, prior to engaging in an activity or reacting to something, devoted Muslims will reflect on their options based on Prophet Mohammed's (PBUH) guidance. All acts that would reduce the prospect of gaining entry to Paradise will be shunned by devoted Muslims in the knowledge that they could face death at any time, meaning they must constantly be ready for the afterlife. Fulfilment of one's aim of entering Paradise will be undermined if one derives enjoyment from *haram* activities. *Haram* and sinful activities, as decreed by Allah, should be avoided, with Muslims needing to be fearful of God, acting in a devout manner, as desired by God (Abdal-Haqq, 2002; Rehman, 2007).

The social conventions, spiritual customs, language and conduct of the Saudi people are interwoven with the daily enactment of Islam. Being answerable to Allah for one's

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2 The Qur'an, (1989). Surah Yousuf, (12/3).

conduct is understood by every Muslim, as one's position as a servant of Allah is accepted. It is believed that Hell is where evildoers will reside, while Heaven will comprise myriad joys available to the virtuous, meaning that death marks the beginning of eternity rather than a finite end to life. The cultural and religious power of Islam's norms have been stressed by Ayoob and Kosebalaban (2009). When individuals are inclined towards inertia and fatalism in the field of health, the creative and robust action required by Islam can be beneficial.

SA's culture is inextricably connected to the principles and ethical norms enshrined in Islam. As Al-Shahri (2002) notes, the practices involved in being Muslim fundamentally shape the daily activities of Saudi citizens and their social perspectives, based on Islam's instructions and associated activities. Thus, the life of Saudi citizens involves moral duties, principles and knowledge, which are all shaped by the scientific, academic, physical and spiritual understanding comprising Islam. Ayoob and Kosebalaban (2009), Al-Shahri (2002), Long (2005) and Aldossary et al. (2008) have also described how Saudi culture is influenced by economic standing, educational attainment and environmental variables. Nevertheless, as Al-Shaikh (2007) emphasised, all socioeconomic changes that have taken place in SA have been underpinned by the infrastructure of Islamic principles.

1.7.7.2 Gender-related Issues

Female and male obligations and roles are dealt with in both the Hadith and the Qur'an. With regard to faith, as Alsaleh (2012) notes, there is equitable treatment of females and males in Islam, with no gender distinctions. Females are obliged and fully able to fulfil the directives and orders of God. As the Qur'an (7/189) states, in the eyes of God there is moral equivalence between males and females, who were forged from one soul.[3] Moreover, as Nasr and Religionsphilosoph (2003) elaborated, the historical spread of Islam depended on the actions of both men and women; indeed, fundamental roles were filled by female Muslims.

Rights of an economic, political, social and spiritual nature are all due to females in Islam. Donno and Russett (2004) and Sidani (2005) are among the academics who have stressed

3 The Qur'an, (1989). Surah Al-Araaf, (7/189).

that social, political and spiritual issues have all been engaged with and discussed by females throughout the history of Islam. In this life, all potential origins of knowledge should be pursued and explored by Muslims, according to Islam. Moreover, Bahramitash (2004) notes that women are accorded the right to access knowledge, engage in business, inherit property and to get divorced.

A number of feminist movements emerged in the Arab world during the early decades of the 20th century. Sidani (2005) described the acceptance by religious authorities and wider Arab society of female participation in traditional employment roles, such as nursing, education and medicine, as well as their right to an education. Social work, teaching, nursing, military and policing roles, the judiciary, ambassadorial work, senior political positions, engineering, medicine and law are all professions that are open to female Arabs (Haddad, 1984, p.149). Moreover, Sidani (2005) notes that over the past three decades, women's literacy levels increased by 300% in Arab states. The Arab Human Development Report (2002) also stressed the considerable efforts made by the Arab world to tackle gender-related issues. Nevertheless, it has been suggested that growing discrepancies between different Arab states and the ongoing, generally limited, levels of female participation in the workforce are significant (Sidani, 2005). As Long (2005) and Sidani (2005) emphasise, the social and spiritual power of Islam continues to have a significant effect on the daily lives of the citizens of Arab states, including SA.

In SA specifically, Alamri (2011) explained that a state female education initiative was established by the Government in 1960. Subsequently, SA's ongoing development has led to an increase female employment and improved educational prospects.

School attendance among girls in SA stood at approximately 50% by the mid-1970s. Five years later, every girl in the country had the opportunity to attend school and from 1980 six universities admitted women (Hamdan, 2005). Nevertheless, as the United Nations Development Program (2008) pointed out, the country's adult literacy rate among women was just 87.1% of that for men in 2003, while only 69. 3% of women possessed writing and reading skills, even given the substantial progress over previous years.

Women's work and educational prospects for females have clearly improved as SA continues to develop. Nevertheless, SA does not legally oblige women and men to undergo formal education, meaning that family perspectives will shape female

participation in education (Alamri, 2011). Moreover, it is evident that within SA, Islam has a significant part to play. The lifestyles of males and females in SA are markedly influenced by established cultural and traditional norms, and social perspectives are significantly affected. Ultimately, a dearth of employment prospects in gender-segregated workplaces is a barrier to Saudi females, even if their participation in education has grown. As a result, women's involvement in the Saudi workforce has declined. Ramady (2013) noted that just 4.8% of SA's labour force comprises women, although they comprise up to 55% of all university graduates. Meanwhile, the female Saudi population of working age stands at 4.7 million.

There are a number of common misconceptions regarding the complicated roles of Saudi women in society. In both the private and public sphere, gender segregation is enforced in line with Saudi social conventions. The Qur'an (33/59) stipulates that female Muslims and the wives of the Prophet must cover their whole bodies with cloaks or veils.[4] Therefore, Saudi women are obliged to cover their hair with a *khimar* (headscarf) and *jilbaab*, while obscuring one's face may also be necessary in certain circumstances. Furthermore, the Qur'an (24: 30-31) necessitates modest attire and conduct among men and women. [5]

Most nurses in SA, whether female or male, face a significant challenge in the form of gender segregation (Meijer, 2010). Ultimately, female and male patients will typically be limited to being treated by female and male nurses respectively. Indeed, most female nurses would not be prepared to work with and treat men, and their relatives would be likely to disapprove of them doing so. Moreover, women's assumed characteristics are considered to be contravened by the nursing role, which is seen as socially unacceptable for women (Meijer, 2010). Nevertheless, El-Sanabary (1993, 2003) and Tumulty (2001a) have found that job requirements such as long shifts and night work, which remove nurses from the domestic sphere for long periods, are well-understood by nurses. Consequently, Saudi society is affected by the resulting friction between nurses and their relatives.

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4 The Qur'an, (1989). Surah Al-Ahzab, (33/59).

5 The Qur'an, (1989). Surah An-Nur, (24/30-31).

The fundamental character (*innate nature*) of women is regarded by Saudi society as being undermined when they participate in areas of work traditionally reserved for men, essentially resulting in the fall and subjugation of women, according to the religious academic Ibinbaz (1985). Nevertheless, women can be involved in fields such as medicine, nursing and education, according to Ibinbaz. Consequently, religious academics typically stipulate the requirement for females and males to be segregated, although they do not challenge female work and education. This is due to the belief that Muslim societies will degenerate and collapse if males and females openly fraternise at work. Therefore, SA has continued to prohibit mixed-gender work environments to safeguard society. This position limits women's ability to contribute to society in SA.

Syed (2010) and Sidani (2005) explain that female Muslims face no limitations on their employment or educational prospects under Islam. However, women must lower their gaze, only leave their home with their face covered, and are prohibited from working alongside males under Islam. According to Muslims, Allah provided all women with beauty, but this should not be viewed by everyone. Islam stipulates that if a woman dresses modestly, it is her character, belief and intelligence that will elevate her and which be observed and revered by men, rather than her beauty. Even so, these religious and social obligations conflict with the requirement for an expanded labour force of nurses. These tensions are investigated in this study within the context of religious and cultural effects on the medical care profession.

1.7.2 Islam and Nursing

During the era of Prophet Mohammed (PBUH) (570-632AD), the Prophet supported the efforts and activities of voluntary Muslim nurses. Although this has given nurses a revered and admired position in Islam, this has not helped to avoid the dearth of nursing staff, or employment and retention difficulties in the contemporary period (Heydari, Khorashadizadeh, Nabavi, Mazlom, & Ebrahimi, 2016). The nascent Islamic community had to be protected during the early Islamic period 14 centuries ago. Subsequently, different rival and powerful civilisations, for example the Persian and Byzantine empires, had to be challenged and Islam disseminated to other areas. During battles, Muslim females fulfilled the role of voluntary nurses, whereas in the pre-Islam period Arab women had the more restricted role of championing and supporting men during fighting.

As Charles and Beth Daroszewski (2011)) and Heydari et al. (2016) note, women's tasks included passing weapons and arrows to warriors, removing martyrs from the field, providing water to dehydrated soldiers and tending to injuries using first aid. Mahir (1970) noted that these activities, which aimed to reduce misery and discomfort, earned them the name *al-Asiyat*. A more structured social health service was subsequently established in which religious obligations shaped nursing practice. Moreover, Sultan (1990) and Al-Osaimi (1994a) note that following the conclusion of a war, Prophet Mohammed's (PBUH) instructions were that nurses should receive an equitable proportion of the loot and spoils, as well as the same prestige and respect as male warriors, as an acknowledgement of their services. In fact, he promoted engagement in such service provision among his own daughters and wives.

Nevertheless, nursing services have also been active outside of conflict. For example, Rassool (2000) pointed out that non-conflict zone nursing was offered from a tent beside Prophet Mohammed's (PBUH) mosque, run by an early Muslim nurse, where patients were often visited by the Prophet. Hasan (1982) and Duncan, Rivard, Arvidson, and Sultan (1990) described how the religious basis of the nursing services offered by Muslim communities reflected that of European countries. The spiritual and moral principles underpinning Islamic nursing practices were championed, with the compassionate basis being stressed. Unfortunately, the reputation of and respect for nursing within Gulf states in particular, as well as across the Muslim sphere generally, has declined during the past 1,400 years.

1.7.3 **SA's Social Environment**

Baki (2004) has described how the expectation of deference to those who are older, as well as women's subjugation under men, characterises the patriarchal society of SA. Domestic roles are considered to be the domain of females, whereas breadwinners and guardians are male, reflecting historical gender roles. Meanwhile, the fundamental societal unit is considered to be the conventional extended family. Extended family gatherings are common in circumstances in which members the extended family do not reside close to one another, which is often preferred. The wellbeing of one's relatives is considered a mutual duty and concern for every member of the family. Indeed, if assistance is required, an individual is unlikely to access official channels directly before

initially seeking help from a relative (Baki, 2004; Kay, 2015). This level of social standing and identity attached to family in SA is the foremost institution underpinning society. Dignity, pride and honour are social values that one is obliged to uphold for one's family, as the collective identity of the family is prominent (Kay, 2015). If living standards and goals are shared by particular families, they might enter into a coalition.

A global labour force characterised by an array of cultural and social norms has grown enormously in SA in recent years in the wake of greater political tolerance and the expanding economy. Welsh, Memili, Kaciak, and Al Sadoon (2014) note that traditional communities in urban areas have been joined by a huge number of employees, students, technical analysts and other professionals to form an international social community. Incremental and evident social developments have resulted from engagement in local communities, places of employment and schools, despite attempts to limit the growing impact of the non-Saudi groups on the indigenous population. Laxer perspectives on traditional values, greater acceptance of other ways of life and altered social and cultural principles have arisen among the growing number of young Saudis from mixed marriages, which have occurred following the increase in the foreign-born population in Saudi Arabia (Kay, 2015).

Non-skilled workers required for unskilled manual labour, for example security guards, chauffeurs and maids, were given visas for SA, alongside nurses, doctors and other skilled foreign workers. Where family members would once have been required to undertake household tasks, it has now become possible for the majority of Saudi families to employ workers from different Arab states, India, and Asia, indicating their social status and affluence (Kay, 2015). In 2007, two million of the seven million international workers in SA were employed as domestic assistants in SA (Gulf News, 2007). Traditional agricultural and shepherding activities began to be incrementally accepted as roles that could be taken over by international workers (Ramady, 2013).

Furthermore, the ban on women driving led many Saudi families to employ Asian chauffeurs on work visas (Kay, 2015). The inclination to choose such chauffeurs, especially among females, may be a result of the greater liberty they have when driving with foreign and non-Arab men. As Parssinen (1980) notes, such liberty entails being able

to engage in personal discussions without being concerned with whether the chauffeur can hear them, or being able to remove one's veil while in the vehicle (p.147).

Distinctions between the earnings of different groups began to emerge with the onset of swift socio-economic progress. An analysis of domestic residential positions (Johnson, 2010) showed that migration and salary status are interrelated in SA. As the salaries of most Saudis from the country's southern area are low, it is apparent that a person's geographical origin is linked to mean household salary in SA (Jenaideb, 1993).

Additionally, in Riyadh, SA's capital, marked differences in household salary have been found (Telmesani, 1995). Individuals earning £3,600 or more per month, £2,200 per month, £1,000 per month and £470 or less per month were considered to belong to the high salaried, upper-middle salaried, low-middle salaried and low salaried sets respectively (Al-Sheikh & Erbas, 2012). Given the strong similarities between Jeddah and Riyadh, Al-Sheikh and Erbas (2012) also believed that these results were transferrable to that location. A decade later, Al-Hayat Newspaper (2005)[6] observed that the growing cost of living in SA will pose considerable difficulties to the increasing number of Saudi residents within the low salaried set.

1.8 Challenges to Nursing Provision in SA

SA is currently suffering from a lack of nursing professionals to meet the demands of the healthcare sector. The reasons for this shortage are various, and include greater expectations for healthcare as a result of technological development, a longer lifespan and an increase in the number of individuals suffering from chronic illnesses or requiring critical care (Abu-Zinadah, 2005). Furthermore, the role of nursing has grown to encompass a number of activities that were formerly the remit of doctors (Coomber & Barriball, 2007). There is a global shortage of qualified nurses: for example, the US is predicted to have a 1.5 million shortfall by 2020 (Villeneuve & MacDonald, 2006). The situation in SA is characterised by an ongoing lack of nursing professionals and turnover issues (Abu-Zinadah, 2005),. The majority of nurses working in the country are from other countries, compared to 29.1% of nurses from SA (Almalki, FitzGerald, & Clark, 2011b).

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The lack of qualified Saudi nursing staff has been attributed to various issues concerning Saudi society, education, systemic issues and personal choices. Furthermore, the number of students graduating in nursing each year is not adequate to address the staffing needs demanded by the growth in healthcare provision. In addition, turnover in the profession is high. This poses serious challenges for hospital administrations and reduces service quality, thus creating a serious problem in health service delivery (Buerhaus, Donelan, Ulrich, Norman, & Dittus, 2005; Nardi & Gyurko, 2013).

Growing Requirements for Nurse Training and Employment

Diploma and degree-level educational programmes around the world train individuals to work as nurses, and there is some evidence to indicate that the educational structures in place limit the progression of nursing to a more professional footing (Karaoz, 2004; Oermann & Gaberson, 2013). The study of nursing specialisms and education at university level are associated with higher professional standards and are frequently an objective of those studying nursing in the West (Park, Chapple, Wharrad, & Bradley, 2007).

In SA, education for nurses in recent years has been provided in the form of associate degrees or diplomas under Ministry of Health (MOH) management, or as Bachelor of Science degrees in nursing (BSNs) offered through the Higher Education Ministry. Planned expansions or improvements to the current nursing education system need to be done carefully, and must involve learning lessons from other states that have taken the same journey. Meanwhile, the existence of varied forms of nursing education has created blurred boundaries between nursing grades in SA (Gazzaz, 2009).

Nurse Education in Hospitals

Gazzaz (2009) investigated the ways in which nursing professionals from SA viewed the career choice of nursing, and found that the majority of the sample, made up of staff and senior nurses as well as interns, felt that on-the-job and in-service training had a significant effect on their intentions after leaving their workplace. Further training and continued professional development were seen as motivating, satisfying and ultimately causing staff to be retained. These learning opportunities might allow skills, practice and knowledge to be increased, but are not evenly provided across different facilities and fields. In comparison with other public sector workers, both staff and senior nurses in

state facilities appeared to express greater dissatisfaction with existing relevant opportunities.

Poor Working Conditions

Working conditions for Saudi nurses are perceived as poor for a number of reasons, including the length of the working day, shift patterns and the contact between males and females required as a part of work. Furthermore, the lack of available nurses means that nursing staff have an increased workload in terms of both hours put in and the number of patients. Along with shift patterns, these reasons were commonly reported by schoolgirls as barriers to considering nursing as a career (Al-Johari, 2001).

Nurses appear to be frustrated, disappointed and regretful of a perceived failure to recognise their value. Together with the high task burden, low salary and lack of incentives, this leads to dissatisfaction in work and reduces retention rates (Aiken et al., 2013; Stone et al., 2007). Furthermore, in some institutions, staff nurses agreed on the failure of the management to listen to problems facing nursing staff (Gazzaz, 2009; Stone et al., 2007).

In addition, female nurses in SA perceive difficulties arising from home-to-work transport, as women were at the time when this study was carried out prohibited from driving, and there is a lack of consistent and secure public transport (Almalki et al., 2011b; El Gilany & Al Wehady, 2001). Additionally, many female nurses have young children and face challenges accessing secure and appropriately priced childcare solutions (Almalki et al., 2011b; El Gilany & Al Wehady, 2001), an issue that is applicable to both the Saudi context and across a range of Arab and Western countries (Demir, Ulusoy, & Ulusoy, 2003; Whittock, Edwards, McLaren, & Robinson, 2002). The challenges posed by transport and childcare can exacerbate difficulties balancing work and family, creating a stressful situation for nurses.

Cultural Disapproval of Nursing

In cultures where opportunities for females to work away from the home environment are limited, nurses have a less positive image, and nursing roles tend to be filled by people of low socio-economic status (Pizurki, Mejia, Butter, & Ewart, 1987; While &

Blackman, 1998). In a study in SA by Gazazz (2009), interviews with female nurses revealed the pressures they face in social terms because of long and antisocial working hours and gender mixing in the workplace. There is a lack of respect and trust in nurses on the part of Saudi society, which forms a barrier for young women in choosing nursing as a career, and has led student nurses to leave their studies or get married due to family disapproval of nursing, or a reluctance on the part of the family to tolerate women working antisocial hours.

In the Saudi context, Hamdi and Al-Hyder (1995) found that family support had a beneficial impact on women choosing to enter nursing. Furthermore, family opposition to nursing as a career choice was evident in relation to girls in secondary education expressing an interest in a nursing career (Al-Johari, 2001; Hamdan, 2005). Few secondary pupils of both genders in SA display an interest in becoming a nurse (Almalki et al., 2011b; Mebrouk, 2008), and pupils explained that their families would not be supportive of nursing as a career choice. Meanwhile, males pursuing nursing as a profession might also be subject to negativity from relations and peers, with Miller-Rosser (2006) reporting one such nurse's statement that his mother kept his career choice a secret from friends.

Research in the Saudi context attributes the low awareness of the scope of nursing careers to a range of issues, including insufficient provision of careers advice and counselling in schools, insufficient promotion of nursing education on the part of universities and colleges, and poor media representation of the profession.

Challenges at the Individual Level

An individual may have an interest in becoming a nurse but be held back due to fear or uncertainty related to the views of society, fear of failure, fear of regretting a career choice or fear of the challenges and risks involved. Research exploring variables that affected Saudi females' decisions to enter the nursing profession by Hamdi & Al-Hyder (1995) found that while one-third of female pupils at secondary schools perceived nursing to be a profession suitable for Saudi females to enter, one-quarter felt that nursing was not compatible with traditional cultural attitudes.

1.9 Importance, Application and Rationale for the Research

Evidence places NGN turnover at up to 30% in the first 12 months of work and as high as 57% in the subsequent 12 months (Martin & Wilson, 2011; Ulrich et al., 2010). This has been variously attributed to workplace bullying, inadequate managerial support for dealing with high-stress events and failure on the part of leaders (Hayes & Scott, 2007; McKenna, Smith, Poole, & Coverdale, 2003). Turnover in the initial 12 months of work places a high cost load on institutions that have invested in recruitment, accommodation and in training NGNs (Friedman, Delaney, Schmidt, Quinn, & Macyk, 2013).

In addition, turnover costs for nursing are calculated to be approximately 1.5 times the basic wage (Friedman et al., 2013). This situation has led to increased actions by the administration in support of NGNs, such as by asking nurse managers to be more involved in individual care for patients, creating a surrounding culture in which other professionals are supportive and kind, supporting and debriefing structures between NGNs, and enhancing CPD (Goodwin-Esola, Deely, & Powell, 2009; Thrysoe, Hounsgaard, Dohn, & Wagner, 2011).

The literature also describes the difficulties encountered by NGNs during their first year of employment in hospitals, during which time a significant proportion leave their jobs (Twigg & McCullough, 2014; Unruh & Zhang, 2013). However, there is inadequate evidence on how NGNs justify their leaving intentions (Kowalski & Cross, 2010). The challenge facing hospitals is to manage the costs associated with NGN orientation, reduce turnover to improve the quality of care, make units more productive, and deal with the costs associated with nurse replacement (Hayes & Scott, 2007; Ulrich et al., 2010).

This research seeks to add to existing knowledge and provide further insight into NGNs' perceptions of their initial transition during the first 12 months of practice. The aim is to improve understanding of how best to help NGNs to perform well and choose to stay in their first workplace, in light of the inadequate numbers of nurses being recruited (Ulrich et al., 2010). Furthermore, improving nurses' confidence may result in increased safety, with fewer occurrences of medical error and, ultimately, lower mortality rates (Wolff, Regan, Pesut, & Black, 2010).

1.10 Contribution to Knowledge Likely to Emerge

Most research regarding the transition of NGN has been undertaken in the West, leaving the evidence base for other countries weak. The societal and cultural approach to nursing varies from country to country, and the specific nature of the culture and social norms in SA do not easily fit with Western solutions. As such, the literature cited earlier does not cover the experiences of nurses in SA, as interpreted by them. Therefore, obtaining a better understanding of what is going on for NGNs in SA will help to ensure that solutions derived from the findings are appropriate, effective and acceptable. The research proposed here is unique in a number of ways. This is the first study to undertake a qualitative case study using fieldwork observations to explore, first-hand, why and how NGNs give meaning to their experiences during the first 12 months of their first destination post in the context of one government hospital in SA. It is also be the first study to examine the interplay between government policy, culture and social attitudes on NGNs' subjective experiences during the initial 12 months of their first destination post.

1.11 Summary

This chapter has described the reasons for carrying out the present study, provided a historical overview of nursing in Saud Arabia, and described the religious and cultural values and current socio-economic trends currently affecting nursing. The next chapter focuses on the NGN transition experience, drawing on existing theory and empirical knowledge to explain the process.

CHAPTER 2: TRANSITION FROM EDUCATION TO PRACTICE

2.1 Introduction

The transition period from student to staff nurse is critical for new nurses. In some cases, the process is so overwhelming that it causes new graduate nurses (NGNs), to leave the field; indeed, NGN attrition is a worldwide phenomenon. For example, the International Council of Nurses (ICN) found that 13–14% of newly qualified nursing staff in the United Kingdom resigned from their posts before the end of their first year of practice; moreover, in Japan and the United States, 11.6% and 29.2% of new nurses, respectively, left their jobs in the same period (Buchan & Calman, 2004). This level of attrition is an economic drain on hospitals (Halfer & Graf, 2006) and represents a factor in nurse shortages, which increase the burden on existing nurses, including those new to the profession (Buchan & Calman, 2004). Determining how to address this problem is an issue of great importance.

The transition from studying nursing to practicing as a qualified professional comprises more than a change in title; rather, it involves meeting new demands and adapting to a new role (Kralik, Visentin, & Van Loon, 2006). Research has suggested that transitioning nurses experience anxiety and culture shock (Kramer, 1975). Moreover, the demands of their new roles have been found to cause emotional challenges. Casey, Fink, Krugman and Propst (2004) investigated the experiences of 270 American graduate nurses and found recurring reports of difficulties, including the following: uncertainty in their ability to apply skills effectively; lack of knowledge regarding clinical work; and difficulties in organising work, relationships with instructors and communicating within a multi-disciplinary team. This array of challenges lowers NGNs' confidence levels, leaving them feeling that they are unprepared for the transition, especially in their first working year.

New surroundings, responsibilities and systems of care provision are unfamiliar terrain for new nurses, making the development of their skill set a priority for accomplishing their duties. In this context, NGNs need to be supervised and supported by experienced nursing staff, as well as advised on the rules regarding how they should act and what they should do as inexperienced professionals in a real-life care setting (Benner, 2001). NGNs need to be supported via positive and helpful feedback, as well as instruction in

unfamiliar skills (Hardyman & Hickey, 2001), making person-to-person relationships an important element of support during the transition period (Whitehead et al., 2013). Programmes of instruction for NGNs are in place in both the United States and United Kingdom, and research suggests that these initiatives benefit NGNs in developing competencies, person-to-person relationships and effective communication, thereby positively affecting the transition experience (Whitehead et al., 2013). Such programmes have not been established among hospitals in SA. There is also research to suggest that the environment in which nurses transition to professional practice, including social and person-based aspects, affects the transition process (Suresh, Matthews, & Coyne, 2013). However, no similar work has been undertaken in SA.

Effective transitions to professional life are built on individuals' perceptions, how they are supported and the ability to release the self from an existing role to adjust to a new reality. Based on this, there is a need for research exploring NGNs' experience in the first 12 months of work to develop a deeper understanding of the period by considering which variables affect the adjustment to clinical practice and the nursing role. Therefore, the current research explores, describes and interprets the experiences of NGNs at one hospital in Saudi Arabia in the initial 12 months of their first posts after graduating nursing school. It also examines the extent to which culture and social attitudes contribute to their experiences and how they make sense of them.

2.2 Transition Period

Definitions of transition in the healthcare literature are variable and differ across disciplines. A transition can be defined as a process of mental change in which a person reacts and adjusts to changes and the new reality that these changes bring (Bridges, 2010); this process is linked with the concept of 'reality shock', which is described below (Kramer, 1974). In this study, the transition concept refers to the shift from the role of student nurse to registered nurse.

The transition period plays an important role in professional development and job satisfaction (Goh & Watt, 2003). All NGNs are different in terms of their adaptation to the new nursing role. Some readily assume their responsibilities, while others may take some time to fully adjust to their new settings (Duchscher, 2008; Kelly, 1996; Mooney, 2007).

Researchers have provided a number of frameworks for explaining the NGN transition process. In 1974, Kramer introduced the concept of 'reality shock' to describe the process of new nurse socialisation. Reality shock captures the inconsistency between NGNs' ideals, rooted in their academic experience, and the circumstances they encounter when beginning their first job. Schmalenberg and Kramer (1976) detailed four phases of reality shock, which are as follows: 1) 'the honeymoon', 2) 'reality shock', 3) 'recovery' and 4) 'resolution'. In the honeymoon phase, new nurses begin their professional careers excited about working in their chosen field. However, this phase ends suddenly and shock soon sets in as NGNs become aware of the differences between the academic world and the realities of professional nursing. The shock phase consists of the four following aspects: 'moral outrage', 'rejection', 'fatigue' and 'perceptual distortion'. Moral outrage reflects NGNs' frustration, anger and confusion about being thrust into a situation that is in conflict with the values they developed during nursing school. The second aspect of the shock phase is rejection, in which new nurses reject workplace norms. Fatigue then follows; this involves exhaustion from the challenges of adapting to the new role. Finally, perceptual distortion is a condition in which NGNs develop a negative attitude towards nursing practice, and potentially, other nurses.

While the shock phase is mainly negative, it is also time limited (for most NGNs), eventually giving way to the recovery phase. During this phase, new nurses are able to look at their work environment realistically, and as a result, tension and anxiety diminish. Ultimately, the NGN enters the resolution phase, when she either resolves previous conflicts and achieves a 'nursing self-identity' or fails to adapt, resulting in more negative outcomes (e.g. leaving nursing).

Tradewell (1996) also explained the NGN transition as a period of socialisation. He borrowed the concept of 'rites of passage' from anthropologist Arnold van Gennep (1908/1960), who described the process of moving from one role to another as a series of stages, which are: 'rites of separation,' 'rites of transition' and 'rites of incorporation'. After finishing nursing school, the new nurse enters an organisational setting (e.g. hospital) and begins the rite of passage. During the rite of separation, the new nurse separates from her old position as student and takes up her new position as professional nurse. The rite of transition is a period between states, when the new nurse becomes

more familiar with the norms of the new environment and role. Finally, in the rite of integration (incorporation), the NGN fully assumes her role as staff nurse.

Other authors have posited a range of theories to portray the NGN transition period (Duchscher, 2008; Godinez et al., 1999; Schoessler & Waldo, 2006). A number of these focus on phases of development as the NGN moves towards completion of the transition process. They also stress that the nature of nursing education affects the transition experience. For example, Duchscher (2008) outlines several nonlinear developmental stages that make up the 'process of becoming' a nurse, namely, doing, being and knowing. It involves 'complex but relatively predicatble array of emotional, intellectual, physical, socio-cultural and developmental issue' (Duchscher, 2008, p. 442).

2.3 Theory–Practice Gap

In the nursing literature, the topic of the 'theory–practice gap' is widely discussed. A universal phenomenon in nursing, this refers to the chasm between nursing education and the realities of clinical practice, which leaves NGNs unprepared for their duties as staff nurses. According to Greenwood (2000a), clinical nurses argue that they are unprepared for professional nursing due to an undergraduate curriculum that does not reflect the real demands of clinical practice (Beecroft et al., 2004; Watkins, 2000). In contrast, academic nurses assert that nursing education is meant to produce nurses who possess critical thinking skills rather than basic competency alone. They argue that clinical nurses should take on responsibility for helping NGNs during the transition process as they adapt to their new role (Greenwood, 2000b).

2.4 Competency

For nurses to perform their jobs effectively, it is critical that they understand what is required of them. Moreover, patient safety depends on nurses reaching certain levels of competence in clinical practice (Benner et al., 2010; Bianchi et al., 2016; Bradshaw, 1997; Bradshaw, 1998). Yet, the philosophy of education in nursing schools creates confusion about the meaning of competence, opening it up to individual interpretation. Additionally, in the literature, there is no clear definition of competency in nursing (Bradshaw, 1997; Bradshaw, 1998; Levett-Jones et al., 2011; Watson et al., 2002). Thornley and West (2010) argued that the concept of the expert nurse is fuzzy and complex, which can make it difficult for new nurses to form a

concept of the expert nurse without repeated exposure to and interactions with expert nurses. Failure to develop a concept of the expert nurse may prevent new nurses from identifying and working with expert nurses during an important time in their career. In addition, opinions differ as to how to assess competency. Moreover, many assessment tools lack reliability and validity, creating discrepancies in the results (Bartlett et al., 2000; Bradshaw, 1997; Bradshaw, 1998; Levett-Jones et al., 2011; Redfern et al., 2002; Watson et al., 2002; Wu et al., 2015; Yanhua & Watson, 2011).

In the United Kingdom, concerns over competency prompted the development of a competency-based curriculum in nursing education (Bradshaw, 1997; Bradshaw, 1998; Bradshaw & Merriman, 2008; Watkins, 2000). Farrand et al. (2006) conducted a quantitative study to assess the effects of 'Making a Difference' (Department of Health, 1999), a competency-based curriculum, on new nurses' confidence in applying their clinical skills. As part of their research, Farrand et al. (2006) mailed questionnaires to 139 students in their final year of nursing. The researchers divided the respondents into two groups, one studying the 'Project 2000' curriculum, in the process of being phased out, and one studying 'Making a Difference'. The findings from the study suggested that student studying the curriculum 'Making a Difference' had higher level of trust across practice area than student studying the curriculum 'project 2000'.

2.4.1 Defining Competency

Fey and Miltner (2000) suggested that competence is more than the possession of knowledge or skills to perform a task. Rather, they asserted that the competent nurses knowledge, skills and personal attributes should be able to be consistently integrated into daily practice to meet established performance standards (Fey & Miltner, 2000, P126). In the literature, Benner's (2001) five stages of clinical competence is used a framework for describing competency in nursing. To develop her model, Benner (2001) adapted the Dreyfus model of skill acquisition (Dreyfus & Dreyfus, 1986) to the field of nursing, which was based on observations of chess players, Air Force pilots, army commanders and tank drivers. According to Benner (2001), nurses pass through five levels of practice on their way to developing competency, which are as follows: novice, advanced beginner, competent, proficient and expert. (In this framework, NGNs can be understood as either novices or advanced beginners.) For nurses, expert practice is reached through a lengthy

process of experiential learning and engagement in various situations, contributing to the development of skills.

While Brenner's (2001) model has greatly influenced nursing, it has also been criticised. For example, scholars have pointed out that the theory favours experiential learning over evidence-based knowledge. In addition, others have suggested that the framework presents an ideal image of the expert nurse without providing specific criteria by which to judge when this level is attained (Eraut et al., 1959; Bradshaw, 1998).

2.5 Support Structures

In light of debates around the theory–practice gap and competency, various measures have been put forth to bridge the gap so that new nurses can effectively develop competency levels (Greenwood, 2000a). For example, preceptorship and mentoring are two mechanisms that have been incorporated into support programmes. Research on the effectiveness of support structures for NGNs has shown that, regardless of their nature, these measures have positive effects on new nurses' confidence and competency (Cubit & Ryan, 2011; Park & Jones, 2010). While the efficacy of support programmes is now widely recognised, these efforts are not applied similarly across countries, and they differ depending on an organisation's resources and commitment to supporting NGNs during the transition period. Moreover, because there is no universal agreement on the best programme of support, strategies vary from institution to institution. Due to the persistent attrition rate among NGNs, some researchers have argued that transition programmes should be jettisoned in favour of supportive practice environments that encourage job satisfaction among nurses, as well as continued learning (Levett-Jones & FitzGerald, 2005).

2.6 Conclusion

This chapter considered various theoretical approaches to understanding the NGN transition process, which socialises new nurses into professional nursing culture if successfully completed. It also related these frameworks to debates on the theory–practice gap and the definition of competency. Despite efforts to clarify these issues, they remain unresolved, and new nurses continue to feel unprepared for clinical practice, encountering difficulties during the transition phase. Although some healthcare

organisations have introduced support measures to ease the transition, significant numbers of NGNs leave the profession during their first year of practice. To date, the NGN transition process has mainly been examined in the Western literature, meaning that the complexities of this experience are underexplored in many non-Western nations. Among the countries in which a detailed understanding of the transition process is lacking is SA. To address this omission, the current thesis aims to explore the experiences of new graduate nurses (NGNs), who have been an active part of the nursing workforce for less than 12 months and are employed in their first nursing post at a hospital in Saudi Arabia. It also examines the extent to which culture and social attitudes contribute to the new graduate nurses' experiences and how they make sense of them. It supplements transition theories with an analysis of the specific cultural and social conditions that shape new nurses' first 12 months of practice in SA.

CHAPTER THREE: SYSTEMATIC REVIEW

3.1 Overview

The transition from nursing student to professional nurse is challenging for many newly graduated nurses (NGNs), who reportedly experience a number of stressors during their first year of transitioning to clinical roles. While a large number of studies across the international literature have reported on the lived experiences of NGNs, to date there has been no attempt to summarise NGNs' experiences, challenges and opportunities during their first year of nursing employment after graduation. A systematic literature review was therefore undertaken to collect evidence on the experiences and perceptions of NGNs during this period, as well as to explore the role of such systematic literature reviews within evidence-based nursing practice. In addition, this review sought to identify any gaps in the relevant literature and to summarise what was already known.

The methodology involved searching the Medline (via PubMed NCBI) and Cumulative Index to Nursing and Allied Health Literature (CINAHL) databases and the Excerpta Medica Database (EMBASE); results were restricted to papers published in English between January 2000 and May 2019. In addition, relevant nursing journals and references from among the retrieved studies were manually searched to identify further studies. The key search terms were words such as 'new graduate nurses', 'experiences' and 'first year of practice', among others. All studies that investigated the lived experiences of NGNs during their first 12 months of transition to professional practice were included for review, but studies involving interns or final-year students, or which described experiences beyond the first year, were excluded.

A total of 3,201 studies were initially identified from searching the three databases, of which 47 ultimately met the inclusion criteria for this review. The included papers were comprised of 30 qualitative and 17 quantitative studies, including 2 mixed-method studies. The majority of the studies were of overall high or moderate methodological quality, as determined using critical methodological appraisal tools. Their data were subsequently extracted to perform a thematic analysis, and four major themes were identified: 1) competence level, theory-practice knowledge gaps, and skill development during the transition period; 2) role transitions, including professionalisation socialisation

experiences; 3) challenges and opportunities; and 4) positive transition experiences. Overall, the results indicated that the transition to staff nursing positions was challenging and stressful for the majority of NGNs worldwide. Identified factors included inadequate clinical preparation during academic studies, a lack of active support after graduation, heavy workloads and personal barriers (e.g., self-confidence). However, these factors improved over the course of the first transition year; the first three months were identified as the most difficult period, and both personal and professional confidence, as well as competence, improved significantly after the first six months.

Based on the results of this systematic review, the main pragmatic and practical recommendations include development of a course for final-year nurse students that focuses on practical skillsets and of mentorship and support programmes for NGNs in healthcare organisations during their first three months of transition. This review also found that the experiences of NGNs have been largely explored through a Western lens, and particularly highlighted a lack of research in Arabic-speaking countries. Further research is therefore needed in these populations, as well as to address the identified challenges and create opportunities for NGNs worldwide that can help them develop coping skills and provide additional professional training in supportive environments.

3.2 Introduction

This chapter reviews the existing evidence on the worldwide experiences of NGNs' transitions from student to the new role of staff nurse, and specifically their experiences during their first 12 months of practice. The chapter begins with a rationale for this systematic review, followed by an overview of the data collection strategy and methodology, a description of the results identified from the literature, and finally a discussion of the results in the context of previous findings and recommendations for further research. While the main focus throughout the review is on the experiences of NGNs during their first year of transition, literature on the impact of these experiences is also explored, where relevant.

Rationale for systematic reviews of general nursing practices

A narrative literature review was long seen as the standard approach for collecting and analysing evidence. However, subjective assumptions can restrict the collection of

available evidence due to the absence of a methodical scientific process to identify pertinent literature, and narrative literature reviews have recently been criticised for yielding biased deductions (Bettany, 2012). Systematic literature reviews have therefore become more common and are now the standard method used to compile evidence within the healthcare context (Pea, 2015). A systematic review is characterised by the use of a scientific approach to determine each study's relevance, assess the quality of the evidence provided in each study, collate all of the study results and produce reasonable interpretations that addresses the research question (Bettany, 2012). Systematic reviews thus reduce the risk of selection bias and enhance impartiality by using a methodical and transparent strategy to identify and select studies.

Evidence-based evaluations of nursing practices and procedures are heavily reliant on systematic reviews (Ten Ham-Baloyi & Jordan, 2016). According to the International Council of Nurses, evidence-based nursing practice is a clinical decision-making approach rooted in problem-solving; it merges the latest high-quality evidence, clinical expertise and assessment and incudes a focus on patient-centred ethics within a setting of comprehensive care (Mackey & Bassendowski, 2016). Evidence-based research and practice, which have been embraced by a large number of nursing organisations, employ thorough investigations and expert analyses with the goal of strengthening the relationship between scientific evidence and nursing behaviours (Garg, Hackam, & Tonelli, 2008; Mackey & Bassendowski, 2016). Moreover, as noted by Mantzoukas (2008), best-practice research promotes evidence-based patient care while fostering nursing knowledge and research.

Rationale for a systematic review of NGN experiences during their first year of clinical employment

It has been well established that the transition from student nurse to the role of staff nurse is stressful (Gerrish, 2000; Holland, 1999), particularly during the first year following qualification as a nurse (Hu et al., 2017; Zhang et al., 2018). Several studies have attributed this psychosocial burden to inadequate preparation, suggesting that students are not sufficiently equipped with the knowledge and skills required for role of staff nurse (Bradshaw and Merriman, 2008; Glen, 2009).

A number of systematic reviews have examined the experiences of NGNs during their transition to professional practice. One such review of the experiences of NGNs in the UK identified a lack of post-qualification support, inadequate preparation for practice, and increased professional responsibilities as major stressors (Higgins, Spenser, & Kane, 2010). Similarly, Walker et al. (2017) examined the experiences of Australian NGNs and found that increased organisational support and an initial structured transition to a hospital setting would facilitate the progressive development of NGNs' competence and self-confidence. More recently, an integrated review of NGNs in acute care settings highlighted the complex nature of the transition to nursing practice (Hawkins, Jeong, & Smith, 2018). Collectively, these reviews emphasise the importance of understanding the experiences of NGNs during their first year of transition into clinical practice and of identifying the challenges that hamper the retention of nurses in hospitals, as well as the opportunities that lead NGNs to pursue long-term professional careers in nursing.

However, all prior systematic reviews have been specific to either a single country or to a particular clinical setting (e.g., acute care, rural medicine, paediatric nursing), or else have included a transition period of greater than one year; to the researcher's knowledge, there have been no integrative or systematic reviews of the experiences and perceptions common to NGNs worldwide during their first year of transitioning to the workforce in hospital settings. Therefore, the purpose of this systematic review was to examine the global experiences of NGNs and to identify their primary challenges and opportunities during their first year of transition to professional nursing practice.

3.3 Methods

3.3.1 Framework

The present systematic review was based on the five-stage methodological framework proposed by the Centre for Reviews and Dissemination CRD (2009): 1) formulation of a research question, selection of relevant domains, and categorisation of the search terms; 2) development of search parameters and identification of pertinent studies; 3) selection of relevant studies according to eligibility criteria; 4) analyses of the findings; and 5) syntheses and presentation of the research findings. In formulating a research question, the focus should be on parameters such as population, interventions and/or exposures, and outcomes (Khan, Ter Riet, Glanville, Sowden, & Kleijnen, 2001). For this review, the

research question was largely determined by the overall study aim, which was to explore, describe and interpret the experiences of NGNs in public hospital settings during their initial 12 months of transition to practice. While initially the research question was focused on NGNs from Saudi Arabia, a preliminary search did not identify any studies in Saudi Arabia. Consequently, the focus of the search shifted to collect evidence from international literature on the experiences of NGNs during the first year of their transitions to practice.

3.3.2 Eligibility criteria according to the PICOS framework

The PICOS framework was applied to delineate and frame the research query more clearly and specifically (Bettany-Saltikov, 2012). The PICOS approach is considered one of the more effective means of delineating and framing queries within reviews since it does not restrict population size to a single category, nor does it limit the selection of pertinent material related to the central research field (Doody & Bailey, 2016). Therefore, using the PICOS framework, the research question was stated as follows: 'How do new graduate nurses (P), during their first 12 month of practice (I), describe their experiences (O), as recorded using qualitative or quantitative approaches (S)?'

Several methods were employed to identify relevant material, namely the use of electronic databases, reference lists and manual searches of major nursing journals. Eligibility criteria were first established in order to narrow the search and answer the specific research question (Table 3.1). The key areas addressed by the inclusion and exclusion criteria were developed based on the PICOS strategy and the inclusion and exclusion criteria were designed to limit the search to the parameters of the research query (Dwan et al., 2013). The included studies consisted solely of research that reported on NGNs' experiences, emotions and thoughts either immediately after qualifying, during a transition period of 12 months or less or during their first year of employment, irrespective of the NGNs' gender, age or other demographic characteristics. In addition, studies were eligible for inclusion if they described NGNs' career-related stressors or job expectations and workloads, supports given to NGNs, factors affecting NGNs' desires to leave the nursing profession or any outcomes relevant to NGNs' clinical workplace environments.

Studies were excluded if they examined populations other than NGNs during their transition to practice, such as student nurses or those not currently employed as new nurses. Studies were also excluded if they reported on a transition period of longer than 12 months, if they focused on factors other than the experiences of NGNs or if they concentrated solely on developmental training programmes. Abstracts, conference papers, opinion-based papers, letters, editorials and comments were also excluded.

Additionally, it was necessary to place some restrictions on the chronology and linguistic nature of the included studies so that the inquiry could be undertaken within a reasonable period of time; therefore, only research published between January 2000 and May 2019 in English was considered. Studies in other languages were omitted as these would have required translation, thereby increasing the project costs and timeline. The year 2000 was selected not only to guarantee the contemporary relevance of the study but also to acknowledge the changes made in nursing worldwide A wide range of far-reaching changes in both education and clinical practice have taken place in nursing. Nursing has changed from the apprentice model to academic settings, and nursing degree courses have become more prevalent. An example is the educational reforms "Project 2000" have been introduced in the UK (Greenwood, 2000b; Watkins, 2000). Consequently, a decision was made to review studies published from 2000 to focus on studies that reflect the current situation of NGNs nurses during their transition period. However, while these restrictions were deemed necessary, they may have introduced some bias by omitting articles that could have been pertinent to the research question.

Table 3.1: General inclusion and exclusion criteria according to the PICO framework

Eligibility criteria	Inclusion criteria	Exclusion criteria
Population	NGNs during their first 12 months of transition from an academic to a practice setting; all ages, races, nationalities and other demographic characteristics.	Nurses who were more than 12 months past graduation; student nurses; midwife graduates; nurses with higher degrees.
Intervention/ Exposure	Exposure to clinical practice during first 12 months after graduation.	Other nursing experiences, such as during orientation, teaching or specialisation, or preceptor experiences.
Comparison	Not applicable.	Not applicable.
Outcomes	The experiences and perceptions of newly graduated nurses.	Irrelevant outcomes, such as the perceptions of preceptors.
Study design	Observational, longitudinal, qualitative or quantitative studies or randomised clinical trials.	Conference papers or abstracts, reviews, case studies.
Other	Articles published in English.	Articles published in non-English languages.

3.3.3 Search strategy

The first step in developing a search strategy was to identify relevant key terms using the PICOS framework, as described by Aveyard (2014); these are shown in Table 3.2. Brettle and Grant (2004) stated that to optimise an investigation, the appropriate search terminology or keywords should be made clear from the outset. In the present study, therefore, search terms were developed that addressed the research question, including 'new graduate nurses', 'transition', 'experiences' and 'first year of practice', as well as combinations with truncated words and Boolean operators such as 'OR' and 'AND', as appropriate (see Table 3.2).

Once the research question was clarified using the PICOS framework, specific databases were searched for pertinent studies. Consistent with the recommendations of Aveyard (2014), the first stage consisted of a limited search query using the Medline and CINAHL databases, which collate the majority of nursing research studies. The results from this preliminary search, including abstracts, headings and indexes, were then used to formulate a wider range of search strings to undertake a broader investigation across the CINAHL, Medline and EMBASE databases. These databases offered a comprehensive means of exploration and filtration and catalogued many studies relevant for this review (Creswell, 2013; Facchiano & Snyder, 2012).

Table 3.2: Search strategy and search terms for each database

Medline (via PubMed)	CINAHL (via EBSCO host)	EMBASE
January 2000–May 2019	January 2000–May 2019	January 2000–May 2019
"Graduate nurse*" OR "beginner nurse" OR "new graduate nurse" OR "newly qualified nurse" OR "new nurse" OR "new staff nurse"	S2 "Graduate nurse*" OR "beginner nurse" OR "new graduate nurse" OR "newly qualified nurse" OR "new nurse" OR "new staff nurse"	'graduate nurse*' OR 'beginner nurse' OR 'new graduate nurse' OR 'newly qualified nurse' OR 'new nurse' OR 'new staff nurse'
"first year of practice" OR "first destination" OR "first 12 months"	S3 "first year of practice" OR "first destination" OR "first 12 months"	'first year of practice' OR 'first destination' OR 'first 12 months'
"Transitional programme*" OR "transition to practice" OR "role transition" OR transition OR "transition period" OR preceptorship OR mentorship OR supervision OR Internship	S4 "Transitional programme*" OR "transition to practice" OR "role transition" OR transition OR "transition period" OR preceptorship OR mentorship OR supervision OR Internship	'transitional programme*' OR 'transition to practice' OR 'role transition' OR transition OR 'transition period' OR preceptorship OR mentorship OR supervision OR internship
"Experience" OR "perception" OR "feeling" OR "thought" OR "stress" OR "job stress"	S5 "Experience" OR "perception" OR "feeling" OR "thought" OR "stress" OR "job stress"	'experience' OR 'perception' OR 'feeling' OR 'thought' OR 'stress' OR 'job stress'
(("Graduate nurse*" OR "beginner nurse" OR "new graduate nurse" OR "newly qualified nurse" OR "new nurse" OR "new staff nurse") AND ("first year of practice" OR "first destination" OR "first 12 months" OR "Transitional programme*" OR "transition to practice" OR "role transition" OR transition OR "transition period" OR preceptorship OR mentorship OR supervision OR Internship) AND ("Experience" OR "perception" OR "feeling" OR "thought" OR "stress" OR "job stress"))	S8 S2 AND (S3 OR S4) AND S5 S9 S2 AND S3 AND S4 AND S5 S10 S2 OR S3 AND S4 AND S5 S11 S2 AND (S3 OR S4) AND S5	#6 AND (2000:py OR 2001:py OR 2002:py OR 2003:py OR 2004:py OR 2005:py OR 2006:py OR 2007:py OR 2008:py OR 2009:py OR 2010:py OR 2011:py OR 2012:py OR 2013:py OR 2014:py OR 2015:py OR 2016:py OR 2017:py OR 2018:py OR 2019:py) #1 AND #4 AND #5 #2 OR #3 Filter:

A detailed manual investigation of the reference lists and bibliography for each of the potential eligible studies was also conducted, as well as a manual search of the major nursing journals. Consultations of sources such as the British Journal of Nursing, Ethos and the British Nursing Index were also undertaken manually. While sifting through the references for each article was a laborious process, it was deemed appropriate since it provided a means of identifying studies for inclusion in the review that might have been omitted by the keyword search.

3.3.4 Data extraction

During this step, 'charting' (Peters et al., 2015), or 'data extraction', of the major data points from each study was undertaken. A data extraction sheet was used to ensure uniformity in the collection of the research data (CRD, 2009). The data extraction sheet consisted of each study's first author, publication year, location of the study, details of the population and sample, research design, method of data collection, data analysis and main findings.

3.3.5 Data synthesis and methodological assessment

The final step related to the synthesis and methodological quality assessments of each study (CRD, 2009). There are two major types of synthesis: descriptive (also known as narrative) synthesis, which involves the characterisation of studies, and interpretative synthesis (Mays, Pope, & Popay, 2005), which involves the production of new knowledge by synthesising data from qualitative studies relevant to the review. An additional type of synthesis is meta-analysis, which adopts a deductive/reductionist approach to integrating the findings of comparable studies (Evans, 2002; Lloyd Jones, 2007).

The descriptive/narrative synthesis approach was used in the present systematic review to present the findings of the included papers. As the samples and outcomes were heterogenous, no data meta-analysis was performed. The identified outcomes were grouped by major theme. The collected data were also organised for thematic analysis, which is a systematic process to encode qualitative research findings and identify common patterns of behaviour (Boyatzis, 1998). The data in this systematic review were mainly descriptive, focusing on the experiences of the NGNs during their first year of transition. Therefore, thematic analysis facilitated the categorisation of their experiences

and perceptions.

The critical appraisal skills programme (CASP) was then used to assess the methodological quality of each included qualitative study (Campbell et al., 2003; Hammell, 2007; Pound et al., 2005). CASP tools are a valuable means of conducting critical and inclusive evaluations of qualitative research using key questions to assess research aims, samples, methods and findings. CASP was developed at Oxford University and is recognised globally as a valid tool for evaluating qualitative research.

Since qualitative and quantitative studies tend to exhibit different ontological and epistemological underpinnings, a different tool was needed to assess the quality of each of the eligible quantitative studies identified by the systematic review (Thomas, Ciliska, Dobbins, & Micucci, 2004). The Effective Public Health Practice Project (EPHPP, 2009) was developed to assess the methodological quality of primary studies, and it has been found to be both valid and reliable (Deeks et al., 2003).

3.4 Results

A total of 3,201 records were initially identified. After removing the duplicates, a total of 2,711 papers remained. They were then screened by abstract and title, after which only 161 potential studies remained. Their full texts were then screened using the review's inclusion and exclusion criteria; 114 papers were excluded by this process, leaving a final total of 47 studies that were eligible for inclusion in this review (see Figure 4.1). The 114 excluded studies were excluded because they were abstracts or conference proceedings, or focused on the experiences of nursing students or preceptors, or focused on issues other than the experiences of NGNs, or reported experiences after implementing an intervention or did not meet the eligibility criteria. The reference lists of several review articles were manually scanned for potentially relevant studies, but no additional articles were identified.

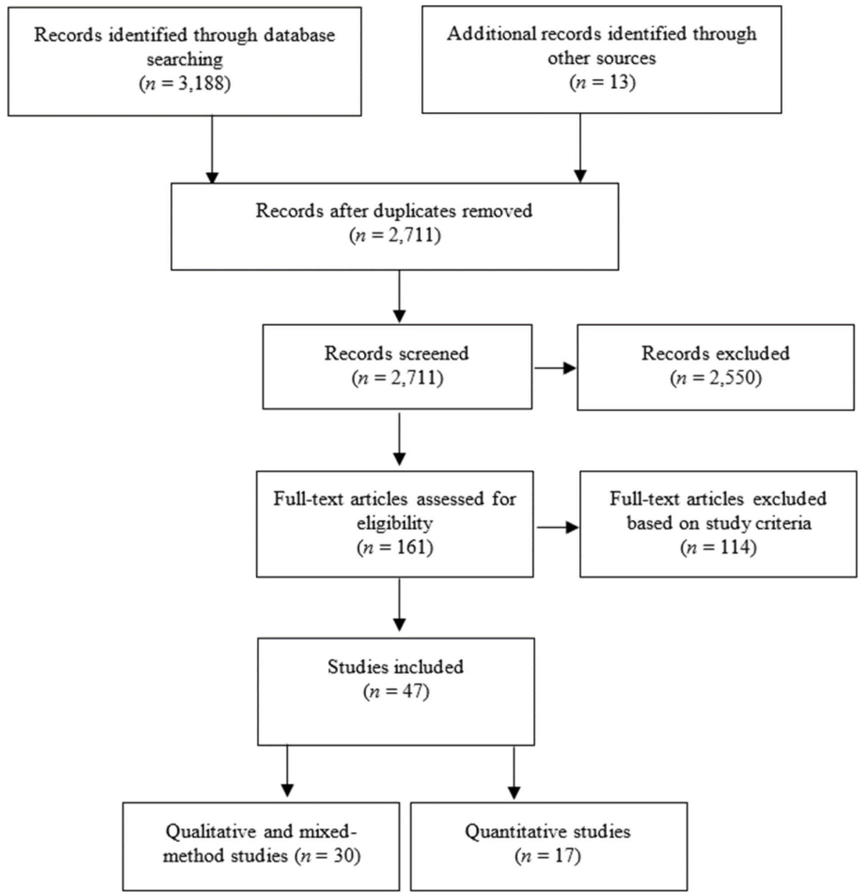

Figure 3.1: Search protocol flowchart

After screening all relevant studies, the 47 studies identified for inclusion were marked as being either qualitative (*n* = 30), quantitative (*n* = 15) or mixed-method (*n* = 2). Subsequently, data on the main characteristics of each included study were extracted, as described in this chapter's methodology section. The extracted characteristics of the studies are shown in Tables 4.3 and 4.4. Each study's quality was appraised using either the CASP checklist (Tables 4.5) or the EPHPP assessment tool (Table 4.6), as appropriate. All studies were then evaluated, compared and organised into thematic categories.

3.4.1 Geographical distribution of the studies

The included studies described the experiences of NGNs transitioning from nursing school to clinical practice in 15 different countries (Table 4.7). The plurality' of the studies took place in the United States (*n* = 9), followed closely by Australia (*n* = 8) and the UK (*n* = 8). Only one study reported on the transition experiences of NGNs in Arabic-speaking country. More than half of the included studies were from developed countries in North America and Europe (Figure 4.2); a wider geographic range would likely to lead to a better understanding of the impacts of transition experiences of NGNs in other regions and their correlations to various work conditions. Table 3.3 summarises the geographical distribution of all studies included in this review.

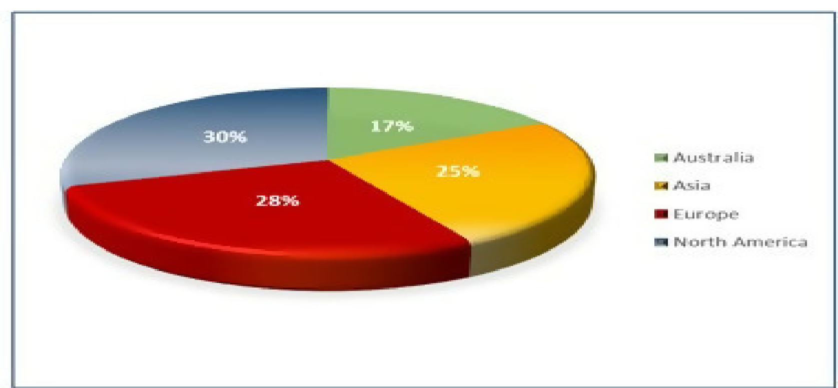

Figure 4.2. Geographic distribution of included studies, by continent.

Figure 4.2: Geographic Distribution of Included Studies, by Continent

Of particular interest to this project were three studies that originated from countries in the Middle East: Oman (a qualitative research study by Al Awaisi, Cooke, and Pryjmachuk, 2015), Iran (a qualitative research study employing by Zamanzadeh, Jasemi, Valizadeh, Keogh, and Taleghani, 2015), and Turkey (a quantitative research study by Tastan, Unver, and Hatipoglu, 2013). The working conditions for nurses in each of these countries are likely to be comparable to those of Saudi Arabia since all have similar education and healthcare systems that integrate cultural and religious components. The research approaches adopted by each of the studies from the three Middle Eastern countries'.

Table 3.3: Geographic distribution of included studies, by country

Continents	Countries	Qualitative studies	Quantitative studies	Total no. of studies
North America	United States	3	6	9
	Canada	4	1	5
Europe	United Kingdom	7	1	8
	Sweden	1	1	2
	Ireland	1		1
	Norway	1		1
	Turkey		1	1
Asia	Taiwan	3	2	5
	China	1	1	2
	Hong Kong	1		1
	Iran	1		1
	Oman	1		1
	Philippines	1		1
	Japan		1	1
Australia	Australia	5	3	8
Total	**15**	30	17	**47**

The purpose of describing the geographical settings of the studies included in this review is to highlight the limited research undertaken in Arabic countries in the Middle East versus the more extensive research undertaken in North America and Europe. Most of the identified studies were conducted in Eurocentric developed countries, such as Australia, the UK and the United States. Apart from the three studies in Oman, no relevant studies from Arabic-speaking countries were found. Knowledge pertaining to the transition experiences of NGNs in SA and other Arab countries is therefore very limited. Although the present research project initially sought to fill this gap in the literature by focusing on SA, the focus during the initial research phases shifted to collecting evidence from studies conducted across the globe in order to gain broader insights into NGNs' experiences and challenges during their transitions from nursing school to clinical practice. The transition experiences of NGNs in SA can thus be better understood in their

broader global context, and this will also allow for the identification of ideal approaches that can be adopted in SA based on global evidence.

3.4.2 Aims and objectives of included studies

High-quality studies were defined as having clear, well-defined and focused research aims. The importance of clarity in describing the research aim relates to the fact that readers use a study’s aim to initially determine whether the study warrants further attention and if its findings will be relevant to practice (Polit & Beck, 2013). All of the studies included in this review had clearly described research aims and unambiguous objectives. In addition to investigating the transition experiences of NGNs, the quantitative studies also explored the effects of challenges, such as stressors, on this subpopulation of nurses.

In addition, several qualitative studies, as well as the mixed-method studies, emphasised particular aspects of NGNs’ experiences and NGNs’ subjective awareness of and insights into the challenges they faced. For example, one study focused on NGNs’ socialisation experiences (Feng & Tsai, 2012), while three others propounded theories about NGNs’ initial transition (Duchscher, 2001; Pennbrant et al., 2013). The research aims of the included studies are grouped into categories and summarised in Table 3.4.

Table 3.4: Research Aims of the included studies, by category

Research objective categories	Number of studies
Explored the experiences of NGNs in clinical placements	22
Explored the personal and work-related challenges experienced by NGNs	12
Explored knowledge and self-concept development among NGNs	4
Investigated the factors that influenced NGN experiences	4
Explored NGNs’ socialisation processes	2
Developed a framework or model about the stages of NGNs’ transition experiences	3

3.4.3 Study designs

The research designs of the 47 primary research studies included in this systematic review are described in Tables 3.5 (qualitative studies; *n* = 30) and 3.6 (quantitative studies; *n* = 17). The quantitative designs included 2 mixed-method studies.

Qualitative study designs

The qualitative studies used a number of different methodological approaches: descriptive (*n* = 14), phenomenology (*n* = 11), grounded theory (*n* = 2), longitudinal (*n* = 2) and comparative (*n* = 1). While their data analysis methods varied, 11 used thematic content analysis and 5 used Colaizzi's (1978) method. The research designs used in these studies were all found to be appropriate to achieve their respective aims and led to meaningful insights into the experiences of NGNs or into relevant factors that influenced them (Taylor, Bogdan, & DeVault, 2015).

Quantitative and mixed-method study designs

The quantitative studies used quantitative descriptive (*n* = 7), longitudinal research (*n* = 4), cross-sectional (*n* = 2), mixed-method (*n* = 2) and comparative (*n* = 2) methodological approaches. The purpose of quantitative research is to produce numerical data which can be used to quantify factors (Punch, 2013) such as attitudes, perspectives and behaviours (Creswell, 2013). Researchers adopting a quantitative approach are typically concerned with extracting particular variables present in the research framework and determining any correlations, links or causality; they also seek to reduce the likelihood of identified relationships being attributable to extraneous variables by controlling the data collection (Creswell, 2013; Yilmaz, 2013). In the present review, quantitative studies were found to focus on identifying the difficulties and challenges faced by NGNs, as well as their consequences.

3.4.4 Participant and sampling strategies

Among all included studies, a total of 7,464 NGNs shared their experiences during their transitions to professional roles. Of these, 778 NGNs participated in the reviewed qualitative studies, two studies used random sampling and one study used stratified sampling.; the remaining one used a convenience sampling approach instead. The NGNs in these studies were asked open-ended questions, with research sample sizes ranging from 5 to 330 NGNs. The quantitative studies had an even wider range of sample sizes, ranging from 14 to 3,266 participants; the total number of all NGN participants in the included quantitative studies was 6,684. There were also considerable variations in the response rates (24–89%) of the quantitative studies.

3.4.5 Data collection and analysis

Collectively, the reviewed studies' methods were suitable for achieving their stated aims and objectives. All but one (Pellico et al., 2009) of the quantitative studies used a self-completed survey questionnaire as their primary method of data collection, likely because this method is very flexible and affords a wide scope (Fowler, 2013). The majority of the qualitative studies used in-depth face-to-face interviews, either with focus groups (*n* = 6) or open-ended questionnaire (*n* = 10). To analyse their findings, the qualitative studies primarily used thematic analysis, content analysis or constant comparative analysis, but a few used other methods, such as grounded theory (*n* = 2), subjective analysis, deviant case analysis or conceptual analysis. The quantitative studies primarily used descriptive statistics, in conjunction with correlation analysis, to analyse their findings (see Tables 3.5 and 3.6).

The methodological quality of each of the included qualitative studies was appraised using the CASP evaluation tool. They were all found to be of either high (*n* = 11) or moderate (*n* = 20) quality. The quantitative and mixed-method studies were appraised using the EPHPP and were also all found to be of either strong (*n* = 6) or moderate quality (*n* = 11); none received an overall rating of weak. The methodological appraisal results for each of the included studies are summarised in Tables 3.7 and 3.8.

3.4.6 Thematic presentation of the finding from included studies

The systematic review identified four major themes among the reported experiences of NGNs during their transitions to professional roles: 1) competence, skill development and knowledge and theory-practice gaps; 2) role transitions, including professionalisation and socialisation; 3) challenges and opportunities; and 4) positive transition experiences.

Theme 1: Competence, skill development and knowledge and theory-practice gaps

Competence

During the first year following graduation, many NGNs reported feeling inadequate and incompetent, underlined by concerns over disparities between theories learned in nursing school and practical applications in clinical practice. This was particularly evident in the studies that focused on NGN experiences at the beginning of their career. An example, NGNs in Ireland experienced anxiety about their medical or administrative duties during the early stages of their placements; moreover, the NGNs attributed their anxiety to limited opportunities to practice clinical applications when studying and training (O'Shea and Kelly 2007). Similarly, a study in the UK found that NGNs exhibited concerns over their clinical competence and proficiency when practising autonomously during the first six months of their transition period; however, after the initial six months, they typically demonstrated increased levels of efficiency and clinical competence that allowed them to practise autonomously and effectively (Clark & Holmes, 2007). Likewise, a study reported that NGNs' confidence and clinical competence improved with practical experience (Newton & McKenna, 2007), and one study suggested that even a pre-graduation clinical training programme could immediately increase NGNs' clinical competence (Cheng et al., 2014).

Knowledge and theory-practice gaps

NGNs also reported that they perceived gaps between the theoretical knowledge that they had learned in nursing school and the practical knowledge that they needed at the beginning of their professional clinical practice. This set the foundation for further negative experiences, such as anxiety, lack of confidence and inability to work

autonomously (Al Awaisi et al., 2015; Hu et al., 2017; Oermann & Garvin, 2002; Rochester & Kilstoff, 2004; Wong et al., 2018; Zhang et al., 2017), and fuelled stress due to encountering unfamiliar events and work practices (Clark & Holmes, 2007; O'Shea & Kelly, 2007; Zamanzadeh et al., 2015). NGNs described this period as being characterised by uncertainty about their duties and unclear and stereotypical self-perceptions (Takase et al., 2012). In addition, some NGNs expressed that they resented their involvement in basic nursing care, which they believed to be below their standard of training (Al Awaisi et al., 2015).

However, several studies found that NGNs' clinical competence, disparities in theory and practice experiences and practical skills continuously improved after their initial six-month transition period (Casey et al., 2004; Cheng et al., 2014; Halpin et al., 2017; Newton & McKenna, 2007; Wangensteen et al., 2008). Casey et al. (2004) found a significant increase in NGNs' self-confidence between six months and one year after beginning their first professional role. Similarly, Wangensteen et al. (2008) found that NGNs' were able to effectively manage challenging situations in the workplace following a period of approximately one year. Likewise, a study in Australia found that NGNs' initial six-month period of practice was typically characterised by self-advancement, efficiency improvements and adapting to an institution's work culture in order to gain the respect of colleagues and improve their professional standing (Newton & McKenna, 2007). Cheng et al. (2014) also found that NGNs' exhibited cumulative skill improvements at both the six-month and one-year marks of practice, and Ortiz et al. (2016) similarly found that NGNs' developed professional confidence continuously throughout their first year of practice. These results are also consistent with those of Duchscher (2008), who found that NGNs demonstrated incremental but rapid improvements in both confidence and competence during the initial part of their first year in a professional role; thereafter, improvements plateaued.

Theme 2: Role transitions, including professionalisation and socialisation

Professionalisation

NGNs highlighted the transition period as being characterised by anxiety due to unfamiliar duties and fears of making mistakes in practice (Duchscher, 2001; Gerrish, 2000; Liang et al., 2018; Oermann & Garvin, 2002; Ortiz et al., 2016; Wangensteen et al., 2008), and some NGNs expressed that the anxiety provoked by the extreme pressure and tension of their new roles led them to consider resigning (Scott et al., 2008; Takase et al., 2012; Zhang et al., 2018). Role ambiguities and uncertainties also contributed to some NGNs' expressed inabilities to focus or engage actively in their new professional roles (Dyess & Sherman, 2009; Ellerton & Gregor, 2003; Wangensteen et al., 2008). NGNs also underscored that working with dying patients and dealing with issues of death could be overwhelming and that this contributed significantly to their feelings of anxiety early in their careers (Casey et al., 2004; Delaney, 2003; Halpin et al., 2017; O'Shea & Kelly, 2007). NGNs blamed their training for their poor clinical performance immediately after graduation and suggested amending training course content to improve its practical relevance and provide trainees with the management skills needed to respond to challenging situations (Delaney, 2003; Gerrish, 2000). Nevertheless, Wangensteen et al. (2008) found that NGNs also demonstrated a profound capacity to adjust to their new jobs and to improve their skills and clinical competence over time.

Socialisation and transitions to professional nurses

Many of the included studies found that NGNs' work environments and relationships with colleagues significantly influenced their experiences during their transitions to professional roles. A supportive work environment was found to be crucial for NGNs' positive development and growth in professional roles, as they often anticipated encouragement and positive reinforcement from experienced nurses (Tastan et al., 2013). Similarly, Malouf and West (2011) reported that NGNs considered acceptance from their colleagues to be a crucial step towards a positive working experience. However, NGNs reported that social success in their new organisations was a complex process that involved adapting to the organisational bureaucracy and familiarising themselves with the organisational culture, as well as establishing interpersonal relationships with colleagues (Feng & Tsai, 2012).

The absence of professional recognition from colleagues, as well as a lack of supportive work environment, could also contribute to negative experiences and feeling of stress and anxiety among NGNs (Dyess & Sherman, 2009). In particular, the presence of the power hierarchy within a healthcare organisation negatively influenced NGNs' transition and adjustment experiences, as shown in a study of Taiwanese NGNs: the comparatively poor professional competency and perceived inadequacies of NGNs, relative to experienced senior nurses, positioned NGNs lower in the power hierarchy and left them feel weak and isolated, thereby establishing a vicious circle in which the NGNs felt uncomfortable requesting support or assistance that in turn impacted their ability to perform tasks and thus further cemented their lower positions (Lee et al., 2013). Discrepancies between personal, professional and organisational values were also a source of social dissatisfaction among NGNs (Feng & Tsai, 2012), who had to navigate an unfamiliar new work environment at the same time as they sought to develop interpersonal relationships with new colleagues.

Many NGNs also referenced communication challenges with senior nurses (Hu et al., 2017) or physicians (Brown et al., 2018). Colleagues, whether experienced nurses or other health professionals, could exert dual influences: while they could facilitate NGNs' adjustments during their transition periods by providing valuable support (Tastan et al., 2013), many NGNs expressed that they often found it difficult to request assistance or guidance from other health professionals (Dyess & Sherman, 2009). A common theme among NGN respondents was the unsupportive and unhelpful attitude of experienced nurses, in particular, which contributed to NGNs' negative experiences during their transition periods (Oermann & Garvin, 2002).

Theme 3: Challenges and opportunities

Workplace support Structure

Several studies focused on the beneficial impact of formal workplace support structures for NGNs, as well as the frequent lack of such support structures (Clark & Holmes, 2007; Ellerton & Gregor, 2003; Gerrish, 2000; Hu et al., 2017; Labrague et al., 2019; Jackson, 2005; Rungapadiachy et al., 2006). Gerrish (2000) and Clark & Holmes (2007) found that

workplace guidance and encouragement from mentors or instructors had a positive effect on NGNs' transition experiences and improved their capacities to manage early challenges. Similarly, Hu et al. (2017) found that official arrangements created by an organisation instilled positive feelings in NGNs during their transition periods. The ability to confidently communicate and gain valuable knowledge from experienced colleagues served as a crucial survival strategy for NGNs in the early stages of their career; it not only reduced their feelings of anxiety (Wu et al., 2012), but also facilitated their professional growth by providing them with necessary encouragement, guidance, skills and knowledge. Moreover, a supportive work environment created by an experienced senior nurse was also found to influence the long-term retention of NGNs by encouraging their loyalty to the organisation, thereby preventing high staff turnover (Wangensteen et al., 2008).

Taken together, the included studies indicated that poor workplace support was a common contributing factor to NGNs' negative experiences during their transition period. The presence of supportive networks was also found to be highly variable among different organisations and even between departments within a single organisation. The implementation of assigned observation periods alongside experienced health professionals or pairing NGNs with experienced mentors during their initial transitions to professional roles could allow NGNs to experience a more gradual introduction to organisational guidelines, protocols and culture, thereby helping to alleviate some of their anxieties and preventing them from becoming overwhelmed (Darville et al., 2014).

Heavy workloads

Several studies identified heavy workloads as a key contributor to NGNs' negative experiences during their transitions to clinical practice (Gerrish et al., 2000; Halpin et al., 2017; Hu et al., 2017; Oermann & Garvin 2002; Wong et al., 2018). Over 75% of NGNs in an American study reported experiencing a high-pressure working environment for at least one or two days per week (Kovner et al., 2007). Workloads were affected by factors such as employee shortages and increased administrative duties, which led to increased responsibilities and obligations overall (Halpin et al., 2017; Scott et al., 2008). One recent study found that workload was consistently the highest reported stressor among NGNs, with inadequate staffing and the need to manage multiple roles simultaneously given as

the main reasons (Halpin et al., 2017). Moreover, greater responsibilities and obligations led some NGNs to feel unable to prioritise patient care and to feel isolated and incompetent (Blomberg et al., 2014; Dyess & Sherman, 2009). Some NGNs also reported that they were unable to provide personalised care to patients due to their administrative duties or general tasks, resulting in poor rapport between nurses and patients (Ellerton & Gregor, 2003; Mooney, 2007; O'Shea & Kelly, 2007). Several additional reports corroborated these findings (Casey et al., 2004; Delaney, 2003; Duchscher, 2001; Newton & McKenna, 2007).

NGNs also stated that unfamiliar events, duties or obligations were sources of considerable stress and anxiety (Amos, 2001; Blomberg et al., 2014; O'Shea & Kelly, 2007).

Workplace conflicts

NGNs expressed that the presence of a cohesive and supportive work environment was essential for positive transition experiences (Malouf & West, 2011; O'Shea & Kelly, 2007). However, in interviews, NGNs described episodes of unacceptable behaviour directed towards them from team managers, senior nurses and healthcare support workers (Halpin et al., 2017). The same study also found that NGNs felt excluded from their team, were openly chastised in front of others and were criticised for asking questions (Halpin et al., 2017). Another study reported that bullying was still a common experience among nurses during their transition periods (Feng & Tsai, 2012). Understandably, therefore, NGNs often exercised caution when establishing relationships with more experienced healthcare professionals, which could manifest as an inability to converse with experienced colleagues (Casey et al., 2004; Dyess & Sherman, 2009). Bullying among nurses and poor nurse-doctor relationships have also been highlighted in recent Saudi studies of more experienced nurses, indicating that this problem is not limited to NGNs (Alkorashy & Al Moalad, 2016; Alsaqri, 2014; Alswaid, 2014).

Theme 4: Positive transition experiences

The nursing profession is an honourable one that confers self-respect and a sense of satisfaction and achievement from helping vulnerable patients (O'Shea & Kelly, 2007; Oermann & Garvin, 2002). Both O'Shea and Kelly (2007) and Oermann and Garvin (2002) found that NGNs reported financial advantages and improved social status over time, as well as enhanced clinical competence and improvements in their skills and knowledge over the course of their transition period. NGNs also frequently reported mentors, supportive environments and teamwork as significant contributors to their positive experiences (O'Shea & Kelly, 2007; Oermann & Garvin, 2002). Belonging to a supportive team, developing professional relationships and working alongside considerate colleagues were also highlighted as positively affecting NGNs' transition experiences (Jackson, 2005).

NGNs also indicated that the senses of satisfaction and fulfilment that they gained from providing effective patient care and treatment were important to them during their transition experiences and inspired them to continue pursuing long-term careers in nursing (Jackson, 2005; O'Shea & Kelly, 2007). NGNs also reported that positive comments and appreciation from patients enhanced their confidence levels and motivated them to improve (Darvill et al., 2014). They also emphasised the importance of colleagues trusting them to work autonomously in building their self-confidence (Darville et al., 2014). Similarly, Jackson (2005) found that the most important positive factors in NGNs' experiences during the transition period were establishment of patient rapport, application of group efforts, high-quality task completion and learning new skills. The application of personal expertise or advanced practical skills also contributed to NGNs' positive experiences, as did being praised for the quality of their work (Jackson, 2005).

3.5 Discussion

This systematic review examined the global experiences and perceptions of NGNs during their first year of transitioning from nursing school to clinical nursing employment. Findings from 47 qualitative and quantitative studies were reviewed, evaluated and synthesised. Four primary themes were identified: competency, socialisation and support, challenges and opportunities and positive transition experiences. Some of these

findings are similar to the major themes identified by Teohet et al. (2013), suggesting that nurses across the globe face very similar challenges during their first year of transitioning to professional roles. Additional themes identified by this review include NGNs' gaps in knowledge and discrepancies between theory and clinical practice, skill development and professionalisation. This review thus helps to provide an understanding of the challenges that NGNs face during their transitions to professional roles, especially during the first six months, and underscores the impact of NGNs' negative experiences on their transition and integration into public hospital workforces.

The reviewed studies revealed that most NGNs felt significant stress, anxiety and uncertainty during their first six months of working in clinical roles, consistent with the transition theory advanced by Duchscher (2009) about NGNs' adaptation to the rigours of nursing tasks and responsibilities. One of the main themes identified during the early transition period was that NGNs tended to report low self-esteem and self-confidence due to limited exposure to practical experiences during their undergraduate nurse training (Duchscher, 2003, 2009). This, in turn, significantly affected their autonomy and self-acceptance as skilled nursing professionals (Darvill et al., 2014; Duchscher, 2009).

Another major theme identified by the included studies was a gap between NGNs' theoretical and practical knowledge, which in turn was also a source of stress for the NGNs (Clark & Holmes, 2007; O'Shea & Kelly, 2007; Zamanzadeh et al., 2015). This widely reported gap was likely due to the course content studied by NGNs during their undergraduate training. NGNs across the globe emphasised that their undergraduate studies were largely comprised of practically irrelevant theory that was widely perceived as being incomplete, impractical and highly 'textbook' and as offering limited application to the practical realities of nursing (Duchscher, 2001; Oermann & Garvin, 2002). However, Ellerton and Gregor (2003) have argued that course content cannot be entirely blamed for NGNs' negative experiences and that student nurses must accept some of the responsibility for maximising the value of their degrees to ensure optimal aptitudes upon graduation. Duchscher (2001) also suggested that neither the course content nor the students were entirely to blame; instead, she attributed NGNs' poor abilities to manage demanding situations and increased responsibilities to the inability of training courses to teach students to function amidst the high levels of pressure and responsibility that are

present in real clinical situations. As such, it is not surprising that NGNs consistently reported that working autonomously, without management or direction, induced feelings of anxiety (Clark & Holmes, 2007; Dyess & Sherman, 2009; O'Shea & Kelly, 2007). However, regardless of the exact causes of the gap in NGNs' practical knowledge, since NGNs prioritised their practical skillsets in their self-assessments of clinical competence, their gaps in practical knowledge and skills significantly contributed to their poor self-confidence and thereby negatively contributed to their poor transition experiences (Zamanzadeh et al., 2015).

The transition period is multifaceted and unpredictable, and many NGNs reported experiencing shock, disorientation and distress during this time, echoing the findings of reports published in the 20th century. Similar to these earlier reports, the studies included in this review indicated that NGNs felt that a lack of recognition from colleagues and an unsupportive work environment contributed to negative working experiences and feeling of stress and anxiety (Dyess & Sherman, 2009). A case-study approach could help to shed further light on socialisation processes among nurses and NGNs.

Since only one of these studies was conducted in an Arabic-speaking country with conditions similar to SA, the applicability of these findings to an Arab context remains largely unclear. Nonetheless, the overview of global results raises topics for further consideration in a Saudi or broader Arab context, including the concept of a gap between theoretical and practical knowledge and the importance of NGN socialisation processes. Moreover, since a number of the reviewed studies identified that NGNs' knowledge, skills and clinical competency improved consistently after their first six months of transition to professional roles (Casey et al., 2004; Cheng et al., 2014; Halpin et al., 2017; Wangensteen et al., 2008), future research on NGN transitions in SA should focus on NGNs' first 12 months of transition, in order to best assess whether NGNs in SA experience the same difficulties experienced by NGNs in other countries.

3.6 Limitations and strengths

The major strength of this systematic review lies in its inclusion of qualitative, explorative, descriptive and quantitative studies with a range of sample sizes and geographic

locations. Nonetheless, it has several limitations. Out of the 47 studies included for review, only 6 used a longitudinal study design. Since NGNs' development of clinical competence and self-confidence is a progressive process, more studies with a longitudinal design are clearly warranted. In addition, this review was restricted to articles published in English, and this, along with the exclusion of all grey literature, may have resulted in the omission of relevant studies.

Moreover, while this review's inclusion of both qualitative and quantitative studies is an overall strength, both forms of research have some general limitations that should be mentioned. Qualitative research has three inherent limitations: first, due to the subjective nature of qualitative data, its methodological validity and reliability are not always clear; second, the identification and avoidance of researcher-related bias is challenging; and third, applying the results of qualitative studies to other situations is problematic. Quantitative research, meanwhile, has its own limitations: the research context is not given consideration (Pickard, 2012); it does not use a natural context for investigation purposes; it does not address the different meanings that individuals might attribute to specific features (Yilmaz, 2013)).

However, both quantitative and qualitative research also have advantages. Surveys, which are widely used in quantitative research, are very flexible and allow for a wide scope of research (Fowler Jr, 2013); not surprisingly, therefore, every quantitative study included in the current review collected data via self-completed surveys. On the other hand, the in-depth interviews favoured by qualitative research can generate data about individuals' attitudes and experiences, as well as the impact of their sociocultural milieus and personal beliefs. Moreover, the detailed data yielded by in-depth interviews can allow for theme-based analyses that address a research topic's aims and objectives (Ellis, 2013).

3.7 Conclusion

The present systematic review identified a number of factors that influenced NGNs' experiences of their transitions to clinical practice during their first year of employment in

hospital settings after graduating from nursing school. Overall, the stress of adapting to new expectations and taking on clinical responsibilities during their first professional roles was found to be highly stressful for NGNs. Inadequately supportive environments, heavy caseloads and new responsibilities that exceeded NGNs' expertise were found to seriously impact NGNs' transition into new healthcare teams and their long-term retention.

This review also emphasised the need for interventions that can minimise the factors that negatively impact NGNs' transitions and their overall transition experiences. A more structured transition that allows NGNs to progressively adapt to a working hospital environment, such as the inclusion of a proactive and supportive health team and a positive organisational culture, could crucially improve NGNs' transition experiences. This sort of transition period would allow for the gradual development of NGNs' clinical competence and self-confidence in hospital settings. However, additional empirical studies on such interventions are needed, and there remains a lack of research on NGN experiences in SA and in other Arabic-speaking countries.

Table 3.5: Characteristics of qualitative included studies (n=30 studies)

Study	Reference (Year) Country	Research Aim(s)	Study Design	Participants	Method/ Data Collection Tools	Data Analysis	Main Findings/ Emerging Themes during Transition
1	Labrague et al. (2019) Philippines	Examine transition experiences of newly graduated Filipino nurses during initial clinical placement.	Phenomenological study (Husserl's approach)	n= 15 NGNs graduated within last 12 months	Qualitative study data collected by structured interviews	Transcription of audio-recorded interviews Colaizzi's (1978) data analysis method: *1*) reading & rereading of participants' narrated experiences; *2)* extraction of relevant information related to the phenomenon studied; *3)* creation of meanings from the information; *4)* thematic formation *5)* narration of the phenomenon; *6)* validation of the results to the participants; *7)* integration of essential data into the phenomenon	NGNs found transition to be both draining and stressful. This was due to perception of discrepancy between teaching at nursing school and then translating into practical reality (transition shock). Emerging Themes: 1. Experience of transition shock 2. Feeling pressured 3. Excitement of learning 4. Support needed
2	Brown et al. (2018)	Identify the lived experiences of first-year employed NGNs.	Phenomenological study (Husserl's approach)	N= 12 NGNs	Data collected by in-depth face-to-face interviews;	Transcription of audio-recorded interviews.	Main findings are described as emerging themes: 1. Preparation/learning at nursing school 2. Key role of hospital orientation

	The USA				1 open-ended question & 4 prompts	Framework used: "reality shock" (Kramer, 1974). Descriptive statistics; demographic characteristics	3. Teamwork environment 4. Practicing self-care 5. Self-confidence & competency 6. Expectation vs reality in interactions with doctors
3	Liang et al. (2018) Taiwan	Identify the transition work challenges of Taiwanese NGNs in rural settings.	Descriptive phenomenological approach qualitative study	n= 15 NGNs graduated within last 12 months	Face-to-face, in-depth semi-structured interviews	Transcription of audio-recorded interviews Colaizzi's (1978) data analysis method	Main Theme: "struggling & breaking through the dilemma of deciding whether to continue nursing or to quit" Emerging Themes: 1. Fear of making wrong clinical decisions2. Overworked and mental stress 3. Entering and adjusting to the profession 4. Self-confidence
4	Wong et al. (2018) Hong Kong	Explore the transition challenges of NGNs into clinical practice.	Qualitative descriptive study	n= 8 NGNs	Semi-structured interview questions based on 8 themes identified through literature	Transcription of audio-recorded interviews Thematic analysis	NGNs show Emerging Themes: The major theme is heavy workload; Others: limited knowledge, communication, expectations, work environment, support culture, blame/complaint culture, change of role and personal attitude

6	Ortiz
	
	(2016)
		Describe challenges of NGNs with lack of professional confidence post-entry into	Descriptive qualitative study	n= 12 NGNs
				
				n= 1, 1-3 months;
				
				n= 6, 4-6 months;
					Two face-to-face,
					
					semi-structured interview
						Manual content analysis;
						
						Thematic coding
							NGNs develop professional confidence throughout the first year of practice.
							
							Main Themes:
							
							Communication; making

	The USA	professional practice.		n=2, 7-9 months; n=3, 12 months	method triangulation method: Interview, Interpretive Interview, and written field notes		mistakes, disparity between nursing school and practice, independence, relationship building, importance of positive feedback and gaining experience
7	Al Awaisi et al. (2015) Oman	Investigate the experiences of newly qualified nurses during their transition period.	Descriptive qualitative study	n= 214 NGNs	Semi-structured, face-to-face interviews: at 6 months, 12 months, observation; documentary analysis	Thematic analysis using a method adopted from Hahn (2008)	Omani NGNs are not drawn to nursing as a career. During the transition period, NGSs experienced reality shock from mainly disparity between textbook descriptions of clinical situations and real-life events. Resentment towards the involvement in basic nursing duties, which NGNs believed should not be part of their role as qualified nurses.
8	Zamanzadeh et al. (2015) Iran	Explore NGNs' readiness for transition from college to professional practice.	Descriptive qualitative study	n= 14 NGNs with < 1 year employment	Semi structured interviews	Content analysis (Gravel, 2012)	Transition experience: lack of practical skills, insufficient theoretical knowledge, poor communication skills, low self-confidence & independence, frustration, pressure and isolation.
	Darville et al. (2014)	Examine transition experiences of a cohort of UK-based NGNs in community paediatric settings.	Descriptive qualitative study	n= 8 NGNs paediatric field	Semi-structured interviews and fieldwork observation	Combination of thematic analysis (Braun & Clarke, 2006) and framework approach (Ritchie & Lewis 2003; Smith & Firth 2011)	1-Shadowing was viewed as a period of being supported, guided and protected; thus, promoting confidence. 2-Shadowing experience was

9	The UK						described as a source of protection against excessive challenging conditions or inadequate support in clinical setting, which created a safety net in the event of mistakes. 3- NGNs' lack of practical experience & poor ability for self-autonomy made them feel less valuable as a team member. 4- Paediatric NGNs did not report the shock type reactions, as described by other NGNs working in acute hospital settings.
10	Lee et al. (2013) Taiwan	Explore and understand the NGNs transition process to practice.	Phenomenological qualitative study	n=16 NGNS <1 year post-graduation in employment	8 weekly focus group interviews (2 hours)	Interview data were analysed according to Sloan's (2002) three moments: 1-In the-moment analysis during the original participant dialogue 2-Analysis of each transcript as individual data sources 3-Analysis across a group of narratives as the data source.	Challenges from school to practical clinical care: 1. Feeling of self-worth: NGNs felt they were viewed as being unqualified. This resulted in covering their anxieties and avoiding asking for assistance. 2. Hiding anxieties: Most internalised their struggles, in order to have a better opportunity at securing a higher role. 3. Hierarchy issues: relationships with senior staff were complicated, due to the disparity in familiarity, prestige and seniority levels.

11	Pennbrant et al. (2013) Sweden	Develop a model describing the professional development of new nurses during their first years of work	Qualitative study	n= 330 NGNs	Open-ended questions	Constant comparative analyses (Bryant & Charmaz, 2010)	Stages of developing skills necessary for working in clinical setting: 1. Evaluating and re-evaluating educational experiences. 2. Developing professional self-efficacy & clinical competence Variables acting as enablers or obstacles: Type of clinical environment, attitudes & perceptions of NGNs relationships with colleagues, and attitudes of NGNs personal friends or families. These factors affect choice of NGNs' intention to remain or leave the profession.
12	Walker et al (2013) Australia	Compare & contrast the opinions of NGNs & Nurse Unit managers (NUMs) with focus on the attitudes towards the different workplace variables that influence opinions of nursing during	Longitudinal qualitative study .	first survey: n=38 NGNs Second survey: n=31 NGNs	A qualitative survey with open-ended questions (developed after a pilot study involving two group interviews n=13 NGNs and three	Content analysis (Erickson & Kaplan, 2000).	-Differences between NGNs and NUMs' perceptions of unprofessional workplace behaviour & coping with death and dying. -NGNs more likely to report unprofessional workplace attitudes. For the NUMs, this was an obstacle to forming strong working relationships. -Stresses relating to death and

		the initial 12 months of practice.		Over two years: n=69 NGNs completed the qualitative survey	individual interviews with NUMs. Further refined after trial with NGNs and Graduate Support Coordinators (n=11).		dying patients were felt more intensely by NUMs than NGNs. -Both groups shared similar opinions on the value and difficulty of rotational shift work and the amount of emotional assistance made available to them.
13	Feng and Tsai (2012) Taiwan	Investigate socialisation encounters of NGNs focusing on transition from school to clinical practice.	Qualitative descriptive study	n=7 NGNs working full shifts in a medical institution	Data were collected through semi-structured, open-ended, & in-depth interviews.	Content analysis & constant comparison (Lincoln & Guba, 1985)	-The majority of NGNs experienced difficult socialisation journeys. -Time factor needed to improve knowledge & clinical skills. -The perception of most NGNs' challenges of the job was due to organisational socialisation journeys involving strengthening ties with fellow nurses getting to know the routines, guidelines, and routines of the wards. -NGNs struggled to handle the clash between professional and organisational values.
14	Malouf & West (2011)	Increase understanding of how NGNs in Australia feel regarding the	Qualitative study	n=9 NGNs working first 12 months of clinical care	In-depth interviews. Each participant was	Constant comparative analysis (Glaser, 1992)	For all subjects, the need to 'fit in' (and develop strong social ties) with ward units was an essential part of the journey from student to professional.

	Australia	journey from student to acute clinical care professional practice.		across Sydney	interviewed three times at quarterly intervals, across their first year of practice.	.	Being 'a part of the team' was based on notions of self-worth and professional competence. All subjects were happy to admit that feeling like a valued member of the team was of paramount importance to their experiences at work. Current NGN Transition Programmes (NGNTPs) involve multiple ward rotations, increasing the demand for the NGN to fit in.
15	Duchsher et al. (2009) Canada	Develop a theoretical system for interpreting the early journey between students and NGNs.	Qualitative Study	n=15 NGNs working their first 12 months	Semi-structured interviews: 1, 3, 6, 9, 12 and 18-months focused group and separate group discussions; from the same nursing programme.	The grounded theory framework was utilised to direct continual analyses and accurately present the developing findings.	Most study subjects experienced a sense of frustration and anxiety relating to 'tradition shock' during their first year of practice. Transition shock emerged as the experience of moving from the known role of a student to the relatively less familiar role of professionally practising nurse; as such, 'transition shock' involves cognitive, emotional, physical, and cultural strains.
16	Zinsmeister & Shafer (2009)	To gain insight into the transition period of graduate nurses through their lived experience during	Qualitative, phenomenological research approach	n=9 NGNs with less than one year experience in clinical settings.	6 Semi-structured Interviews. Interviews were conducted	Interview data transcribed. qualitative data analysis methods used according to Miles & Huberman (1994). Thematic analysis	The key theme was a supportive work environment that was most important during the transition period. Five thematic areas identified:

	The USA	the first 6 months to 1 year of nursing practice.			until data saturation occurred.	Content analysis	positive preceptor experience, comprehensive orientation process, self-confidence, clarity of role expectations and sense of professionalism.
17	Duchsher et al. (2008) Canada	To investigate and examine the aspects of the new nurses' transition experiences into acute care.	Qualitative phenomenology study	n= 14 NGNs (all female). All had completed the same four stage baccalaureate nursing scheme, in one of either two locations in Canada.	Research strategies included: demographic survey at the start of the research; six face-to-face interviews at 1, 3, 6, 9, 12, and 18 months. At the initial two instances, conducted by focus groups with NGNs from a second city.	Conceptual analysis of the transition experience with overall representation of this experience and the processes encompassed within it (Graneheim & Lundman, 2004)	The transition between student and acute care professional included the following formally identified stages. Preparing, learning, acting, obscuring, changing, deconstructing, expressing, isolating, rediscovering, investigating, and interacting.
18	Wangensteen et al. (2008)	Illuminate how newly graduated nurses experience their first year as a nurse.	A qualitative design	Purposive sample of 12 nurses working in hospital settings	One to one interview sessions.	Conventional content analysis (Hsieh & Shannon 2005)	The study's subjects provided first-hand accounts of their encounters. These reports were evaluated and classified into one of eight groups. They are as follows: desire for a more nurturing work environment;

	Norway						desire for more praise; a desire for a better induction; understanding of duties; stress and unpredictability; desire for satisfying encounters; developing skills; and handling of obstacles. The study's subjects faced many challenging situations. For example, administering care to dying individuals and individuals suffering serious medical episodes like cardiac arrest. They appeared to handle these stressful incidents with skill. They expressed gratitude for the chance to learn and saw the work as a necessary part of their journey. Receiving feedback was described as essential in the process of gaining nursing experience

19	Clark & Holmes (2007) The UK	Increase awareness of how confidence and expertise is generated for nurses; determine how this evolution is viewed by managers and fellow colleagues.	Qualitative exploratory study	n= 34 NGNs (n=55 experienced qualified nurses, n= 11 practice development nurses) 55 participants	Twelve focus groups comprising 6–10 participants; each group was homogeneous; comprising either newly qualified staff, experienced qualified nurses or practice development nurses.	Content analyses based on Huberman and Miles's (1984) framework	Ward managers and senior staff seemed to think poorly of the recently qualified nurses. The nurses themselves challenged this notion by claiming that they were told to undertake jobs that they were not confident about completing. Most managers believe that

				were included in the focus group, n=5 ward managers were interviewed individually and their data were added to that obtained from the focus groups.	5 individual interviews		recently qualified nurses are not good enough to be on the ward at the point of assignment. There has not been enough training or support to give them the skills and knowledge needed to operate effectively and autonomously.
20	Maben et al. (2007) The UK	Investigate newly qualified UK nurses' experiences of implementing their principles and beliefs in contemporary nursing practice.	Longitudinal qualitative study	Stage 1: n= 72 student nurses in their final year of training. Stage 2: n= 49 continued to stage two of the study. Stage 3n= 26 NGNs interviewed at 4-6, 11-12 months.	Stage 1 baseline data: a 24-item self-administered questionnaire with open-end questions, adapted from Macleod et al. (1996) Stage 2: in-depth interviews. Phase 3: questionnaires were mailed to the interview subsample.	All interview sessions were recorded on tape. They were subsequently converted into written form and evaluated using the Guba and Lincoln (1985) system.	The majority of nurses experienced frustration and some level of 'burnout' as a consequence of their ideals and values being thwarted. These feelings resulted in anxiety, unreliability. For some, it was enough to prompt a complete abandonment of nursing.
21	Newton & Mckenna (2007)	Investigate how graduate nurses develop their knowledge and skills throughout their graduate studies, as well as	Qualitative approach	N= 25 NGNs sample comprised recently qualified nurses. All were completing a	Focus groups were undertaken between 4 and 6 months, 11 and 12 months following completion of the graduate	Thematic analyses based on the seven stage system created by Coliazzi (1978).	The twelve months after graduation is a time that is defined by huge amounts of personal and professional learning. While nursing skills have been taught within tertiary environments for a long time, the

	Australia	identify factors assisting or hindering knowledge and skill acquisition.		graduate nursing scheme in one of four clinical locations.	programme.		study subjects still felt unprepared for clinical practice. The journey from student to working nurse was a dramatic and stressful one.

22	O'shea & Kelly (2007) Ireland	Investigate the past encounters and experiences of recently qualified nurses assigned to clinical placements; the investigation was undertaken up to half a year post-initial assignment.	Phenomenological qualitative approach	n= 10 diplomat staff nurses who were more than six months and not more than seven months post-registration	Face-to-face in-depth interviews	Thematic analyses based on the work of Coliazzi (1978)	NGNs experienced exhaustion & mental drain, due to overwhelming feelings of responsibility & seriousness of the role. Anxieties & concerns linked to nursing potentially induce disturbances in physical & psychological health. Stress related experiences: physiological disturbances, such as insomnia and weight loss or anxiety working as a part of a multidisciplinary unit; concerns about a lack of staff support & cooperation, legal issues, & inaccurate task descriptions. Satisfying aspects of the role: gaining respect, feeling appreciated, making a difference, feeling like a member of the team and earning money.
	Rungapadiachy et al. (2006)	Determine whether the experiences, thoughts, and feelings of NGNs usually change as they gain more experience. The	Qualitative study	n=14 NGNS originally interviewed (interviewed regarding their perception of the role of the MHN, while	Semi-structured interviews (4 –60 mins)	Transcript were analysed using a qualitative approach based on grounded theory(no other details)	Lack of role clarity; gap between the theories of mental health nursing taught during their training and the practical demands of working on the wards. NGNs felt like there was not

23	The UK	focus was on nurses who were still working in a clinical care setting six months post-initial assignment.		they were still mental health student nurses (MHSNs) and re-interviewed. Aforementioned 11 participants were then interviewed (a second time) while working as professional nurses.			enough opportunity to apply their learning. Most of their time was spent delivering medications and completing ward checks. These skills were not covered by the nursing programme and had to be acquired onsite. Lack of support from managers and medical staff, and lack of resources (time, staff and information).
24	Rochester & Kilstoff (2004) Australia	Investigate the experiences of graduate nurses; the focus was on the journey from student to enrolled nurses (EN).	Descriptive qualitative study .	n=6 NGNs (two females and four males)	Semi-structured in-depth telephone interviews (1-2 hours) using a questionnaire developed for an earlier study on transition that was found to be valid and reliable (Kilstoff, 1993).	Content analyses based on a framework provided by Richards (1999)	The journey from student to clinical care professionals is intimidating & anxiety inducing, even if study subjects already have some expertise as ENs. Two key concerns: 'role compatibility' and 'value conflicts.' The interpretation of 'transition,' as it pertains to the journey from student to clinical practice, is not sufficiently in-depth to really define the experience.
25	Jackson et al. (2005)	Provide a descriptive account of newly qualified nurses' experiences of a good day and	Phenomenological descriptive qualitative approach	n=8 NGNs were involved in a purposeful convenience sample. The research subjects each	Two interviews were conducted with each participant (with a non-identified period). Additionally, an	Content analyses were based on the Giorgi (1975, 1979) System	The study's subjects listed the following as being part of a 'good' shift; strong and happy connections with patients, knowing that you have completed something useful/rewarding, completing

	The UK	an explanation of how a good day on the ward and the emotions that such positive experiences elicit.		belonged to a cyclical scheme designed to increase clinical knowledge, confidence, and expertise. To be part of this scheme, the nurses had to have been working in the surgical department for less than 12 months.	informal group interview was conducted to clarify themes.		all of assigned tasks, contributing to team tasks, and undertaking personal tasks to a high standard. These themes contributed to feelings of job satisfaction and the pleasure of nursing. The study subjects were keen to improve their knowledge and skills, although they did not always have the right experiences, training, and support to perform, as well as expert nurses. Nurses need to ensure that all levels of knowledge are addressed before they can undertake care.
26	Duchscher (2001) Canada	Offer a greater understanding of the socialisation journey experienced by NGNs.	Phenomenological qualitative study	n=5 nurses had graduated from a four-year baccalaureate degree nursing programme within two months after the study began.	Two in-depth interviews, 1 semi-structured interview within 2 months of the new graduates commencing practice 2- A second interview was conducted 6 months later	Constant comparative approach (no more details)	The study's subjects expressed feelings of frustration and an inability to focus. They felt they were not given sufficient time to undertake tasks and were in need of more support from both experienced nursing colleagues and other recently qualified nurses. Most individuals experienced feelings of low self-esteem, dissatisfaction, frustration, dejection, and isolation.

27	Ellerton & Gregor (2003) Canada	Investigate the adequacy of preparation for the role of hospital staff nurses as perceived by graduates.	Descriptive qualitative study	n=11 NGNs from Nurses of Nova Scotia Sample: convenience sample of 11 nurses who agreed to participate with a Bachelor of nursing employed in an acute care setting at 3 month following graduation.	Open-ended interviews (lasted for around 60-90 minutes)	Content analysis (Coliazzi, 1987)	A lack the capacity for helpful communication with patients and family. To achieve this knowledge, they had to shadow and replicate the techniques utilised by more experienced colleagues.
28	Delaney (2003) The USA	Investigate and explore graduate nurse transition experiences during orientation.	Phenomenological qualitative study	n=10 NGNs were on a hospital caring based orientation programme. Sample: Purposive sample of 10 graduate nurses who agreed to participate.	In-depth Interview (lasted between 30-60 minutes).	Phenomenological techniques were used to analyse the results (no other details)	The journey from student to clinical care professional is a frustrating and challenging time for most graduates. Preceptors played an important part within this journey. They had a substantial impact upon the cognitive and emotional responses of the subjects. There were many differences between work and study; the study's subjects felt stressed and under pressure when attempting to increase their knowledge and to fit in within the bureaucratic setting.

29	Ramritu & Barnard (2001) Australia	Investigate nurses' understanding of competence.	Phenomenological qualitative study	n=6 NGNs. All were working in one of two paediatric care facilities. They had been in the position for no longer than three months.	Semi-structured interviews	Analyses using 8 steps identified by Dean (1994)	The study's subjects highlighted eight aspects of 'skill' and 'ability'; they are as follows: efficient use of tools and equipment, safe methods, a high level of autonomy, good time management and organisational skills, clear ethics and morals, developing awareness, and a good understanding of clinical requirements.
30	Gerrish et al. (2000) The UK	Investigate the experiences of recently qualified nurses, with a particular focus on the journey from student to full professional; to contrast these experiences, thoughts, and feelings with the ones from qualified nurses working thirty years ago.	Qualitative study	In order to ascertain their perceptions of the transition from student to qualified nurse n=10 NGNs (1985) Moreover, n=25 additional NGNs who became fully qualified in 1998.	In-depth interviews	Thematic analyses and a constant comparative analysis (a contrast between the two given study groups)	Unlike the subjects who qualified in 1985, the recently trained subjects felt substantially more pressure. They found the delivery of drugs and other treatments very stressful. A number of subjects missed out on the opportunity to shadow fully trained mentors during the delivery of medications. In many cases, this was because of workload pressures. Recently qualified nurses tend to see themselves as unprepared for the tasks that they have to undertake. Nurses are able to adhere to a

							more dynamic and responsible form of training if they are assisted by a preceptorship program or initiative. Follow-up research investigated some of the advantages posed by providing recently trained nurses with more assistance and advice. It focused on the benefit of these things within the first three months post-training and placement.

Table 3.6: Characteristics of quantitative and mixed method included studies (n=17 studies)

Study	Reference (Year) Country	Research Aim(s)	Study Design	Participants	Method/ Data Collection Tools	Data Analysis	Main Findings/ Emerging Themes during Transition
1	Halpin et al. (2017) The UK	Explore NGNs' stressors and stress experiences during first 12 months' transition to practice.	Longitudinal, explanatory sequential mixed methods cohort study	Adult field NGNs: n=288, recruited at graduation (Phase 1) n=107, 6 months post-graduation (Phase 2) n=86, 12 months post-graduation (Phase 3) n=14, one-one interview at 12 months (Phase 4)	One-to-one interviews: 12 months post-graduation Nursing Stress Scale	Quantitative data from the NSS analysed by SPSS Statistics. Qualitative data analysed by: six stage "thematic analysis" related to NQN work-related stress (Braun & Clarke, 2006)	Most reported stressor: 1. "death and dying" at qualification point and after 12 months 2. Workload at 12 months 3.Unacceptable behaviour; or attitude from healthcare co-workers
2	Zhang et al. (2017) China	Explore NGNs' longitudinal change of intention to leave and identify potential factors of intention to leave during the	Quantitative longitudinal study	n=343 NGNs	6 part questionnaire: demographics, intention to leave, Occupational Stress scale for newly graduated nurses TCSQ, Nurse Professional Identity	Descriptive statistics, quantitative data analysed by SPSS, logistic regression analysis for intention to leave	Predictors for high prevalence rates of intention to leave are occupational stress & professional identity

		first year of practice.			scale, and Work Locus of Control scale (Chinese version)		
3	Cheng et al. (2015) Taiwan	Explore changes in job stress and job satisfaction among NQNs at three stages during their first year of practical work.	Descriptive, correlational longitudinal quantitative design with three follow-ups at 3, 6, 12 months post-graduation employment	NGNs: n=206 n=56.8%, 3 months post-graduation n=50%, 6 months post-graduation n=36.9%, 12 months post-graduation in practice	Three surveys: at 3,6 and 12 months post-graduation 2 Scale surveys: 1.Clinical Stress Scale (CSS) (developed by the research team based on literature reviews and focus group discussions,46 items, five-point Likert scale. Cronbach's α=0.94 2. WENSS (Halfer & Graf): four-point Likert scale. Cronbach's α=0.92	Data analysis: demographics, perceived job dissatisfaction and concerns using descriptive statistics. Relation mapping of occupational contentment and occupational worry using the Pearson correlation.	-No significant difference in job stress at 3,6 and 12 months post-graduation -NGNs significantly increased their satisfaction with their job at 12 months when their job stress also decreased, At 3 months: NGNs working half-day shifts were less stressed and more content than those working 8-hour shifts.
4	Blomberg et al. (2014) Sweden	Explore job-related stress of new nurses with respect to local institutional supervision.	Cross-sectional comparative, quantitative study	n=200 NGNs having qualified in 2011 from three separate Swedish institutions and now employed as nurses.	Through a questionnaire mailed to the participants with a numbered scale ranging from 1 = no stress at all, to 10 = high stress, produced by the authors of the study.	Descriptive statistics and Non-parametric tests' data analysis consisted of descriptive statistics and non-parametric tests	Regardless of the working environment, new nurses are subject to high stress levels. New nurses indicate stressors, including overwork, the pressures of patient interactions, and the issues.

5	Cheng et al. (2014) Taiwan	Investigate the relationship between clinical competence, clinical stress, and intention to leave; explore the effect of the pre-graduation clinical training programme on clinical practice.	Longitudinal quantitative survey	n=206 pre-graduates in the last stages of a RN-to-BSN course at the participating institution. The sample consisted of n=198 respondents to a pre-test and post-test survey.	Questionnaire survey includes: The Clinical Competence Questionnaire (CCQ) developed by Liou and Cheng (47-item 5-point Likert-type scale). The Clinical Stress Scale (CSS) (developed by the investigators and	Data analysis was largely through descriptive statistics, using Spearman's correlation to consider atypically distributed factors, and Pearson's correlation for the typically spread factors.	Additional training exercises did successfully raise the medical capability of the trainees. The medical capabilities improved greatly directly post-exercise; their capabilities did fall slightly after three months in their graduate position.
6	Parker et al. (2014). Australia	Explore new graduates' experiences of entering the nursing workforce.	Mixed method cross sectional design; the quantitative core component of the study was supplemented by qualitative methods	n=1,604 NGNs employed in public-sector contacted. Final sample size n=282 NGNs (24%); 55 members of this latter group also took part in focus groups (6-10 participants each).	Online survey and focus groups. The survey was produced in response to prior studies, particularly aspects of a study by Hegney & McCarthy study (2000). The content validity was checked by 115 practitioners and teachers involved in the field.	SPSS was used to analyse the quantitative results, while the qualitative information was coded and themed using the methodology by Sandalowski (2010).	Factors: accessibility and intensity of assistance NGNs' personal ability to acclimatise to new situations in employment; exact circumstances of their job and environment.
7	Read & Laschinger (2013)	Examine the relationship between newly qualified nursing staff and being subjected to maltreatment in	Quantitative descriptive study	Secondary data analysis on data from Laschinger et al. (201	Survey questionnaire	Descriptive statistics and Pearson correlational analysis	Within their working environment, recently qualified nurses were subjected to rudeness from fellow colleagues, discourtesy from management and

	Canada	the work environment.		(907 randomly drawn registered nurses). n=342 new graduate nurses (48% of eligible participant)			bullying. Discourtesy in their place of employment was correlated with occupational and professional discontent; reduced work-related fulfilment; increased emotional fatigue; impaired physical and psychological well-being; and the likelihood of higher rates of employees leaving an organisation and subsequently needing to be replaced. The adverse impact of poor treatment in their work environment increased the prospect of NGNs wanting to leave their existing positions. This may ultimately result in the abandonment of their nursing careers altogether.
8	Tastan et al. (2013)	Investigate the aspects that impact upon the experiences of newly qualified	Descriptive, cross-sectional, qualitative study	n=263 NGNs consisted of three groups of graduate nurses employed in a	Survey questionnaire 26 items for the survey were developed by the authors based on a	Largely descriptive statistics; paired sample t-test and Mann-Whitney U-test used to contrast the nurses' beliefs	The transitional phase is hard for many new nurses, although support from more senior nurses can make this time

	Turkey	nursing staff.		martial teaching and research institution. The sample consisted of 234 nurses who responded to the invitation.	review of the literature	regarding their transitional experiences with different factors. An independent samples t-test contrasted the average level of working hours of those desirous of leaving nursing against the hours of those not desirous of leaving nursing.	easier. Undesirable circumstances, such as overworking may result in lower levels of respite and a greater desire to leave nursing. Acclimatisation exercises are of some use in helping nurses with the transition into professional employment. The most commonly referenced emotion felt by newly qualified nurses was 'disappointment' during transitional stages.
9	Takase et al. (2012) Japan	Investigate how graduate nurses' perceptions of the demands–abilities and supplies–needs misfits altered with time, and whether they affected nurses' desire to	Longitudinal quantitative survey	n= 279 nurses qualified in March 2011 with no previous practical nursing skills. 176 of these nurses took part once or more. Of these, 150 took part in their third month of employment,	Questionnaire survey including demographic questions, The Holistic Nursing Competence Scale (36 items. Seven-point Likert scale, the reliabilities of the measurements ranged from 0.94 to	Data analysis was descriptive, with multiple regression investigation utilising STATA (version 12).	Graduates perceived both demands–abilities and supplies–needs misfits, The degree of the demands–abilities' misfit became reduced towards the end of the first year on the job.

		continue within their profession.		109 in their sixth month, 102 in their ninth month, and 96 after a year's work in the field. 62 took part throughout the entire duration of the study.	0.97), The Work Environment Scale (developed by the first author, 10 items which were derived from the findings of Takase et al. (2009). The Five-point Likert scale, which reliabilities the scale measurement ranged from 0.86 to 0.87; Modified Withdrawal Cognition Scale (Mowday et al., 1984), modified Takase et al. (2008). A seven-point Likert scale. The reliabilities of the scale in this study were as follows: 0.70 (1st data collection), 0.61 (2nd), 0.68 (3rd) and 0.69 (4th).		As for the impact on graduates' turnover intention, the graduates' abilities and their perception of the environmental supplies served as more significant predictors of their turnover intention, rather than the misfits per se. Newly qualified nurses are aware of mismatches between their occupation and themselves, but the degrees of mismatch change over time. Separate factors affect new nurses' desires to remain in the job at different times, to different degrees.
10	Wu et al. (2012) The USA	Investigate the prevalence of stressful factors affecting new nurses, and the relation of these to the respondent's desire to leave	Quantitative survey study	n=402 NGNs recruited. N=154 NGNs participated (response rate of 38%)	Data was collected through a questionnaire survey incorporating a 52-item Job Stress Scale for Newly-Graduated Nurses and 34 items from the Simple Coping Style	Analysis consisted of descriptive statistics, with t-tests and one-way analysis of variance (ANOVA) to reveal how many stress factors were affected depending on demographics, such as training schedules or prior	Clinical abilities regarding difficult patients or crisis situations may be more problematic for newly qualified staff. Those with a BSN are more likely to be stressed, particularly

		their job.			Questionnaire. The latter scale was developed by Yeh and Huang (2007) with a 6-point Likert scale and a Cronbach's alpha of 0.79-0.95 (Yeh & Yu, 2009). Those from the Simple Coping scale (Xie, 1998) involved a 3-point scale (0 = never, 3 = always), a Cronbach alpha of 0.89 for the overall scale, with 0.78 for the passive coping subscale and 0.89 for the positive coping subscale (Cai et al., 2008).	role experiences. Relations between stress factors and coping strategies were analysed using Pearson's bivariate correlations.	with regards to difficult or challenging patients, co-worker and patient interactions, or technical problems. Those with an Associate Degree tend to experience lower stress levels overall, although they may be more concerned by administrative factors such as research development or institutional commissions.
11	Pellico et al. (2009) The USA	Investigate the perceptions of Newly Licensed Registered Nurses' (NLRNs) experiences, as reflected in their comments provided in a national survey that sought to gain a better understanding	Secondary analysis of a nationwide data set in which NLRNs were surveyed regarding their work environment. Data were collected by a	Population consisted of NLRNs spread among 51 randomly chosen Metropolitan Statistical Areas. Stratified sampling occurred at regional and state level. The data were received in response to a	This article reports the findings in response to the open-ended question, "If you would like to make any other comments about the survey, please feel free to write below or on the back of this booklet"	Content analysis was performed using Krippendorff's 1 technique	There was a clear disparity between nurses' beliefs regarding career and what they found after practising as a NLRN, particularly regarding co-workers, their ideas of nursing as a profession, and appropriate clinical conduct. NLRNs were concerned regarding the

		of the work life of NLRNs.	cross-sectional mailed survey	cross-sectional survey administered by post. 3,266 nurses replied initially (56%), while 1,195 (37%) provided additional comments in answer to an open question. Responses not linked to the study were omitted (583) leaving a sample size of 612 to be critically considered.			requirement for them to function quickly as a skilled, seasoned RN. NLRNs are often subject to pressure from a variety of sources, including managers, or insurers, as well as being overworked and held overly accountable, as well as experiencing low recompense in return. Comments also reflected ill-treatment by co-workers, such as clinical denigration, egotism and discourtesy, which negatively affected the stress and morale of NLRNs. Nevertheless, NLRNs did reflect positively on their future careers overall.
12	Scott et al. (2008) The USA	Investigate the effects of personal factors, orientation, continuing education, and shortfalls in staff levels on the satisfaction,	Quantitative survey	Population: nurses who were currently working and newly licensed by the North Carolina Board of Nursing for a period not shorter than 6	Questionnaire survey developed by the North Carolina Centre for Nursing (NCCN) (internal consistency and reliability were confirmed (Shaver & Lacey, 2003).	Descriptive analysis. The relationships between categorical independent variables and the outcome variables of nurses' turnover, job and career satisfaction, intent to leave their current position, and intent to	The first year post-graduation is particularly influential in directing the future path of individual nurses, which may affect long-term professional development and satisfaction.

		intent to leave their job, and intent to leave the profession.		months and not longer than 2 years. Sample: Random stratified sample of 329 newly qualified nurses.		leave the nursing profession using Univariate analysis.	There is a connection between insufficient NGN orientation and turnover orientation in initial positions, which can affect new graduate nurses' job satisfaction and retention. The best predictors of career satisfaction were educational preparation and job satisfaction.
13	Kovner et al. (2007) The USA	Describethe characteristics and attitudes toward work of newly licensed RNs.	Cross-sectional, two-stage, quantitative survey	The population consisted of new RNs randomly chosen from 51 Metropolitan Statistical Areas and nine rural regions across 35 states and the District of Columbia. The sample consisted of 3,266 returned and qualifying surveys, representing 56% of those contacted.	Mailed questionnaire survey developed by the authors' study; all scales had Cronbach scores of 0.7 or greater)	Descriptive statistics (means and proportions) were computed. Data analysis consisted of means and proportional descriptive statistics.	Most new RNs are satisfied and do not intend to change career. Many RNs were unhappy with the level of supervisory support available. Those whose first professional degree was an associate degree were more intent on leaving than those whose first professional degree was a bachelor's degree.

14	Cowin & Hengstberger-Sims (2006) Australia	Explore the development of graduate nurses' self-concepts, and develop an understanding of any relation between nurses' self-concepts and graduate nurse retention plans.	Descriptive correlation quantitative survey design with a longitudinal element (repeated measures)	n=220 NGNs who had completed a Bachelor of Nursing degree in Sydney, Australia, at a large institution. The sample consisted of 187 students who responded to the self-awareness and retention survey at the first point in the study timeline (Time 1, or T1). Of these, 83 of the newly qualified nurses took part in the second point in the research (Time 2, or T2).	Questionnaire survey including the nurse general self-concept (NSCQ) and the nurse retention index (NRI). Validity has been established for both measures (Cowin, 2001; 2002).	Data analysis consisted of descriptive statistics with a correlation coefficient.	Newly-qualified nurses remain flexible throughout the first 12 months after graduation, especially in relation to whether they will stay in nursing or not. Self-conception of graduate nurses is highly correlated with a desire to remain in the profession. Graduate nurses are split between those highly content to remain in nursing, those who will probably leave the profession, and those who have left the profession.
15	Casey et al. (2004) The USA	Identify the stresses and challenges faced by graduate nurses in the first year of theory into practice.	Descriptive, comparative, quantitative survey	The population consisted of newly qualified nurses from a total of six acute care institutions. 784 surveys were distributed; a convenience	The Casey-Fink Graduate Nurse Experience questionnaire survey (developed by the investigators and pilot tested)	Descriptive statistics using SPSS	Most stressful factors: low self-esteem; gaps in clinical understanding or the ability to critically assess situations; co-worker relations; the need to rely on co-workers contrasting with the desire for workplace

				sample of 270 was achieved, at a response rate of 34%. The survey was optional.			independence; challenging or disappointing workplace circumstances; managerial or organisational abilities; and the ability to converse with other professionals. Newly qualified nurses require a great deal of personal and work-based support to successfully develop from trainee to practicing nurse, particularly in their first graduate year.
16	Chang & Hancock (2003) Australia	Examine the socialisation process of newly graduated nurses who studied under the university-based system.	Quantitative Survey	The population consisted of university-level nursing graduates emerging from 13 establishments across New South Wales, Australia, with two to three months of experience employed in teaching hospitals (one of four possible institutions). The first sample	Questionnaire survey adapted by the author from the Job-related Tension Index developed by Kahn (1964) and was included eight items in the questionnaire subscale, which were adapted from a study employed by Mohrman et al. (1978).	Data analysis undertaken with descriptive statistics and correlation coefficient	Nurses responded that the transition stage was characterised by a lack of clarity regarding working terms and duties. Major issues that led to concerns were the uncertainties of the job, and overwork. During the early transition period, uncertainty concerning duties was most prevalent, although in the later months,

				incorporated 154 respondents, a response rate of 77%. This cohort was again contacted after 10-11 months, with 110 respondents (from the original 154, a rate of 71%).			overwork was more prevalent in adding to stress levels.
17	Oermann & Garvin (2002) The USA	Describe the stresses and challenges that new graduates experienced in their initial clinical practice within hospital institutions.	Quantitative survey	The sample consisted of 46 newly qualified nurses from three Midwestern hospitals in the USA.	Questionnaire survey with open- ended questions including a Clinical Stress Questionnaire (CSQ) (Pagana, 1989). Inter-rater reliability for the open-ended questions was 0.89. alpha coefficient for the CSQ was 0.85.	Means and proportional descriptive statistics were used to analyse the data, while content analysis was undertaken on the open questions.	The newly qualified nurses were most commonly concerned by their patient care tasks, encountering fresh clinical challenges and large workload. Even though the majority of respondents were optimistic during their graduate year, their concerns about patient care and clinical challenges is significant. The largest issues for newly qualified nurses related to the use of their theoretical comprehension in practical situations, and how to gain new abilities.

Table 3.7: Critical appraisal of the qualitative studies using the CASP tool (n=30)

Study	Reference Year	Methodological Quality	Finding Presentation Quality	Discussion Quality	Overall Quality of Evidence
1	Labrague et al. (2019)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The study provides good conceptual insight into the phenomenon of interest.	The overall interpretation of results considered the aims, limitations and results from similar studies.	High quality of evidence
2	Brown et al. (2018)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The findings were analysed according to thematic content.	The study was presented thorough discussion of findings that directly related to the research question.	Moderate quality of evidence
3	Liang et al. (2018)	The research design was a phenomenological qualitative study appropriate to address the aim of the research, which was to identify challenges faced by new NGNs during transition.	The findings were analysed using Colaizzi's (1978) data analysis method, which is commonly used and appropriate for this kind of research.	The study clearly discussed the emerging themes from the interviews and discussed in context of previous studies.	High quality of evidence
4	Wong et al. (2018)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The findings were analysed as thematic analysis, which is common for this type of research.	The study discussed each theme in-depth and was supported by previous studies.	Moderate quality of evidence
5	Hu et al. (2017)	This is a qualitative study, and it was conducted using a conventional qualitative content analysis method to identify stressors in 25 NGNs in Chinese	The analysis was done according to Corbin & Strauss's (2008) data analysis method	There is an in-depth discussion of the findings within the context of previous findings. Limitations are discussed.	High quality of evidence

		hospital settings.			
6	Ortiz (2016)	The selected participants were suitable to provide access to the type of knowledge sought by the study. 12 NGNs were interviewed using semi-structured interviews.	The findings were presented & analysed through Thematic coding.	Key thematic findings are discussed in the context of previous studies. Limitations and future directions are discussed.	Moderate quality of evidence
7	Al Awaisi et al. (2015)	The case study design, sampling process, data collection, and data analysis methods used were appropriate to the research question. The methodology included semi-structured interviews and fieldwork observations.	The study provides good conceptual insight into the phenomenon of interest. The study provides a context for the work and status of nurses in Oman, as well as an insight into NGNs' experiences.	The reported findings are supported by extracts of raw data. The overall interpretation of results considered the objectives, limitations and results from similar studies, and other relevant evidence is also described.	High quality of evidence
8	Zamanzadeh et al. (2015)	This is a qualitative study, and it was conducted using a conventional qualitative content analysis method. 14 nurses were selected through purposive sampling, and the data was collected using semi-structured interviews in teaching hospitals in Iran.	The study provides good conceptual insight into the phenomenon of interest.	The reported findings are supported by extracts of raw data. The researchers critically examined the findings & selection of data for presentation. A clear statement of findings was provided.	Moderate quality of evidence
9	Darville et al. (2014)	The study design, sampling process, data collection and data analysis methods used were appropriate to the research question. Semi-structured interviews and fieldwork observations helped generate a better understanding of NGNs behaviour during their transition.	The study provides good conceptual insight into the phenomenon of interest.	The study offered a good presentation of the findings, and featured a comprehensive great discussion that directly related to the research question.	High quality of evidence

10	Lee et al. (2013)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The use of 8 weekly focus group interviews (lasting 2 hours) illuminated the complexities and provided a more comprehensive understanding of the study's target phenomenon. It provided good conceptual insight into the phenomenon of interest.	There is an in-depth description of the analysis process and sufficient data is presented to support the findings.	High quality of evidence
11	Pennbrant et al. (2013)	The study collected data from two national cohorts of nurses within the population & employed longitudinal analysis. The data was self-reported. It was collected through postal questionnaires that were mailed to the prospective respondents. The methods were appropriate to the research question, Because the data were collected by means of a closed and open-ended survey. The large number of respondents (330) provided ample material for analysis, but must be balanced against the survey format, which did not allow follow-up questions or qualitative sampling principles to be applied. The phrasing of the research questions may have affected the findings.	The study provided a good conceptual insight into the phenomenon of interest. The analytical focus was on the experiences, issues and opportu nities of being a new graduate.	The study provides a good, clear description of the findings, and offers an in-depth description of the analysis process.	Moderate quality of evidence
	Walker et al. (2013)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The study provides good conceptual insight into the target phenomenon.	The overall interpretation of the results considers the objectives, limitations and results from similar studies;	Moderate quality of evidence

12		The selected participants were suitable for providing access to the type of knowledge sought by the study. The surveys' format did not allow for follow-up questions or the application of qualitative sampling principles. In addition, the method of qualitative data collection via open ended survey questions may have limited participants' responses, may also have prevented the clarification and exploration of interesting responses, such as is possible in face-to-face interviews.	It is the first stage of a larger project investigating GNs ' transition experiences in their first year of clinical work, in order to develop a targeted program to improve GNs ' workplace experiences during their first year practice.	other relevant evidence was also described. The findings are discussed in relation to the original research question.	
13	Feng & Tsai (2012)	The study uses a qualitative descriptive approach, with a purposeful sample. A total of 36 individuals were considered, but only seven were eligible and invited to take part. Data was collected via semi-structured, open-ended, in-depth interviews, and the content analysis data analysis methods employed were appropriate to the research question. The sample size was small sample, and the sample was non-random.	The study provides a good conceptual insight into how NGNs experience the process of socialisation.	The reported findings were supported by extracts of raw data. The findings are reported clearly, and discussed sufficiently in relation to the original research question.	Moderate quality of evidence
14	Malouf & West (2011)	This qualitative study included a sample of 9 NGNs. Data was collected via in-depth interviews. Each participant was interviewed three times, and data analysis was conducted via constant comparative analysis methods appropriate to the research question. There is no description of the sample selection process, and no details regarding the demographic	The study provides good conceptual insight into the phenomenon of interest, based on a theoretical framework.	The reported findings are supported by extracts of raw data. The influences of contradictory data are accounted for. There is a clear statement of findings, and the findings are discussed in relation to the original research question.	Moderate quality of evidence

		characteristics of the sample.			
15	Duchsher et al. (2009)	The study design includes a sample of the size n=15. The study used semi-structured interviews to collect data, and employed data analysis methods appropriate to the research question. The researcher explained how the participants were selected, and explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study. The sample was small and non-random.	The study offers a good conceptual insight into the phenomenon of interest.	Sufficient data is presented to support the findings.	Moderate quality of evidence
16	Zinsmeister & Shafer (2009)	This study used qualitative, phenomenological research approach. 9 NGNs with less than one year experience in clinical setting were interviewed. The data analysis method was appropriate to the research question. The interviews lasted 30 minutes, which is relatively short for a phenomenological inquiry.	Even though a small sample size, the study provides a good conceptual insight into the NGNs perception of their first year as a period of transition with positive attitude.	Discussion of the identified themes is thorough in the context of previous findings. The Authors described limitations well, such as the use of one interviewer that may have lowered the consistency of the way in which data were retrieved.	Moderate quality of evidence
17	Duchscher (2008)	The study used qualitative phenomenological methods. A total of 14 graduates (all female) undertook six face-to-face interviews (at 1, 3, 6, 9, 12, and 18 months post-graduation). The data analysis methods used are appropriate to the research question.	The study provides good conceptual and theoretical insight into the stages by which new nursing graduates transition into their professional role.	The findings are well-reported, and are supported by extracts of raw data. The developed theory reflects the experience of BGBs.	High quality of evidence

18	Wangensteen et al. (2008)	The study employs a qualitative design, using a purposive sample of 12 nurses working in hospital settings. Data is collected via one-to-one interviews, and is analysed using conventional content data analysis methods appropriate to the research question. The interviews in this study were conducted approximately one year after the participants had graduated. The professional development experienced by the participants during that time may have affected the nature and content of their descriptions of their graduate year.	The study provides good conceptual insight into the NGNs perception of their first year as a period of growth and development.	The study provides a detailed presentation of findings, supported by appropriate quotations which enhance transferability.	Moderate quality of evidence
19	Newton & McKenna (2007)	The study used a qualitative approach and included a total of 25 NGNs from 4 different centres. The data collection and data analysis methods employed are appropriate to the research question of how graduate nurses develop their knowledge and skills throughout their graduate studies. The methodology also identified factors that assist or hinder knowledge and skill acquisition. The participants were voluntarily recruited, which limited the generalisability of the results.	This study provides excellent insight into the target phenomenon. The transcripts of the focus group interviews were precisely analysed. This made it possible and appropriate for the researchers to identify the participants' experiences as graduates, and to identify the descriptive themes associated with the factors that influenced the subjects' acquisition of skills and knowledge.	The findings are well-presented, including several quotations for added voracity.	Moderate quality of evidence
20	Clark &	This was a qualitative exploratory study,	There is a good exploration of	The researchers explain how	Moderate quality of

	Holmes (2007)	employing non-random purposive sampling. Data was collected through twelve focus groups, and the methods used to analyse data were suitable for the research question. Due to the influence of and interactions between participants, there is inevitably some uncertainty about the accuracy of the data obtained.	the concepts relating to NGNs' competence levels at the time of their registration.	the presented data were selected from the original sample, and clearly demonstrate the analysis process. Sufficient data were presented to support the findings, and contradictory data were considered. The researchers returned the transcripts and interpretation of the data to the participants for verification. This helped to enhance both the validity of the findings and the credibility of the conclusions.	evidence
21	Maben et al. (2007)	This was a longitudinal qualitative study, utilising purposive sampling, with data collection and data analysis methods appropriate to the research question. The researcher described the participant selection process, and explained why it was best for the selected participants to provide access to the type of knowledge that the study sought.	The study provided good insight into concepts relating to The tension between the ideals of nurses and the ability of individuals to practice their nursing mandate.	The study yielded well-reported findings, supported by extracts of raw data. The researchers examined critically the influence of their own role and potential bias and the selection of data for presentation during data analysis. Findings are clearly stated. The findings related to the original research question are discussed.	Moderate quality of evidence
22	O'Shea & Kelly (2007)	The study used a phenomenological qualitative approach that was appropriate to achieve the aim of the study. Purposeful sampling was utilised as a way to make sure that the subjects were	The study provided a good conceptual insight into the lived experiences of newly qualified nurses.	The findings reported are supported by extracts of raw data that provide clear details regarding the nurses interviewed.	High quality of evidence

		representative of the wider population, whilst face-to-face in-depth interviews were used for data collection in conjunction with thematic data analysis methods that were appropriate to the research question. The researchers explained how the participants were selected and explained why the participants they selected were the most appropriate to provide access to the type of knowledge sought by the study. The sample size was small sample (n=10), and sample selection was non-random.		The study utilised phenomenological hermeneutic methodology, which yielded a wealth of in-depth data, enabling the researchers to draw a number of conclusions with great insight.	
23	Rungapadiachy et al. (2006)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question.	The study provides a good conceptual insight into the phenomenon of interest.	The study provides a clear statement of findings. The findings are discussed in relation to the original research questions.	High quality of evidence
24	Jackson (2005)	The study employed a phenomenological descriptive qualitative approach. The sample was a purposeful convenience sample, with data collected over two interviews (within a non-specified time period). The study used content data analysis methods, which is appropriate to the research question. The sample size was small (n=8), and sampling was non-random.	The study provides a good conceptual insight into how the experience of a positive day at work affected NGNs perception of nursing.	The study itself fulfilled its purpose, in that it has interpreted the experience of a good day for NGNs, and identified the themes that are the main components of such days. An extensive amount of data was collected, and each individual theme warrants further exploration.	High quality of evidence
25	Rochester & Kilstoff (2004)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question. A	The study provides a good conceptual insight into the transition of NGNs.	The study provided a clear statement of findings. The small sample size may decrease the	Moderate quality of evidence

		total of two female and four male nursing graduates were selected. Data collection occurred via semi-structured in-depth telephone interviews, (1-2 hours length) using a questionnaire developed for an earlier study on transition that was found to be valid and reliable (Kilstoff, 1993). The sample size was small.		generalisability of the results.	
26	Ellerton & Gregor (2003)	The researchers sought to interpret and illuminate the actions and subjective experiences of research participants. Thus, it was appropriate to use qualitative research methodology to address the research goal. The study design, sampling of 11 NGNs, (recruited by convenience), data collection, and data analysis methods were appropriate to the research question. Participants were recruited from a single clinical site.	The study provides a good conceptual insight into the phenomenon of NGN transition based on the theory principle.	The reported findings are supported by extracts of raw data. There is a lack of detail about the nurses interviewed.	Moderate quality of evidence
27	Delaney (2003)	This was a phenomenological qualitative study, with a purposively-selected sample of 10 graduate nurses. The data collection and data Analysis methods were appropriate to the research question. The researcher justified the research design and discussed how they chose their methodology.	The study provides good conceptual insight into the terms and the concept that relate to the journey of becoming a nurse.	The Reported findings are supported by extracts of raw data.	High quality of evidence
28	Duchscher (2001)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question. The study used only a small sample 5 NGNs.	The study provides a good conceptual insight into the phenomenon of interest.	The reported findings are supported by extracts of raw data. A clear statement of findings is provided, and there	Moderate quality of evidence

				is adequate discussion of the evidence, both for and against the researchers' arguments.	
29	Ramritu & Barnard (2001)	The researchers sought to interpret and illuminate the actions and/or subjective experiences of the research participants; thus, qualitative research was the right methodology for addressing the research goal. The study design, sampling process, data collection and data analysis methods were appropriate to the research question. The study sample comprised a total of six recently qualified nurses.	The study provides a good conceptual insight into the phenomenon of interest.	The researcher critically examined their own role, potential bias and influence during the processes of data analysis and selection of data for presentation. A clear statement of findings is provided and there is adequate discussion of the evidence.	Moderate quality of evidence
30	Gerrish (2000)	The study employed a qualitative design based on a grounded theory approach, using in-depth individual interviews and thematic analysis methods appropriate to the research question. The sample selection process is unclear.	The study provides good conceptual insight into how NGN perceive the experience of transition from student to qualified nurse.	The study provides a clear statement of findings and an adequate discussion of the evidence, both for and against the researcher's arguments.	Moderate quality of evidence

Table 3.8: Critical appraisal of the quantitative studies using the EPHPP Tool (n=17)

Study	Reference Year	Methodological Quality	Finding Presentation Quality	Discussion Quality	Overall Quality of Evidence
1	Halpin et al. (2017)	The longitudinal design provided insight into whether stressors changed for the participants over their first 12 months post-graduation. Moreover, longitudinal design reflected that transition is a process over time. However, attrition, which is an established risk with such a design, led to smaller than desirable sample sizes at 6 and 12 months post-graduation. The NSS may also have been a limitation, as it may not have captured all sources of stress for NGNs.	The study provides a clear exploration and good conceptual insight into transition in newly qualified nurses through an exploration of their stressors and stress experiences during their first 12 months post-graduation. Data were adequately described, and the finding analyses were fully described.	Descriptive and inferential statistics were used to clearly describe and discuss the quantitative findings of this study. A six stage “thematic analysis” process was utilised, as detailed by Braun and Clarke (2006) producing themes and subthemes relevant to NGN work-related stress. The results of the study provide valuable information concerning NGNs and their stress levels.	Moderate quality of evidence
2	Zhang et al. (2017)	The longitudinal design verified subgroups of occupational stress over time. The tools used were Occupational Stress scale for NGNs TCSQ, Nurse Professional Identity scale, and Work Locus of Control scale (Chinese version).	The study used descriptive statistics, and logistic regression analysis for the intention to leave. Data collection over time was explained with a group-based trajectory model.	The study discussed findings clearly in context of previous findings.	Moderate quality of evidence

3	Cheng et al. (2015)	The study used a descriptive, correlational and longitudinal design with three follow-up interviews. It used convenience sampling, and the study design, sampling process, data collection and data analysis methods were appropriate to the research question. A total of 206 students were contacted, and the response rates were 56.80%, 50% and 36.90%, respectively, for these three time points (3, 6 and 12 months). Two instruments were employed and developed by the research team, based on literature reviews and focus group discussions that were held in a pilot study.	The Cronbach's alpha for the current study was 0.94. The validity test was confirmed by factor analysis. The longitudinal and repeated measure data was analysed and explored very clearly in this study, providing a good conceptual and insightful perspective into how the levels of job stress and job satisfaction vary over time. Data were adequately described, and the finding analyses were fully described in the method section.	The study offered a good presentation of the findings using descriptive statistics. In addition, the Pearson correlation was applied to examine the relationship between job stress and job satisfaction. In the discussion section the researcher detailed all the results that pertain to the overall aim of the study.	Moderate quality of evidence
4	Blomberg et al. (2014)	This was a multicentre study, with a sample size of 200. 113 subjects answered the questionnaire, yielding a low response rate of 57% (113/200), and there was no control group. Additionally, the possibility of sample bias should be considered as a non-probability sampling method (i.e. convenience sample) was used, and there was a rather low response rate. These limitations impact upon the study's generalisability. Further self-reported questionnaires may contribute to the over or under-reporting stress. The data collection tool used was valid and reliable.	The job-related stress of new nurses with respect to local institutional supervision was described and explored in a clear manner and the analyses process was fully and adequately described for all the variables and data. The finding analyses were fully described in the method section.	Descriptive and inferential statistics were used to clearly describe and discuss the findings of this study. The results of the study provide valuable information concerning NGNs and their stress levels. The study also highlights the significance of clinical group supervision, and the role of clinical supervision in supporting those who report high levels of stress.	Moderate quality of evidence

5	Cheng et al. (2014)	The study design, sampling process, data collection and data analysis methods are appropriate to the research question. The sample only included students studying in the two-year RN-to-BSN nursing programme at one university.	The study provides good conceptual insight into the relationship between clinical stress and intention to leave among new graduate nurses.	The findings are well-presented and discussed clearly.	High quality of evidence
6	Parker et al. (2014)	A mixed-method cross-sectional design was used, combining quantitative and qualitative approaches. Data was gathered by an online survey and focus groups. The sampling approach was not clearly described. Results: A total of 282 new graduates, aged 21 to 54, responded to the online survey (response rate 24%). Only students from 2 universities were sampled, and there was no comparison group.	The study provides good conceptual insight into Kramer's honeymoon hock phases, which are regarded as the most difficult phases for new graduate nurses. Data were adequately described, and the finding analyses were fully described in the method section.	The study offered a clear description of the findings for both quantitative and qualitative sections. As per Sandalowski (2010), qualitative descriptions of low-level inference were informed by the coding and theming of qualitative survey data. Individual researchers conducted a coding and categorisation of the focus group transcripts, according to the themes. The results of all researchers were then subjected to cross comparison and revision in order to enhance consistency. The findings were grounded and reported through the use of excerpts from all of the focus groups; thus, ensuring the auditability and representativeness of the data.	High quality of evidence
7	Read & Laschinger (2013)	The study design, sampling process, data collection and data analysis methods were appropriate to the	The study provides clear exploration and good conceptual insight into the relationship	The study offered a good presentation of the findings using descriptive statistics and Pearson	Moderate quality of evidence

		research question. The validity and reliability of the data collection tools were not discussed.	between newly qualified nursing staff and their experiences of maltreatment in the work environment. Data were adequately described, and the finding analyses were fully described in the method section.	correlational analysis, and the statistical significance of the findings is clearly described. The discussion section discussed all the results that pertain to the overall aim of the study.	
8	Tastan et al. (2013)	This study was designed and undertaken as a descriptive and a cross-sectional study. The population consisted of 234 (89%) NGNs. A survey questionnaire developed by the authors on based literature was used. No validity and reliability tests in the Turkish scale exist that measure the evaluation of NGNs' transition to clinical practice.	Factors influencing the experiences of various groups of NGNs may change from year to year; therefore, 3 year data collection is too long. Data were adequately described; demographics were fully presented and the finding analyses were clearly described in the method section. Descriptive statistics were clearly presented.	The findings were clearly discussed in the context of previous studies.	Moderate quality of evidence
9	Takase et al. (2012)	This study had a longitudinal design, was multicentre, included a clear description of inclusion and exclusion criteria, and utilised a valid and reliable collecting data tool. The credibility of the study is limited by two issues. Firstly, the withdrawal cognition scale has a low reliability rating, stemming from the reverse-wording of one question, which was answered inaccurately by a small number of subjects.	The different factors influencing the graduates' turnover intention at different times and to different degrees were well-explored. The longitudinal dataset was useful for capturing the changes in the perceptions of the misfits, and the effect of these on turnover intention. Data were adequately described, and the finding analyses were fully described in the method section.	The data analysis was descriptive, with multiple regression investigations utilising STATA. This was suitable for achieving the aim of the study. The discussions and conclusions justified by the results and the limitations of the study were discussed.	Moderate quality of evidence

		However, this is a minor issue, as removing the data from those respondents made little difference to the findings, but improved the data reliability to > 0.7. Secondly, the statistical power and representation of the sample is limited by its small size (n=62).	There was a lack of power calculation to determine the sample size.		
10	Wu et al. (2012)	The convenience sample comprised over 400 (N=402) graduates who were contacted as part of a non-random convenience sample. The response rate (38%) was low.	The study provides good insight and analyses into the factors affecting the stress levels of new nurses, and the relation of these to the respondents' desire to leave their job. Demographic data were clearly presented. Data were adequately described, and the finding analyses were fully described in the method section.	The study offered a good presentation and clear discussion of the findings. Results from this study may assist educators, managers & researchers in developing the nursing curriculum to address workplace stressors, and suggest coping strategies to help prepare student nurses for their future professional roles.	Moderate quality of evidence
11	Pellico et al. (2009)	Data was collected via a cross-sectional survey, mailed to NLRNs from 34 states and from the District of Colombia. The samples were stratified by region and by states within each region, taking account of variations in city size. Response rate was 56.5% (n=3066 NGNs).	Good presentation of the research aim and concept. Data were adequately described, and the finding analyses were fully described in the method section with the basic and demographic data clearly detailed.	The qualitative findings of the remaining comments were presented. Content analysis was performed using Krippendorff's 1 technique with his unit of analysis of themes.	Moderate quality of evidence
12	Scott et al.	The study design was appropriate to	The study provided good	The simple descriptive and	Moderate quality

	(2008).	the research question. The methodology – including random stratified sampling, data collection and data analysis methods – was also appropriate. The survey tool contained questions from previous nursing research conducted by the centre, & was subjected to a validity review by an expert panel. An earlier nursing study by Shaver and Lacey (2003) supported the internal reliability and consistency of the satisfaction items. As 93.3% of respondents were female, the study had a clear gender bias.	conceptual and analyses insight into the socialisation of NGNs, including what occurs before work, and what happens when work begins. Data were adequately described, and the finding analyses were fully described in the method section. Using v2 analysis, a p value of .05 or lower was used to determine statistical significance in all analyses.	inferential analysis provided an overview of the sample, including the presence of missing data and outliers. The authors' discussions and conclusions justified by the results and the limitations of the study were discussed.	of evidence
13	Kovner et al. (2007)	The study employs good methodological approaches. The sample consisted of 3,266 returned and qualifying surveys. The survey was mailed to a random sample of NGNs in multiple centres. A response rate of 56% was received.	There is a limited exploration of the phenomena of interest, and no exploration of any correlation or relationships among the variables.	Discussion included both significant and non-significant results. As only 13% NGNs worked in nonhospital settings; caution in generalising these findings must be exercised.	Moderate quality of evidence
14	Cowin & Hengstberger-Sims (2006)	This study used a descriptive correlation design with a longitudinal element. Repeated measures sampled 187 students out of a possible 220, who agreed to complete the self-concept and retention survey at T1. Of these 187 participants, 50% were aged	Data were adequately described, and the finding analyses were fully described in the method section. The study provided a clear description and analyses into the longitudinal development of the self-concept of graduate nurses. A general linear model (GLM)	Multiple regression analyses were conducted to determine any relationships between the dimensions of nurses' self-concepts with their retention plans. The discussions and conclusions justified by the results and the	Moderate quality of evidence

		between 20 and 22 years of age (M ¼ 23). Over 95% of the participants were female. There was no discussion of gender bias and no justification of the sample size.	analysis of variance with repeated measures was utilised in order to assess any significant changes over time.	limitations of the study were discussed. The discussion section detailed all the results that pertain to the overall aim of the study.	
15	Casey et al. (2004)	This study employed a descriptive, comparative design using survey questionnaire methods to study NGNs experiences in 6 institutions. The sample size was 784, and the study had a low (34%) response rate.	The stressors and challenges experienced by cohorts of working graduate nurses were explored and identified. Data were adequately described.	In the discussion section, the researcher discussed all the results that pertain to the overall aim of the study. The limitations of the study were discussed.	Moderate quality of evidence
16	Chang & Hancock (2003)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question. The demographic characteristics are well-described. Participants in the first survey comprised 154 (representing a good response rate of 77%).	The study provided good analyses into the socialisation process of new graduate nurses. Data were adequately described, and the finding analyses were fully described in the method section.	The data were clearly discussed using descriptive statistics and correlation coefficient. The discussion section detailed all the results that pertain to the overall aim of the study.	
17	Oermann & Garvin (2002)	The study design, sampling process, data collection and data analysis methods were appropriate to the research question. The study surveyed 46 new graduates in three hospitals in the Midwest region of the USA, using a reliable and valid scale.	The study aimed to examine the stresses and difficulties faced by new graduates in their clinical practice.	A one-way ANOVA was used to determine whether there were differences in the amount of stress and challenges based on the type of unit in which graduates were currently working. The discussion were clearly presented and related to the	

				overall aim of the research.	

Chapter 4: Methodology and Research Design

4.1 Introduction

This chapter explains the aim, objectives and questions of the research. It also presents a critical justification for the research design and a detailed description of the research methods employed to gather the study data. Throughout this chapter, I discuss some of the philosophical underpinnings of qualitative research and the ethical challenges encountered in undertaking this work. Finally, the processes of sample selection, data collection and subsequent data analysis are described in this chapter.

4.2 Research Aims

The aim of this study is twofold. First, it seeks to explore the experiences of new graduate nurses (NGNs), who have been an active part of the nursing workforce for less than 12 months and are employed in their first nursing post at a hospital in Saudi Arabia. It also examines the extent to which culture and social attitudes contribute to the new graduate nurses' experiences and how they make sense of them.

4.3 Research Questions

The research questions are as follows:

1) How do Saudi nurses experience, perceive and interpret their first year of experience in practice as qualified nurses?

2) What are the effects of the culture, context and social attitudes on their experiences?

4.4 Research Objectives

The research objectives are as follows:

1. To explore, describe and interpret the experiences of NGNs during their initial 12 months of work at one government hospital;
2. To examine the extent to which culture and social attitudes contribute to their experiences and how they make sense of them; and

3. To make recommendations to improve the retention and recruitment of Saudi nationals.

4.5 Philosophical Framework

Because the main aims of this research are to understand how NGNs make sense of their new nursing workforce experiences and how culture and society influence the nurses' impressions, it is necessary to select appropriate methods for exploring the individual perceptions of the NGNs in the hospital working environment. The methodological perspective that is most helpful in interpretive and experiential research like that adopted in the present study is a perspective that recognises that subjective knowledge and understanding represent a valid form of knowledge. As advocated by Annette Street (1992) in her ethnography of nursing practices, a researcher should pay attention to the participants' real-life working environment to elicit a full contextual understanding of the participants' transition experience. My research design had to allow the opportunity to observe NGNs' interactions and investigate subjective meanings. This type of investigation involves what sociologist Kathy Charmaz (2008) calls a social constructivist approach. This perspective acknowledges the reciprocal creation of knowledge between the researcher and participants, so that both parties generate subjective understandings of the world.

A social constructivist research philosophy refers to the assumptions the researcher makes in terms of how she views the world and reality and the 'development of knowledge and the nature of knowledge' (Saunders et al., 2012, p. 127). Therefore, this research philosophy considers the researcher's views of the world according to a subjective frame of reference. The researcher's reality and knowledge base influences how the research is conducted and how hypotheses are developed (Denzin & Lincoln 2011; Saunders & Tosey, 2013). Moreover, there is no 'one-size-fits-all' approach to research in the social constructivist approach. Each researcher should carefully select the most appropriate research paradigm, taking into full consideration the aims and objectives behind the research, as well as the potential results (Baxter & Jack, 2008; Saunders et al., 2012).

Conducting a case study and taking a constructivist approach are especially useful research elements when there is little information on the topic being researched in a specific context and it is necessary to explore how issues are dealt with in the context (Park, 1991). In the present case, this notion applies to research on the practices of new nurses in a hospital in Saudi Arabia. Moreover, as Rodwell (1998) asserts, a constructivist approach does not investigate the semantics of a phenomenon from an external viewpoint; rather, it relies on the researcher acquiring detailed knowledge as it is perceived by the relevant participants. Thus, it is of great importance that I understand that numerous realities could exist in relation to the phenomenon being investigated, namely, the reality regarding NGNs' experience in the workplace. In accordance with Berger and Luckmann's (1966) assertion that knowledge emanates from social activities, it was crucial to this research to explore the participants' understanding of their social world. Thus, it was vital to be immersed in the participants' working environments and communicate with them during their ordinary daily working practices.

4.5.1 Overarching Themes of the Research Philosophy

A research method needs to be chosen that will adequately address the research question, but this selection also depends on the researcher's ontological and epistemological views. According to Pickard (2013), a research philosophy is based on three overarching themes, which are as follows:

- Ontology: the nature of reality;
- Epistemology: the relationship between the knower and the known; and
- Methodology: how to obtain the knowledge.

These are described below.

4.5.2 Ontology

Ontology refers to the nature of reality (Bryman & Bell, 2015; Pickard, 2013; Saunders et al., 2012), and the researcher's ontological position affects the assumptions they make and the questions they ask about social phenomena (Saunders et al., 2012). Generally, ontology is considered either objective or subjective, as described below. In addition, Phillimore and Goodson (2004) explain that ontology is the belief system that influences a person's interpretation of knowledge and facts.

4.5.3 Epistemology

Epistemology refers to the connection between the researcher and the existence of factual knowledge (Phillimore & Goodson, 2004; Saunders et al., 2012), including how those facts are acquired. According to Phillimore and Goodson (2004), an individual's epistemological stance is affected by their belief concerning knowledge and how best to acquire that knowledge. For the case study approach taken in this research, the epistemology is based on the argument that 'there are multiple realities integrated into the form of multiple constructs' (Guba & Lincoln, 1994, p. 110). Guba and Lincoln (1994) explain that the epistemology of a qualitative case study methodology is founded on the idea that multiple realities co-exist, and this creates multiple possible constructs to research. In my research, each NGN will have her own unique experience of becoming a full-time nurse and learning the minutiae of her new position.

4.6 Methods and Methodological Approach

It is important to select the research methods that can best help to address the research question (Creswell, 2003). According to Smith (2001) and Polit and Beck (2013), the process of choosing an appropriate methodology involves an evaluation of various methodologies, which may lead to different approaches to the research. Echoing some of the discussions that have already emerged on the importance of the research philosophy, the two paradigms that have a major effect on the choice of research methods are the positivist and relativist paradigms, also known as quantitative and qualitative approaches (Polit and Beck, 2013). These involve opposing worldviews and different assumptions about reality (Creswell, 2013).

4.6.1 Objectivism

According to Saunders et al. (2012), 'Objectivism represents the position that social entities exist in a reality external to and independent of social actors' (p. 131). Objectivism aligns with the positivist perspective in the way each of these theories view reality (Saunders et al., 2012), which means that objectivism focusses on an external reality that has a predetermined nature and structure (Sexton, 2003). This perspective is encountered largely in the natural sciences; however, it is also found in those branches of

the social sciences that seek to make generalisations and gather statistical and testable data.

A positivist methodology focusses on a scientific approach with the aim of ensuring objectivity. Positivist researchers collect and analyse numerical data to discover a single truth and find clear causal factors that are indisputable, as opposed to attempting to interpret the data (Polit & Beck, 2013). The two main benefits of a positivist methodology are that the study can be easily reproduced and the findings can be generalised (Creswell, 2013). A positivist methodology produces statistical data and can easily include a large number of participants (Polit & Beck, 2013), for example, through questionnaires and surveys. However, positivism does not consider the human experience and how people have different perspectives on their experiences; instead, it simply focusses on cause and effect (Creswell, 2013).

4.6.2 Subjectivism

Subjectivism focusses on social activities and the interactions between individuals, phenomena and processes, and it is used to gain an understanding of social situations, including how various phenomena influence people and the causes behind this. Subjectivism is linked to interpretivism (Saunders et al., 2012) and posits that there is no one fixed reality. Our social worlds are made up of multiple realities, as perceived by different individuals (Sexton, 2003). Thus, objectivism and subjectivism involve two contrasting philosophical assumptions. Objectivist thinkers think they can mitigate bias and create true, objective knowledge, whereas subjectivist thinkers think that every subject exercises the power to have an independent interpretation and construct meaning (Guba & Lincoln, 1994). Researchers need to be cognisant of the ways their biases and assumptions shape the outcomes of their research. Given the interpretive and subjective aims of the current research, the researcher has tried to make it evident how her personality has ultimately been moulded by an Islamic and Arabic cultural background and the researcher's individual values, beliefs and education have resulted in viewing reality from a certain perspective, including having experience as a preceptor nurse.

Qualitative methods are typically used by relativist, interpretivist or constructivist researchers (Proctor, 1998). The aim of qualitative methodologies is to explore the effect

of social conduct and gather an in-depth range of knowledge (Ellis, 2013). The methods used include interviews, focus groups or observations, and may involve case studies, with the aim of obtaining a comprehensive understanding of the phenomenon being researched (Denzin et al., 2006; Yin, 2013). Positivists tend to criticise qualitative research methods because they assume they are less rigorous and there are questions about the validity and generalisability of their findings to wider populations. However, qualitative methods are better than statistical and anachronistic data at providing an in-depth understanding of the human experience (Park, 1991).

The researcher aimed to gather subjective, descriptive accounts of the study participants' experiences and make individual observations of their actions to help in the critique of the NGN experience. In this document, the terms 'fieldwork', 'observations' and 'participant observations' are used interchangeably. As such, the study commenced with the assumption that personal experiences, feelings and emotions could be gathered from these NGNs while accepting that these experiences, feelings and emotions are embedded in the sociocultural world in which the NGNs reside.

It was determined that it would be necessary to spend time with the NGNs in the 'field' setting to gain insight into their interpretations and the context in which their views were developed. As promoted by Wolcott (1999), the researcher's role was acknowledging and detailing both the individual and collective meanings of the shared experience and developing an understanding of the experience from the participant's perspective; hence, the decision was made to carry out a field-based observational study. It has been suggested that witnessing, inquiring, contributing, listening to and collaborating with the observed parties is the most effective way of gaining insight into personal knowledge (Mason, 2002).

4.6.3 Qualitative Methods

Qualitative methods can refer to any research method that can describe and explain the experiences and actions of people in our social environments (Flick, 2014; Vivar et al., 2007). While Hammersley and Atkinson (2007) assert that an absence of rigid methodological principles is fundamental to effective social research because researchers should choose the method most appropriate for uncovering the required information, interpretive research about meaning needs flexible data gathering methods. It is further

argued by Blumer (1969) and Hammersley and Atkinson (2007) that humans develop distinct and exclusive identities through daily experiences with each other, and thus, that their individual interpretations of the social world ultimately determine their behaviours. Crotty (1998) explains that qualitative approaches allow deep insights into society and specific contexts to be obtained (e.g. during transitions like those the nurses experienced in this study).

Adopting a comprehensive, person-centred perspective, qualitative research can help the researcher to gain insight into the opinions of individuals with regard to their lives and the lives of those around them (Jones, Torres, & Arminio, 2006; Speziale et al., 2011). Stake (1995) explains that qualitative research has a different aim than positivist research does; qualitative research is not completed to map every corner or solve every puzzle that the world presents. The role of qualitative research is portraying the level of complexity and subtle meanings in the world. Table 4.1 provides an overview of some of the major qualitative methods that researchers use, especially in the social science disciplines.

Table 4.1: Overview of Some Qualitative Approaches

Methodological Approach (Qualitative)	Advantages of Method	Disadvantages of Method	Reason for Accepting/Rejecting Method
Ethnography	This approach involves observing an issue in context. The phenomenon is investigated and interpreted by the researcher in accordance with the views expressed by the participants (Noyes, Popay, Pearson, & Hannes, 2008; Nurani, 2008). Individuals' willingness to provide information is not a key factor.	It is susceptible to observational bias. The Hawthorne effect could apply; this is when participants typically perform better when they are under observation. It does not enable an understanding of why people behave as they do. This method is typically time consuming. It takes a longer time to generate and analyse data than these steps require in other methods.	This approach was selected due to its focus on cultural and social interaction in daily life.
Phenomenology	It investigates the construction of conscious experience from a subjective perspective along with its intentionality.	It is difficult to describe or interpret a phenomenon in its real context while completely avoiding bias (Shi, 2013).	It is a more descriptive approach that centres on providing meanings for phenomena that all participants have experienced by conducting detailed interviews.
Grounded Theory	Interpretations come from the data, and the research does not refer back to the available theory (Hussein et al., 2014).	Experienced researchers are needed to collect the data.	There is a high risk of mistakes. Researchers could record individuals' experiences without understanding the social processes behind them.
Case Study	Explains, describes and investigates issues in their real-life contexts (Yin, 2009). Observation of phenomena occurs in the natural context (Zainal, 2007).	Sample limitations make it difficult to make generalisations. Represents depth of evidence rather than breadth.	This approach was selected because a case study enables multiple sources of evidence to be used, which aids in addressing various behavioural and historical issues that affect a single case (Baxter & Jack, 2008; Stake, 2003; Yin, 2013).

Patton (2005) explains that the use of qualitative research has increased over the last 25 years, especially in the health and nursing sectors. The modern qualitative, non-statistical methods used in such research, known as the qualitative turn, have generated a vast amount of substantive information and advice. There are several advantages of qualitative research that have been described in the literature. These include its ability to elucidate human emotions, such as anger, love, rejection, effort and weakness (Alvesson & Sköldberg, 2009). In comparison, such an understanding would be difficult in quantitative research, as these emotions are subjective and cannot be quantified. Furthermore, qualitative research allows for a complete view or picture to be generated, which is an important aspect when considering nursing philosophies (Bennett & Elman, 2006; Opdenakker, 2006).

4.6.4 Critique of Qualitative Methods

Despite the advantages of using qualitative research for specific studies, there are also several disadvantages that need to be considered. First, qualitative research is time consuming and requires a long duration to be performed effectively (Anderson, 2010). The researcher also needs expert knowledge on the numerous qualitative techniques that can be used. The collation and organisation of the data, which often take the form of handwritten notes, can be time consuming and complex, as this information needs to be arranged into themes or categories that 'make sense' (Anderson, 2010; Bowen, 2009). Furthermore, due to the unique manner in which qualitative research is completed, it is often difficult for particular studies to be replicated (Burns & Grove, 2005). Denzin (2008) notes how qualitative research is value laden, so the role of the researcher should be acknowledged; this is a characteristic of the methods criticised by positivist researchers, as the research is not objective.

Qualitative methods are frequently critiqued by positivist researchers because the regulations they abide by are unclear, and it is possible to invalidate findings using qualitative methods just by interpreting the data differently (Rolfe, 2006). In contrast, some researchers, such as Stern (1994) and Johnson, Long and White (2001), favour combining different methods to study a single structure, organisation or dilemma

because it provides an authentic, logical and knowledge-filled analysis that accounts for multiple perspectives on a problem or experience.

4.7 Qualitative Research Design

The research approach adopted for this study relies largely on qualitative methods, including a case study approach and ethnographic field methods. Ethnographic research uses field research, participant observation and semi-structured and unstructured interviews, among other methods, to describe shared cultural features and the complex context in which people work and cope with the circumstances of their daily lives (Denzin, Lincoln, & Giardina, 2006; Richards & Morse, 2013). Knoblauch (2005) points out that such studies can include field observation, field notes and transcripts, communicative activities, and coding. Therefore, a qualitative case study informed by ethnographic methods was utilised in this study to seek an appropriate answer to the research questions.

4.8 Case Study Research

There are a vast number of case study research proponents, including Robert K. Yin, Robert E. Stake and Sharon B. Merriam. These authors have provided extensive evidence in favour of the case study approach and given detailed information on the ways in which such research can be conducted effectively.

Case study as a methodology was described by Stake (1995) as a means of enquiry that enables the researcher to complete an in-depth exploration of a specific activity, event or process involving one or more people. Stake (1995) also explains that it is normal for case studies to be completed over a sustained time period and that they utilise several data collection methods.

While there is no specific or concise case study definition in the literature, Gillham (2000) has provided descriptions of the case study approach. He explains that the case study is one that investigates real-world human activity that can be understood only by incorporating the setting and context in which the activity occurs and includes influences from other sources that then act to blur the boundaries of the study. Gillham (2000)

furthers this by explaining that case study research can be used to answer guided questions that require different kinds of evidence to be drawn from the case setting; however, this evidence needs to be strategically and comprehensively abstracted, collated and analysed to gain the most robust answer for the question (Gillham, 2000).

A further definition of the case-study approach provided by Simons (2009) describes case studies as in-depth explorations of the unique complexity of a real-life context of a project, institution, policy, system or programme taken from numerous perspectives. An inclusive research-based approach uses different methods to collect the evidence; the overall aim is to gain a comprehensive understanding of the real-life context to inform community or civil action, professional practice and policy development (Simons, 2009). Nevertheless, Simons (2009) limited the utilisation of case studies to specific settings.

Another precise definition of a case study was attempted by VanWynsberghe and Khan (2007), who determined that case study research was transparadigmatic and transdisciplinary. These authors explained that case study research is transparadigmatic because the case study is relevant as an exploratory investigation or a small manageable example of a phenomenon, regardless of the research paradigm, whilst it is also transdisciplinary because case studies have no specific disciplinary orientation. The researchers furthered this definition by suggesting that the case study investigation requires the researcher to meticulously delineate the phenomena for which the data are collected, that is, the process, concept or event. In so doing, VanWynsberghe and Khan (2007) included all the significant facets of a case study in their definition while also attempting to dispel the latent critiques and scepticism about the rigor or generalisability of qualitative data approaches like the case study approach discussed above.

While Yin (2009) is a staunch proponent of the use of case studies in qualitative research, his definition does not comprehensively describe all aspects of the approach. Yin (2009) defines a case study as 'an empirical inquiry that investigates a contemporary phenomenon within its real-life context, especially when the boundaries between phenomenon and context are not clearly evident'. Therefore, the inquiry of the case study 'copes with the technically distinctive situation in which there will be many more variables of interest than data points and as one result relies on multiple sources of

evidence, with data needing to converge in a triangulating fashion, and as another result benefits from the prior development of theoretical propositions to guide data collection and analysis' (Yin, 2009, p. 18). As such, Yin's definition focusses purely on the technical aspects of the case study, neglecting the importance of in-depth inquiry. It is also considered that the definition is more suited to a deductive, quantitative enquiry approach designed to test hypotheses rather than the more inductive, qualitative approach.

From the various definitions, it can be determined that case study research can be used to investigate and comprehend the unique complexity and particularity of people or institutions in the real-world context of a contemporary event. However, although there are scholars who are firm proponents of the idea that social science will be strengthened by the completion of a large number of effective case studies, Flyvbjerg (2006) warned of a number of shortcomings associated with case study research. These include the ideas that practical knowledge is not as important as theoretical knowledge and concepts cannot be generalised from a single case, with the result that a single case study can make no significant scientific contribution. Case studies can only be used as a means of generating hypotheses with other methods, and there are other methods that are better suited to testing hypotheses and developing theory. According to such researchers, there appears to be verification bias with the use of case studies; moreover, they contend that specific case studies are difficult to summarise.

4.8.1 Defining the Case

The case study for the present research used a sample of NGNs who were completing their first 12-month period of their destination post; the setting was King Khalid Hospital (KKH) in the Northern Province of SA and the aim was to explore their interpretations and descriptions of their experiences. KKH is a hospital run by the Saudi Arabian Ministry of Health. It is a non-profit, secondary care institution with a population base of around 100 000. The hospital has 250 beds and offers a range of hospital amenities, from surgical through to pharmaceutical services. The daily outpatient numbers normally average 1100 patients, and the average hospital stay is 4.6 days. As of June 2016, the hospital employed 238 paramedics, 130 doctors and 400 nurses, of which, 14 were NGNs.

To develop my research involving this case study among NGNs at KKH in Saudi Arabia, I followed Yin's (2009) delineation of five design components that characterise good case study research. These consist of the following: research questions, a study purpose or propositions, unit analysis, a logical link between data and propositions and effective criteria for results interpretation. The approach is summarised in Table 4.2 below.

Table 4.2: Yin's (2009) Five Design Components of Case Study Research

Research Questions	How do Saudi nurses experience, perceive and interpret their first year of experience in practice as qualified nurses? What are the effects of the culture, context and social attitudes on their experiences?
Study Purpose	To explore the experiences of new graduate nurses (NGNs), who have been an active part of the nursing workforce for less than 12 months and are employed in their first nursing post at a hospital in Saudi Arabia. To examine the extent to which culture and social attitudes contribute to the nurses' experiences and how they make sense of them.
Unit Analysis	Participants NGNs
Links between Data and Study Purpose	Analysing the data collected for preliminary Links
Results Interpretation Criteria	Coding the data with clear criteria

4.8.2 The Rationale for Selecting Qualitative Case Study Research

As the previous studies have not fully identified the experiences of NGNs during this transition phase in different cultures, the present study will fill this research gap using qualitative methods to determine how NGNs view and experience their transition period within SA culture. The study findings will contribute to and enhance existing knowledge on NGNs in hospitals in the Middle East as there is little existing research on providing care in this cultural context.

While there are many proponents for case study research and clear benefits to using such a technique to explore the NGNs' experience during the transition phase, it is still necessary to acknowledge the limitations of the research. First, as VanWynsberghe and Khan (2007) explain, the quality of evidence derived from case study research can be questionable. Many scholars suggest that there is a lack of rigour in case studies as many of the previously completed studies have failed to include a systematic report of the findings, and therefore, cannot limit reporter bias (Flyvbjerg, 2006). Nevertheless, lack of

rigour and bias are also common in other types of research, so these limitations are not restricted or solely applicable to case study research. Noor (2008) also criticises case studies by suggesting they lack generalisability. However, Yin (2009) provides an effective counter-argument for this by stating that, while case studies are clearly not generalisable to the overall population, they could easily be generalisable to a theoretical proposition. Moreover, as Yin (2009) explains, this lack of generalisability of the results to the overall population is again not confined to case study research.

4.9 Ethnography

Ethnography is one of the basic qualitative methodologies that goes back to early anthropological research. It was used by early researchers to obtain insight into individuals' experiences of culture. Haviland, Prins, Walrath, and McBride (2007) assert that ethnography's objective is explaining the cultural meaning and significance of key practices. It is based on a desire to understand individuals in their cultural context. Furthermore, Roberts (2009) and Cruz and Higginbottom (2013) explain that this methodology has been developed in the field of anthropology (the study of human culture), which requires a researcher to immerse him or herself in the culture (Morris et al., 1999), and thus, gain insight into customs and behaviours that are typical of that culture.

4.9.1 Background on the Ethnographic Method

Ethnography concerns social interactions, activities, beliefs and opinions that are common to a specific group, team, company or community, and the roots of this methodology can be found to date back to anthropological research in small, remote communities that was conducted in the early 1900s by researchers that include Bronisław Malinowski and Alfred Radcliffe-Brown, who lived in such societies for long durations and recorded the social structures and belief systems of these communities (Reeves, Kuper, & Hodges, 2008).

The primary objective of an ethnographic approach is gaining deep and holistic understandings of individuals' opinions and behaviours, in addition to the natural aspects (visual and aural factors) of the communities in which they live, by collecting information via in-depth interviews and observations (Snow, Morrill, & Anderson, 2003). Hammersley and Atkinson (2007) assert that an ethnographic researcher has the task of recording a

culture and the opinions and behaviours of individuals in that culture. They add that the approach's objective is to understand individuals' perceptions of the world. The primary characteristics of ethnographic research are demonstrated in the box below.

Box 4.1: Primary Characteristics of Ethnographic Methods (Schensul & LeCompte, 2012)

- With ethnographic methods, there is a strong focus on investigating the nature of a specified social issue instead of trying to address hypotheses regarding the issue.
- There is a tendency to focus on unstructured data, that is, data that are not yet coded when collected, and thus, do not form a closed set of analytical categories.
- Only a few cases are explored in detail (usually just one case unless using multi-sited ethnography). Data are analysed by explicitly interpreting meanings associated with human behaviours. Such analysis predominantly produces results in the form of verbal descriptions.

4.9.2 Ethnographic Research in Nursing

In the field of nursing research, ethnography is primarily used by nursing anthropologists who incorporate it into field studies. Such nurses have been highly trained in anthropology and transcultural nursing practices. Most of their research consists of comprehensive field studies, otherwise known as 'maxi' ethnography studies. Leininger (1985) points out that the application of mini-ethnography enables nurses to concentrate on one key area in the nursing/patient care field, and thus, small-scale ethnographic research is becoming critically important for research in the nursing field.

In a nursing context, Simmons (2007) states that an ethnographic researcher must monitor the actions of other nurses in the same context, document the findings in the form of field notes, and carry out interviews to acquire detailed information regarding new nurses' experiences. In addition to being the principal researcher for this project, I also have experience as a preceptor nurse, and thus, I was able to witness NGNs working in their context in a detailed and intimate way. As I spent much time during my research in a hospital environment, I gained familiarity with the context required to carry out this research. I talk more about my positionality and some of my influence on the research in the reflexivity section 4.15 later in this chapter.

4.9.3 Rationale for Choosing Ethnographic Methods for this Study

While conducting my field research, I found there were numerous benefits to using ethnographic methods. One was that it was possible for me to become completely immersed in a culture by conducting observation of the participants, which ultimately enabled me to gain a deep insight into the NGNs' experiences and their manifestations in various contexts, as noted in similar research by Polit and Beck (2010).

Another key benefit of using an ethnographic method was that I could be effective in identifying and assessing unanticipated issues. Other types of research that are not based on observation can easily overlook unanticipated issues (Sangasubana, 2011). For example, semi-structured interviews can overlook key issues from the participant's perspective. This omission can occur as a result of relevant questions not being asked or participants choosing not to mention something. I would be better able to recognise these issues should they arise with being immersed in the field site and in direct communication with the nurses participating in the study.

When carried out well, another advantage of an ethnographic approach is that it provides a detailed and authentic representation of the behaviours and attitudes of participants (Cruz & Higginbottom, 2013). Thus, ethnographic methods can be effective in revealing participants' subjective attitudes and behaviours owing to its highly subjective nature.

The Stages of Ethnography

According to Simmons (2007), one goal of an ethnographer should be trying to become almost like an insider. This thus requires researchers to access the field or community, establish relationships with individuals in the community, and to identify issues such as roles, reciprocity, and conflict (p. 7). Janice Morse is trained as an anthropologist and is faculty in the nursing department at the University of Utah. She along with her colleague Lyn Richards have described unique stages that arise when carrying out ethnographic data collection processes (2012). The stages are described below:

Stage 1

The first stage requires the researcher to get into the setting. The researcher at this point is a stranger in the setting, and thus the key objective here is to gain entry.

Throughout this stage, there is progression towards ‘fitting in’; this is often an uncomfortable period when the researcher feels unfamiliar in the setting.

Throughout the initial stage, I found it is useful to focus on concrete tasks and familiarise myself with the contextual structure and hospital environment. Furthermore, I first identified the participants in the setting during this first stage. I had to keep a record of observations and personal reflection. Richards and Morse (2012) assert that field notes are of paramount importance throughout the first stages to document initial impressions and observations.

Stage 2

Richards and Morse (2013) point out that the second stage requires the researcher to get to know the participants and other staff within the specified context. Familiarisation with the routines and responsibilities of staff enabled me to feel more comfortable in the setting. I identified participants and began to develop a relationship with the participants involved in my study, and while this raised some risk of bias, it was key to collecting rich data and getting the participants to open up. The process of informal interviewing starts in this stage and is documented in the form of field notes. Fieldwork and journal entries are the key means of collecting and documenting the information obtained through observations and interviews conducted by the researcher during this stage.

It was in this stage that I started the research as a participant observer and thus carried out informal discussions. I was able to commence the process of collecting data through the initial integration into the cultural context in question. By conducting observations and informal discussions, I was able to gain insights into the culture’s complexities by investigating the dynamics I saw evidenced in the work culture at the hospital (Huby, Hart, McKevitt, & Sobo, 2007). It can, however, be difficult for the researcher to gain acceptance and familiarity in the culture they are seeking to research. It was suggested by Pope (2005) that a participant observer is often used as a synonym for ethnographic researcher, since the researcher is actively involved in the group under investigation. As an ethnographer, I thus became part of the culture I was studying, which ultimately enabled me to understand the feelings of individuals whilst developing trust and acceptance in the context.

Stage 3

Richards and Morse (2013) describe the third stage as a period when the researcher is more familiar with the context and with the personnel. They thus consider this to be the acceptance and cooperation stage of the research. This was therefore the right time for me to carry out interviews with participants based on the trust and relationships developed throughout the first two stages.

Final Stage

Richards and Morse (2013) describe the last stage as a withdrawal period, during which the researcher's attention turns to data analysis. It is in this stage that the data is reviewed and analysed in order to solve ambiguities, complete thin areas and confirm previous results.

4.9.4 The Limitations of Ethnographic Methods

Although there are many benefits to using ethnographic methods to collect data from the field, it is also important to consider that there are numerous downsides to ethnographic methods to consider. First, this type of research requires lengthy time periods for the ethnographers to communicate with participants and observe their behaviours (LeCompte & Schensul, 2010). Thus, ensuring consistent access to the research site can be problematic, especially if some authoritative individuals (gatekeepers) in the community. Consider the research to be damaging to their reputation or counter to the best interest of the community in some way.

It can be difficult to thoroughly record the social actions that transpire in a ward setting because such recordings require a variety of temporal, spatial, legal, and behavioural factors to be addressed. Interactions that occurred directly between the researcher and the participants throughout the course of the fieldwork for this study were sometimes met with suspicion due to conventional opinions that research into healthcare often requires researchers to be detached instead of involved.

4.10 Risks Associated with Ethnography

As previously mentioned, ethnographic studies require the researcher to observe and interact with participants in the research context. There are some key risks associated with ethnography. These are outlined below.

4.10.1 Researcher Bias

It is crucial that ethnographic researchers are highly capable of avoiding any possible mistakes when carrying out ethnographic research. In the present case, this means that I must be able to conduct in-depth and complete investigations and eliminate possible bias when collecting and analysing data (Hammersley, 2016).

4.10.2 Participants Representative

It is crucial for the participants to be as representative of the wider target population as possible (if this is a required dimension of the study design). The subjects must also be completely open in their responses. Naturally, the quality and persona of the researcher and their role in the research design all largely influence both of these concerns. Thus, a large part of the responsibility for avoiding risk in ethnographic studies falls on the researcher (directly or indirectly).

4.11 Qualitative Approach: Rationale

The choice of a qualitative research approach for this study was made for several reasons. First, Denzin et al. (2006) explain that qualitative approaches allow for the study of phenomena in their natural environment, while Esterberg (2002) explains that such methods are effective for developing an understanding of specific social processes in a given context. Second, as Creswell (2005) and Stake (1995) explain it is vital for the researcher to play an active role in a qualitative study. In the present research, the researcher collected, collated, analysed and interpreted all the data. This approach allowed the researcher to gain a deeper understanding of the reality and experiences of NGNs' initial workforce entry. Third, as there is a dearth of information on Saudi new nurse experiences, the comprehensive nature of the qualitative approach allowed the researcher to collect an in-depth subjective insight into the participant nurses and their experiences during this transition period.

Fourth, it is well documented that the qualitative research approach is adept at distinguishing the meaning of individuals experience of a specific event and clarifying their unique perspective (Burns & Grove, 2005; Golafshani, 2003; Kothari, 2004). As this study aims to interpret the experiences of Saudi NGNs during the initial stages of entry into the nursing workforce, qualitative research is deemed the best approach. This allows the researcher to pursue individual impressions and interpretations to give a complete view of how someone thinks and rationalises his or her actions. This is an important aspect when considering the nursing philosophies of individual nurses (Bennett & Elman, 2006; Opdenakker, 2006).

Attributes of Qualitative Researchers

Brink and Wood (1998) and Cho and Trent (2006) explain that use of inductive reasoning helps the researcher to develop insights and concepts from the collected data in some inquiries, allowing the researcher to explain personal actions from the perspective of the participants. Morris et al. (1999) describe an emic approach as examining issues from the perspective of native participants, as the background and culture of participants affects their outlook on reality.

Holloway and Wheeler (1996) explain that the researcher can also create a realistic picture of the reality of a participant's life. However, to do so, the researcher must display specific attributes, including honesty, flexibility and friendliness. He or she must also be a good listener and non-judgmental. Furthermore, the researcher must refrain from imposing biases and pre-existing expectations on the gathered information (Mouton & Marais, 1992).

It can also be advantageous to the results of the study to employ an etic approach[7], illustrating the meaning that an outsider like a researcher attributes to the particular events or life experiences they are researching. This is an outsider view, although it is still a valuable or meaningful perspective. Sometimes, members of the culture or society can be so immersed that they do not realise how they are behaving or there is something that is being taken for granted that can be appreciated more easily by an outsider.

When conducting the analysis, the researcher is responsible for understanding the phenomena so the concepts can be positioned into categories, motifs and themes

(Eatough, 2012). The richness of the observational setting can determine the level of understanding. The data are usually analysed by identifying themes and can be in the form of words or quotations from transcripts and documents (Neuman, 2002). The analysis follows a comprehensive, holistic approach that considers the relationship and interactions between specific aspects of the study sample. By combining all of these elements, qualitative research allows the researcher to generate a complete picture.

4.12 Pragmatic Dimensions of the Study

Luck, Jackson and Usher (2006) explain that there should be a pragmatic approach that follows a specific system when conducting case studies so that the research questions are answered and the data collection method is appropriately directed. This section of the chapter outlines the pragmatic steps taken to design the study framework and address the ethical issues that arise with data collection. These methods include ethical and access considerations, participant recruitment and sampling strategy, data collection and analysis of the findings.

4.12.1 Ethics

Guillemin and Gillam (2004) explain that ethical approval is significant in research. As such, ethical approval to conduct this research was sought and received from the ethics panel at the University of Salford. Furthermore, the KKH authorities and director of Health Affairs from the SA Ministry of Health reviewed the statement of purpose and study design and granted permission to undertake this study (see Appendices 9 and 10). It is a priority for the researcher to rigorously pursue and maintain ethical standards. The study has been completed in a manner that respects the ethical requirements of research, including respecting the rights of the participants and avoiding dishonesty Welman, Kruger and Mitchell (2005). Furthermore, as suggested by Long and Johnson (2007), a robust ethical framework incorporating the benefits versus harm approach has been followed and is further detailed below. As this is a field-based study, observations have been made of individuals not directly involved in the study, including patients. As such, posters explaining the nature of the study and the minimal risk to nurses and patients were displayed in all wards where the observations were conducted. These posters provided details about how patients or their relatives could opt out of the

observations (see Appendix 4).

Autonomy and Informed Consent

Prior to the commencement of the study, written informed consent was sought from all the participants (see Appendices 2 and 3). The participants were informed of their option to participate, right to decline participation in the study and right to withdraw from participating in the research at any time without consequence. A participant information sheet for the NGNs and other hospital staff was designed and distributed throughout the hospital (see Appendices 5 and 6). Following the distribution of the information sheet, a meeting was arranged with the NGNs and researcher so that details of the study could beprovided and the participants' rights could be orally explained. The ways in which the results of the study were to be communicated were also discussed.

The NGNs were provided with a consent form that described the study. It had been translated to Arabic by an official translator before being given to the participants. The NGNs were allowed to take the form with them to consider their participation more fully at home or once their shift ended at work. The NGNs were asked to return the signed form within 1 week if they wished to participate in the study. Following this, mutually agreeable times and dates for interviews with the participants were scheduled. Participants and potential participants could raise any questions about the study using the contact information provided by the researcher. The signed consent forms were secured in a locked filing cabinet in the researcher's office. The storage of any personal data followed the UK Data Protection Act (1998) principles and UK Department of Health Caldicott (2003) to ensure high levels of data protection.

Anonymity and Confidentiality

Kaiser (2009) explained the importance of confidentiality when collecting individualised data, stating that confidentiality and anonymity are vital in meeting ethical principles. Following the advice of Orb, Eisenhauer and Wynaden (2001), participants' confidentiality was maintained by following a stringent protocol during the recruitment, data collection, analysis and reporting processes. This included the removal of any names of participants from any observational or interview data. To ensure anonymity, pseudonyms and codes for each of the participants were made. Furthermore, any quotes, personal information,

or specific traits that could have identified the participant were removed.

To protect the data, any digitally recorded interviews and conversations were transferred onto a password-protected computer on the same day as the recording was made. Access to the computer was restricted to me and my supervisors. The transcribed interview data were stored in the same way. Any handwritten, paper-based notes taken during field observations were stored in a locked filing cabinet. In line with the UK NHS guidance, all data associated with the study will be kept for a maximum of 5 years before being destroyed.

Minimisation of Harm

By ensuring that the privacy and confidentiality of the participants was maintained at all times, any potential for harm, embarrassment or distress was effectively minimised. A private room was utilised for all interviews to maintain privacy and confidentiality. This was located in the participants' departments. The participants could choose the times for their interviews at their convenience. They could also decide on whether to inform their superiors about their participation. Despite written consent being gathered from all the participants at the start of the study, process consent was also gathered verbally at the commencement of each interview or observation. The researcher remained sensitive to any participant becoming upset or distressed during any interview or observation, and in such cases, data collection was terminated immediately.

Near Miss or Poor Practice

At times, adverse events, near misses or poor practices were observed during the fieldwork of this study, and they were reported to the necessary department or supervisor because the safety of patients, relatives and staff had precedence over the study. As the researcher is a preceptor nurse, there was a moral and legal duty to act in the patient's best interest and abide by the professional code of conduct. Thus, patient safety had priority over the research activity. Where occurrences were observed that could have been harmful to the patient or any other person, the researcher intervened immediately. The reasons for intervention were given and the incident was reported using the standard operating procedure. Any poor practice that did not immediately endanger the patient was discussed with the participant and reported to the appropriate

supervisor.

4.12.2 Gaining Access to King Khalid Hospital (KKH)

Seidman (2013) explains that gaining access to the location of research is a crucial study design step. However, the researcher was already familiar with the KKH prior to the commencement of the study, as her training had previously been carried out at the hospital. This familiarity aided the researcher in gaining access to the facility for data collection. Nevertheless, formal channels needed to be followed, so the ethical approval gained from the University of Salford was submitted to the Office of the Advisor for Academic Affairs at KKH along with a summary of the study proposal. Following this, an approval letter was received from the KKH advisor. There was also a nurse instructor who introduces me to all the departments and directed me and gave me advice about who to approach and how to communicate with the NGNs because she knew the nurses who were the most appropriate subjects for the study and knows the hospital well.

4.12.3 Sampling Strategy

Sample choice is of fundamental importance in qualitative research, affecting the overall strength and value of the research (Mason, 2010). According to Patton (2005), the most usual choice for case studies is purposive sampling, as this offers the optimal conditions for gathering the most appropriate data for the research. Purposive sampling is a form of non-probability sampling where the sample is chosen by the researcher as issues or themes arise during the research process (Teddlie & Yu, 2007). As such, the researcher is free to request participation from any individual he or she thinks will aid in the attempt to answer the research question.

For this research, 9 out of a total of 14 NGNs—that is, nurses in their first 12-month employment period as newly qualified nurses—agreed to participate and were enrolled in the study along with four head nurses (HNs) who worked alongside these NGNs during their transition periods. The Boxes below show the demographic data for the NGNs and HNs.

Box 4.2 Demographic Data for New Graduate Nurses (NGNs)

Type of Participant	**NGNs**
Age Range	23–25 years old
Gender	Female 100%
Marital Status	Single 100%
Origin	From Hail 80% From outside Hail 20%
Total Number	9

Box 4.3 Demographic Data for Head Nurses (HNs)

Type of Participant	**HNs**
Gender	Female 100%
Nationality	Non-Saudi 90% Saudi 10%
Language	Non-Arabic speaking 90% Arabic speaking 10%
Total Number	4

While Mason (2010) claims that a sample number of one may be sufficient in some examples of qualitative research and there is no requirement to gather a representative sample, it was considered prudent to enrol as many participants as the time and other limiting factors allowed. The number of participants enrolled was higher than anticipated and is considered to be sufficient to provide enough data on the range of experiences that are prevalent among NGNs in the various wards and departments across the hospital.

Nurses from four different departments were included in this study, with three NGNs enrolled from the paediatric unit, three from the female surgical unit, two from the emergency department and one from the paediatric ICU. Interviews with the HNs were conducted to obtain another perspective on the NGN experience, creating a richer understanding of the hospital's environment. The transitions literature suggests that positive relations with colleagues (Chen et al., 2001; Delaney, 2003; Duchscher, 2008; 2009; Dyess & Sherman, 2009) and strong social support (Beecroft et al., 2008; Evans, 2001; Rydon et al., 2008; Wangensteen et al., 2008; Zinsmeister & Schafer, 2009) are critical to ensuring smooth NGN transition experiences. Additionally, interviews with HNs provided greater insight into the dynamics among nurses and their impact upon the NGN process.

Discussions with HNs analysed whether their personal experiences with the transition process influenced current practice and interactions with new nurses. In addition, interviews explored strategies (if any) employed by senior nurses to mentor or manage junior colleagues. These conversations also enabled supervisors to share their attitudes toward NGNs, including their impressions of NGNs' skills and knowledge. Specifically, as many of the HNs were foreign nurses (three of the four), their views on Saudi society and Saudi NGNs helped to highlight the cultural dimensions of the HN-NGN relationship. This dynamic is a significant influence upon the Saudi NGN experience, and a topic that will be examined in the following chapters.

4.12.4 Participant Recruitment

The participant information sheets that were previously mentioned were distributed by a third party (nurse instructor) to all the NGNs and HNs who were most experienced in the target hospital. The participant information sheet provided a summary of the study, confidentiality practices and consent procedures that were followed. The researcher's contact details were also provided on the sheet, which allowed the prospective participants to ask any questions they may have had before the study commenced. A meeting was arranged between the NGNs, HNs and researcher to provide details of the study and explain their rights as participants and their rights to withdraw from the study at any time. The confidentiality procedures and methods that would be adopted to distribute the findings of the research were also explained at the meeting.

The consent forms were distributed (Appendices 2 and 3), and the prospective participants were given a 1-week period to respond. The signed consent forms were returned to the chief nurse, who collected them and then passed the details of the willing participants onto the researcher. A mutually convenient time was arranged for an

interview between the researcher and participants, during which time, the researcher scheduled a convenient time and location for the research observations with each NGN. Prior to the commencement of observations, further verbal consent was sought. The participants' right to withdraw from the study was fully respected at all times.

The posters that were displayed in the hospital wards provided information about the study in areas of the hospital where observations were taking place. These posters included information informing individuals who were not directly involved in the study that they could be observed as part of the fieldwork. Ways of opting out of the study for these individuals were clarified on the posters. The decision to opt out of the study was respected at all times. This opt-out approach is supported by Hewison and Haines (2006), who suggest that such a method ensures that the rights of the individuals are continually respected by allowing them to decline any indirect involvement with the study, while at the same time, enabling the largest number of observations to be made of the practice experience.

4.13 Methods of Data Collection

Case studies can incorporate numerous data collection methods and do not exclusively depend on one technique (Ary et al., 2014). Examples of such methods include interviewing, observation and document reviews (Ary et al., 2014). Each technique focusses on a single issue or entity to collect data that can aid in understanding the focal point of the research. Table 4.3 lists the advantages and disadvantages of the various data collection methods applied in case study research, as outlined by Stake (1995) and Yin (2009).

Table 4.3: Types of Evidence Yin (2009)

Source of Evidence	Advantages	Disadvantages
Documentation	Stable: repeated review Unobtrusive: exists prior to case study Exact: provides exact names, dates, etc. Broad coverage: extended time span	Retrievability is difficult Selectivity could be biased Reporting bias reflects author bias Access may be prohibited
Archival Records	Accurate and quantitative.	Privacy could prevent access
Interviews	Targeted: focusses on case study topic Insightful: provides perceived causal inferences	Bias could result from poor questions Response bias Incomplete recollections
Direct Observation	Reality: addresses events in real time Contextuality: addresses events in context	Time consuming Selectivity: may miss facts Cost: observers need time
Participant Observation	Same as above Provides in-depth insight into social behaviour.	Same as above Bias due to researcher's actions
Physical Artefacts	Provides great insight into cultural features and technical operations	Selectivity Availability

For this study, observational data were collected (along with interviews) by means of fieldwork observations. They were carried out to gather information on the day-to-day working practices of NGNs in the hospital wards, and they included both formal and informal conversations. Face-to-face, semi-structured individual interviews were also conducted with the NGN and HN participants.

Table 4.4 Data Collection Methods

Participant Group	Method of Data Collection	Duration	Timeframe	Location
New Graduate Nurses (NGNs)	Observations/field notes	2–3 hours/one day /week	18 December – 30 April 2017	At different departments at the hospital
NGNs	Semi-structured interview	23–50 minutes	May 2017	At private room on the ward where participants work
Head Nurses (HNs)	Semi-structured Interview	23–50 minutes	May 2017	At private room at nursing office

4.13.1 Observation Fieldwork and Participant Observations

Whyte (1984) states that fieldwork can obtain data that cannot be retrieved by other methods. I started this research with some vision about the topic from the previous literature. I was also affected by the accuracy of Street's (1992) work, which aided me in considering the importance of spending some time with participants in their field during their daily work. Street (1992) confirmed that this allowed her to produce an in-depth understanding of her participants' experiences. Having read her work, I desired to simulate her methods (fieldwork), which were in line with my philosophical point of view.

According to Patton (2002), it is common to incorporate participant fieldwork observations in case study research. Hammersley and Atkinson (2007) describe participant observation as a data collection method that requires the researcher to engage in people's daily life over a length of time. They explain that this type of method is useful for gaining improved insight into the values and behaviours of participants in a cultural context to throw light on the problem being studied. This is particularly the case when an insight into the social nature of the institution is required. In addition, by examining the notes taken during observation, I was able to raise additional questions and elicit the participants' perspectives on some of the behaviours that were observed and data gathered from additional sources (Simons, 2009).

Various authors have characterised the range of roles that researchers can play in the field (Adler & Adler, 1984; Gold, 1958; Junker, 1952; Spradley, 1980). Gold (1958) presented a typology based on four categories: "the complete participant," "the participant as observer," "the observer as participant," and "the complete observer." In Gold's taxonomy, the complete participant actively engages with the research setting, although does not disclose her true identity to informants. As with the complete participant, the participant as an observer plays the role of an insider, although in this case, informants are aware of the researcher's purpose in the field. Using this approach, the participant as an observer observes informants informally and/or conducts interviews with them. Contrastingly, the observer as a participant has limited social interaction with informants, typically relying on one-time interviews for information. Finally, the complete observer does not establish any social relationship with informants; instead observation is covert, occurring through eavesdropping or behind a two-way mirror, for example.

Based on Gold's (1958) classification scheme, I played the role of participant as observer during my fieldwork. Firstly, my identity as a researcher was made known to the hospital staff before the research began. In addition, I gathered data by informally observing behaviour on the hospital wards (and by conducting scheduled interviews). What is more, as time elapsed, I interacted more fully with informants and, on occasion, I assisted them with certain work-related tasks or socialised with them during breaks.

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

Field Notes

Choosing this type of method was a challenge for me, knowing that my city—located in the northern part of SA—has a traditional and closed lifestyle. It is not easy to involve myself deeply with people's lives, during work or any other time. The first challenge was finding multiple participants who would agree to participate in this study, which seemed unacceptable as it was required to immerse myself deeply in their work and daily interactions. My colleagues stated before I received the ethical approval that people in this city do not have enough information regarding this type of data collection method (observations); in their view, I would not be able to target any participants, and I would lose time as a result. Thus, it would be better to carry out interviews instead. As they stated, changing the data collection methods later would require an update to the ethical approval from the university, which would take a long time to receive. I went against this

advice because I thought that I had a unique opportunity to complete observations as a sponsored and full-time student.

I consider myself to be a female risk taker, as deciding to study abroad was a big decision. Choosing to complete my PhD in research methods was a great challenge for me as a Saudi female from the traditional region of Hail. However, I believe my experience of working on such a research project has been quite remarkable and important for me. Finding the answers to the research question concerning nurses has meant that I have had to become deeply involved in nursing theory and research. Despite the challenges and obstacles of being a married Saudi mother, I am still interested in my work; I consider my PhD study to be a good opportunity for me to improve myself in such a highly regarded educational environment as that of the United Kingdom. I strongly believe that performing this research project, with its complicated methodology, will stay with me forever; it will be the starting point for performing further research in the Saudi nursing context, which will facilitate recommendations to improve the nursing profession in my home country.

When I first met with the participants to obtain their consent, I explained the research aims and my role clearly and in detail, and I gave them enough time to ask questions. I found that most of them agreed to participate because they wanted someone to hear their voice. I started my first observation in the female surgery department; at the time, it was stressful, and I felt like a stranger. I met with the participant at reception and she seemed stressed out as well; she still did not know me very well and was suspicious about my role. To alleviate such suspicions, I always wore my university identification to show the participants that I was a researcher rather than an investigator. To decrease the participants' stress, I initiated the observation by talking with the participants in general and not focussing on their work. In addition, I tried my best not to write anything down in front of participants; instead, I was keen to write everything down immediately after each observation when I returned home. On some occasions, when participants were struggling to perform some procedures, they appeared anxious, as they looked at me as an expert who would judge their performance. However, I did not comment on their performance, and I followed what Roberts (2007) suggests by being honest and clear with them and explaining to them that I was acting as a researcher rather than an expert evaluating their performance.

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

During this time, I was in regular contact with my supervisor, and we met regularly during the data collection phase via Skype and discussed the observations. We also considered how I could improve myself in relation to writing down the observations in more detail and avoiding being biased. In addition, I kept a reflective journal, writing down all the feelings and challenges I experienced; I then discussed them with my supervisor. With all these practices, I was able to build a good relationship with the participants, which helped me later when I was conducting the interviews.

4.13.2 Interviews

Gill et al. (2008) describe research interviews as either structured or unstructured verbal communications between the participant and researcher, during which, the participant divulges pertinent information to answer the research questions. Semi-structured interviews allow flexibility, enabling the researcher to adjust, clarify, and explore different avenues as required. Simons (2009) also explains that interviews are effective methods to determine the differing experiences of participants. Furthermore, semi-structured one-to-one interviews were considered appropriate to maintain confidentiality and to encourage the participants to divulge any sensitive information that they may have been reluctant to express in a group situation. The researcher thinks that the interview process allowed for a more in-depth exploration of the participants' subjective interpretations. As

Byrne (2004) explains, such insight cannot be gained from observation alone. Indeed, Hammersley (1992) explains that, if research relies only on observation, without considering the verbally expressed views of the participants, then it is possible to misinterpret their actions.

To maintain focus in the interviews, a flexible interview guide was developed (see Appendices 7 and 8). This guide related to the research questions and observations that had been made in the field. The interview guides were reviewed by the supervisors. As suggested by Doody and Noonan (2013), the participants were encouraged to ask questions and raise any issues they felt were relevant to the research that may not have been reflected in the questions.

Verbatim transcription of the digitally recorded interviews was completed to ensure no information was inadvertently lost. Each formal interview was conducted at the end of the nurse's shift or during break time and was scheduled to last for an hour; these interviews took place in May 2017. The NGNs were interviewed in a private room on the ward where they worked. The principle language for the interviews with the NGNs was Arabic, as this is the primary language of SA. As such, it was considered that the participants would be more comfortable and more likely to express their feelings and experiences in Arabic rather than English. In contrast, the HNs were interviewed in English because most of them were foreign. The formal interviews were digitally recorded, and the recordings were uploaded onto a password-protected computer as soon as possible after the interview (same day).

Preparing for the Interview

The interviewer gained insight into the nursing experience and environment in which the nurses worked by reviewing the existing literature related to nursing experience. Qualitative studies on the subject were reviewed to understand how the researchers in those studies used the interviews to gain a better understanding of the nurses' experience. Significant insight was gained from the fieldwork observation with the NGNs, as well as reviewing all the previous literature related to the topic, and the researcher acquired at least a passable level of knowledge on the environment in which the participants worked (Knox & Burkard, 2009).

Becoming Acquainted: The Initial Relationship

At the commencement of the interview process, the two parties (the interviewer and interviewee) are normally strangers. This frequently leads the respondent to feel self-conscious, and nervous. Therefore, it is necessary for the interviewer to project him or herself in an encouraging way that will break down any resistance in the respondent. First impressions are important, as the participant will make a rapid decision on whether to become involved during this initial phase. As such, it is prudent to have all the necessary information available for the potential participant, including the study information and researcher's credentials. This will put the participants at ease and make them feel that they are involving themselves in legitimate research (Rubin & Rubin, 2011). For this study, the researcher aimed to become acquainted with the participants prior to each interview by holding a number of informative meetings on the purpose and design of the study. There was also time to become acquainted with the research participants during the fieldwork observation that was performed before the interviews. This allowed for the development of a good rapport before the private interviews were conducted.

It is advisable to explain and discuss the practical facets of the research with the participant. This can include the use of a certain interview room or recording device, but importantly, it should also comprise explanation of how long the interview process will take and how the interviews will be scheduled. It is the interviewer's responsibility to create a comfortable and secure atmosphere where the participants will be confident in speaking openly about their situation (De Vos, 1998). For this research, the researcher explained to the respondents that the conversation would be digitally recorded and then transcribed verbatim.

Conducting the Interview

To commence the interview, the interviewer usually asks a broad, general question first. Doody and Noonan (2013) explain that it is then necessary to encourage the participant to keep talking by maintaining eye contact, nodding and uttering sounds to indicate interest. Probes can also be used to encourage further discussion on a specific area of interest (Burns & Grove, 1998).

Role of the Interviewer

It is frequently necessary for an interviewer to probe the participant to gain an in-depth insight into the matter being studied. This probing encourages the participant to divulge extra snippets of information; however, it is necessary for the probes to remain natural so that the responses from the participant are not influenced in any way, thereby introducing bias. The following approaches are used to probe participants: open-ended questions, tracking and clarification. The researcher found it necessary to prompt the participants on some occasions.

- **Open-ended questions**

Open-ended questions require the respondents to answer more fully, and therefore, such questions give them more opportunity to express their feelings, concerns or emotions on a certain topic (DiCicco-Bloom & Crabtree, 2006). When participants are talking, they often respond to their own words and provide further information (Parahoo, 2014).

- **Tracking**

It is necessary for the researcher to keep a strong focus and track the direction of the interview. It is important to show interest, understand the progress of the interview and encourage communication by paying attention to both the verbal and non-verbal dialogue of the interview (De Vos, 1998).

- **Clarification**

The interviewer is often required to ask for clarification on specific points. This can be achieved by asking the respondent for further information. Similarly, if the interviewer thinks the respondent has misunderstood a question, then the interviewer can clarify the matter (Polit & Hungler, 1999).

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

The effective analysis of data is vital for the success of the study. The research design involves more than gathering the evidence in a way that provides answers to the problem (Baxter & Jack, 2009): In this study, the researcher simultaneously collected and analysed the data as the themes of the study were continuously updated. The large amount of data generated in this study is typical of qualitative case study research, which is why such projects are considered difficult to manage.

4.14.1 What is Thematic Analysis (TA)?

Thematic analysis (TA) is an analytical technique that can be used to systematically identify, organise and provide information regarding the patterns that are prevalent in a set of data (Tuckett, 2005). The focus on meaning (theme) throughout the dataset enables the researcher to identify and understand collaborative and implied meanings and experiences. Thus, this method is effectively a means of establishing common factors regarding how a topic is discussed and understanding such common factors (Joffe & Yardley, 2004; Tuckett, 2005). Nonetheless, it is important to note that common factors are not always significant or meaningful. The thematic patterns that can be identified by a researcher using TA must be relevant to the topic and research question at hand. Analysis must provide the answer to the question, even if the question that requires answering does not arise until the analysis is conducted, as often occurs in qualitative research. There are many different patterns that can be found in any dataset, and thus, the objective of analysis is establishing which themes are relevant to answering the questions proposed (Fereday & Muir-Cochrane, 2006). It will also be important to ensure that I manage differences that are identified through the process of analysis such that they are accounted for rather than managed out of the final account.

Miles, Huberman and Saldana (2013) pointed out that there are numerous approaches to analysing qualitative data, all of which are extremely diverse and demonstrate different objectives emanating from epistemological and ontological principles. It is generally agreed that analytical categories or themes must be applied in qualitative data analysis to evaluate social phenomena (Pope, Ziebland, & Mays, 2000). However, the analytical process must be transparent. Seale, Gobo, Gubrium and Silverman (2004) point out that this may be accomplished by incorporating thoroughly established processes and

principles. This is of paramount importance for establishing the validity and accuracy of the results.

Braun and Clarke’s (2006) qualitative TA was applied in the analysis stage of this research. This is a flexible and popular means of qualitative data analysis that is widely used by many researchers. Howitt and Cramer (2008) note that Braun and Clarke’s (2006) method of conducting TA is methodical and highly effective at helping researchers discern relevant themes.

4.14.2 Why use TA?

TA is an approach that allows the researcher to extract meanings and concepts from qualitative data. This involves ‘identifying, analysing, and reporting patterns (themes) within data’ (Braun & Clarke, 2006, p. 79), a method that the researcher can follow to organise data and interpret the research topic/question (Braun & Clarke, 2006). The accessibility and flexibility of TA are the two main reasons why this framework is useful for researchers (Braun & Clarke, 2014). First, TA benefits those who are new to qualitative research by offering a tangible and workable method among a suite of other tools that can appear vague, confusing, theoretically challenging and complicated (Braun & Clarke, 2014). TA also offers a qualitative research technique that educates the user as he or she systematically codes and evaluates the data, a skill that can later be used in connection with wider conceptual phenomena (Braun & Clarke, 2014). Finally, while TA has been criticised for lacking an epistemological underpinning, Braun and Clarke (2006) argue that instead, this is a strong point as it allows the framework to be applied more flexibly and in conjunction with a range of theoretical perspectives.

4.14.3 TA Steps

Braun and Clarke’s (2006) framework includes six steps to systematically manage data and conduct analysis. These steps include the following: 1) becoming familiar with the data, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes and 6) writing the report. Braun and Clarke (2006) stress that these

steps should not be viewed as linear, requiring completion of one stage of analysis before beginning another. Rather, TA is a recursive process that may involve revisiting or repeating steps as the analysis proceeds.

To ensure methodical, rigorous and comprehensive analysis of the data, I adhered to Braun and Clark's (2006) framework throughout the analytical stage of the research process. I chose this method as a newcomer to qualitative research who was interested in employing a straightforward and detailed approach that could take me through the process of interpreting data step by step. In addition, as researchers have argued, TA is especially useful for identifying meanings in the text (Joffe, 2012; Pollio & Ursiak, 2006).

4.14.4 The TA Process

For the initial step, I read and re-read my observation field notes and interview transcripts several times to engage in data immersion and (re)acquaint myself with the data. I also kept notes, writing down my early impressions and ideas about the data. To a significant extent, this process was made easier because of the substantial amount of time I had spent in the field gaining an understanding of the dynamics of the study setting. The existence of field notes provided real-time, in situ analytical insights to integrate with the thoughts that emerged during the data re-familiarisation process.

In the second step, I set out to closely code the transcripts/filed notes to start organising my data in a meaningful way. As Seale (2004) notes, coding schemes develop inductively through a data-driven process or deductively based on pre-existing frameworks, concerns in the literature or the researcher's subject knowledge. As discussed above, my approach to coding was largely inductive, as I wanted themes to emerge from the data without the restrictions that an organised theory would impose (Thomas, 2003). However, my familiarity with various transition theories in the nursing literature, as well as my focus on the NGN transition process, meant that I brought these perspectives to coding, thereby introducing some element of top-down, deductive analysis to the task. However, since I was exploring cultural and social influences on the transition process, which are not integrated into existing transitions models, these perspectives were not wholly applicable to my analysis. Moreover, as Merriam (2009) argues, all research involves a theoretical framework which may be explicit or implicit, whether an inductive or deductive approach is used. In this case, I used transitions theory as more of "scaffolding," (p. 66) which

enabled me to draw on it as a frame but not use it in a way that was overly determinative of the findings.

During this stage, my supervisors provided expert guidance with coding. After an initial meeting, we decided to manually code hard copies of the transcripts/filed notes line by line, using open coding, while taking note of important words, phrases, patterns, topics and ideas throughout the text. To this end, my supervisors and I each took two transcripts to code, using pens and highlighters to accentuate and mark relevant text; when this task was completed, we reconvened to compare our results and determine how well the codes aligned with the research questions.

After a lengthy discussion that involved modifying our codes, we came to an agreement about the coding categories I would use moving forward with the analysis. (For an example of coded excerpts from transcripts, please see Table 4.5**.** For an example of coded excerpts from the fieldwork notes, see Table 4.6.

Table 4.5: Excerpt from a Coded Interviews

Code	Interview Data
Not My Choice Average Role	I did not choose nursing from the outset. My first ambition was to be a nutritionist, but because of the preparatory year and the average [I achieved], I had to enter the nursing school
Parental Pressure	My parents were the ones who chose the profession for me. At first, I rejected the idea, but then I was Convinced
Reality Shock	I was shocked that what I studied in college was different from the work here in the hospital; it is completely different.
Different in Reality (No) Appreciation (No) Respect High Responsibilities	The everyday reality is different, as well as the people and leaders. I expected that there would be good behaviour and respect from them. However, when I got the job, I did not receive any appreciation from them and other staff, or respect, and they gave me responsibilities beyond my ability, which I did not expect.
Lack of Awareness	Prior to being in nursing, I was unaware of it. I thought that it was the same as many jobs in the medical field, but I did not know exactly what being a nurse entailed.
Limited Practice	because at university, we focussed on theory rather than on practice. Practice as a nurse, however, is very different.
Cry Difficult Lack of Experience Stressful	Sometimes, I cry, because it is very difficult to deal with them. It is stressful, as they have respiratory difficulties, and sometimes they have had a tracheostomy, and I don't have any experience in dealing with those patients. It is a very stressful situation.
Servant	Sometimes, they treat me like a servant, and they ask me to take responsibility for everything. The perception regarding nurses, particularly by the elderly, is that they are basically servants.
More Theory	The programme prepared me well in theory part,

Table 4.6: Excerpt from a Coded Field Notes Observation

Code(s)	Field Notes
Crowded Ward During Visiting Hours	I chose to attend the ward from 4 p.m., which was the most suitable for me as my children go to school in the mornings and the evening would have been too late for me. I attended the same female surgical ward I described in my previous observation. It was crowded with visitors when I began the observation because my arrival coincided with the start of visiting time.
Complaint Relationship with Head of Department Investigation Unfairness	She started to describe the shift by saying that the head of department on the morning shift told them that she would be making a complaint about the afternoon shift nurses because one of them had left the hospital to buy some items from the market, which is not allowed. She then asked the morning shift nurses about the incident, but they all denied that it had happened. However, the department head went ahead and filed a report with the hospital administration, and the administration subsequently requested the attendance of the nurses in question to investigate the complaint. The participant concerned expressed her anger about the way the department head handled the original complaint from the afternoon shift's head nurse (HN), complaining that it was not dealt with fairly and that the HN should have asked the other nurses their perspective before filing her report with the hospital administration.
Busy Lie Angry	The participant looked at him and told him that there are other patients to see, she was busy and this was not an urgent issue, so there was no need to lie. The participant addressed the problem, and it was clear from her response and voice when speaking to the boy that she was angry. We returned to reception, where the participant was still angry about this case, and she said it was not acceptable

As suggested by several authors, I wrote memos to discuss the meaning and possible implications of each of my codes, as well as (preliminary) ideas about their relationship to the research questions (Corbin, 1986; Lofland & Lofland, 1985; Strauss & Corbin, 1998). These helped to codify the existing codes and develop new ones and explore the data in a way that challenged or built on earlier understandings.

The third stage of analysis involved searching for themes. According to Braun and Clark (2006), a theme captures the main ideas about data in relation to the research question(s) and reflects patterned responses or meanings in the dataset that are significant (p. 82). To extract themes, I combined codes that were similar or related to a common aspect of the data. Ultimately, all the codes relevant to the research question were merged to form themes. As suggested by Braun and Clarke (1996), I also considered the different levels of themes, designating them as overarching themes or subthemes that were associated with the broader categories. These themes and subthemes were generally descriptive, depicting patterns in the data that were pertinent to the research questions.

As a fourth step, I divided analysis into two tiers, as suggested by Braun and Clarke (2006), to refine my themes. The first analytic tier involved assessing how well the data fit with each theme. This was accomplished by reading through collated data extracts that had been assembled for each theme, using a cut-and-paste technique in the Word transcript documents. The second analytic tier required evaluating how well the themes applied to each individual interview, as well as across the entire dataset, facilitated by another review of the data. This also gave me the opportunity to check whether any data had been missed during the previous coding effort. Braun and Clarke (2006); Mason (2002) to visualise the linkages between themes and subthemes and identify any that could be discarded or added to the analysis.

In the fifth stage, I engaged in the final refinement of my themes, defining and naming them. To this end, I considered the narrative relevant within each (sub)theme and how these stories related to the overall narrative of the data. I also decided on names for each (sub)theme that were 'catchy' and effectively conveyed their 'essence' (Braun & Clarke, 2006). (For an example of the development of themes and subthemes, see Table 4.7

In the final stage, which involved writing up the report, I selected excerpts from the transcripts/filed notes that illustrated the various themes, providing clear and vivid examples of the subject under discussion and the arguments being made (Braun & Clarke, 2006). These excerpts also provided a richness to the storytelling that would not have been possible without the inclusion of transcript and fieldwork data.

Table 4.7: An Example of Reorganising Themes into Broad Organising Themes and Subthemes

Initial Codes	Initial Broad, Organising Theme	Initial Subthemes	Final Subthemes	Final Broad, Organising Theme
Not my choice **Caring Nature** **Parental Pressure** **Low Grades** **Many Duties** **No Support** **(No) Appreciation** **Unprepared** **Lack of Experience** **Different in reality** **Lack of Awareness** **Uncertainty** **High Responsibilities** **More Theory** **Stressful** **Expectations** **Servant** **Lack of Respect** **Low-status Profession** **Feeling Pressured** **Disappointed** **Lack of Confidence** **Fear** **Challenge to Have Food**	New beginnings	Decision to become a nurse Realities of practice Lack of clarity of nurse responsibilities Emotional stress Treated like a servant	Decision making Role ambiguity Limited clinical practice Emotional costs Role minimisation Symbolic disregard	Difficult beginnings

4.14.5 Potential Pitfalls to Avoid in TA

TA presents several disadvantages and difficulties ('pitfalls') that can compromise the data analysis and limit the explanatory power of the results. These limitations have been laid out by Braun and Clarke (2006), as well as by other scholars versed in TA (Javadi & Zarea, 2016; Vaismoradi, Turunen, & Bondas, 2013). The first pitfall involves conducting a biased analysis that arrives at a pre-determined conclusion rather than the dataset. As I discuss in the Reflexivity section (4.15), I tried to the best of my ability to remain

detached and unbiased during the research, analysis and writing phases of my thesis, although I recognise that it is impossible to eliminate all subjectivity from the process. Also, because I largely used inductive coding, rather than a top-down approach, I was able to lessen the potential for this pitfall.

A second pitfall centres on failing to analyse the data (or engaging in low-level analysis of the data) so that there is no analytic narrative to support the data excerpts selected during analysis. In this case, the researcher may simply present a series of quotations or examples from the data without describing what they mean and using them to put forth an overarching argument. Because I followed Braun and Clarke's (2006) framework closely, the possibility of this outcome was reduced.

A third pitfall concerns using the questions asked during data collection (e.g. in interview schedules) as themes rather than engaging in analytical work that interprets patterns and meaning throughout the dataset (Braun & Clarke, 2013). A major risk is that the themes developed may only relate to the research questions (i.e. the researcher's assumptions) rather than the data, creating a biased reading of the data. To avoid this dilemma, as discussed in the previous section, I primarily took an inductive approach to analysis, which allowed themes to emerge organically.

A fourth pitfall entails producing a weak analysis in which themes do not work as distinct, independent units of analysis (e.g. there is significant overlap between themes) and in which themes are neither internally consistent nor coherent. This mishap may occur when a researcher overlooks some aspect of the data during analysis or fails to produce enough examples from the data to support the various themes. However, since I adhered to Braun and Clarke's (2006) framework throughout data analysis, this outcome is less likely.

The fifth pitfall involves incongruity between the data and analytical arguments the researcher is making. This can stem from researcher bias, as prejudgments result in making claims that are ultimately unsupported by the data extracts rather than an objective assessment of the data that matches up with the analytical assertions. This pitfall is also evident when the argument being made is not proportional to the data or there is no consistency between the data extract and analytical claims. Again, because I followed Braun and Clarke's (2006) step-by-step frame, I think the chances of this

negative outcome have been minimised.

Finally, the sixth pitfall involves a discrepancy between the theory and analytical argument or between the research questions and type of TA being employed. A related concern is that an otherwise positive analysis does not include a discussion about its theoretical underpinnings or detail how it was conducted. To avoid this pitfall, I have carefully detailed how I undertook the thematic analysis in the previous section, including the use of inductive analysis. To the extent that I relied on transitions theories, I used them as a guide or tool to frame the analysis rather than as rigid concepts imposed on the data.

4.15 Reflexivity

Within qualitative research, reflexivity is a continual process of reflection that helps the researcher to determine how she may be affecting the research project and provide a more impartial analysis. This requires the researcher to examine how her "assumptions, beliefs, 'conceptual baggage,' and preconceptions" (Mann, p. 27) impact the entire research process, including the subject of the investigation, the analytic approach, data collection and the presentation of the findings (Malterud, 2001). In short, reflexivity involves awareness of the conditions under which knowledge is created.

As I began this thesis, I was aware that my background as a preceptor nurse in SA, started her new job without any prior experience who had gone through the same training process as the participants, had the potential to shape the research process. As Abdulrehman (2017) notes, reflexivity takes on particular significance for "native researchers" (researchers conducting research in their country of origin) who may be desensitised to cultural norms and thus less likely to notice patterns and dynamics that are a part of the local way of life. To address this issue, I engaged in a number of practices to actively reduce bias, particularly during my role as a participant observer at the hospital.

Prior to and during the data collection phase, I journaled as a means of reflexivity (Lincoln & Guba, 1985; Madison, 2005). I used my journal entries to keep track of my decision-making, such as my choice of methods and research setting, as well as to reflect on the ethnographic process and the role of my values, perspectives and past experiences throughout the experience. In essence, I was both an insider and an outsider in the

context of my field work. While I had some familiarity with the research setting (hospital), I had no current personal or professional ties with the facility (e.g. the participants were not my coworkers), which helped to lessen bias. In addition, as a preceptor nurse, I had not worked as an NGN but as a preceptor. This meant that similarities between my work experience and the participants' work experiences were minimised, limiting preconceptions about NGNs and the transition period that I brought to the research.

During conversations with participants, I made a constant effort to avoid introducing my thoughts or opinions about nursing or the NGN experience. I also refrained from writing field notes in front of the participants, to build rapport and make them comfortable, as well as to avoid interrupting any series of events. Semi-structured interview questions allowed each participant to express their opinions in detail and with limited interference. Additionally, I engaged in regular debriefing sessions with my supervisor who offered advice on the difficulties I encountered in the field and coached me on how to avoid bias during my interviews and observations.

As discussed in the section on Thematic Analysis, I continued journaling during the analysis phase of the research process. This enabled me to write down my impressions of the data as well to reflect on how my role as a researcher might be influencing my interpretation of the data. I also took measures during data analysis to avoid privileging particular viewpoints over others (e.g. head nurses vs. NGNs) and compared the viewpoints of each group with one another to determine similarities and differences between them. I also maintained contact with my supervisor, meeting frequently to talk through my (preliminary) findings and continue taking stock of the potential for bias. Finally, during the writing phase, I included discussions about reflexivity and bias in the thesis and incorporated reflections about my experiences as a preceptor and as a researcher in the findings chapter to share with the reader.

4.16 Analytical Rigour

There is much debate surrounding the issue of evaluating qualitative research. There are various stances regarding how to conduct such evaluation, with some, such as Morse et al. (2002), stating that qualitative research should be evaluated by applying the same standards used in quantitative research assessment. Others suggest that, since qualitative

research is vastly different from quantitative research, unique measures exclusive to qualitative research should be applied (e.g. Mays & Pope, 2000). Thus, trustworthiness is suggested as an alternative assessment method to ensure validity and reliability in qualitative studies. Trustworthiness for qualitative research can be categorised into credibility/internal validity, dependability/reliability, transferability/external validity and conformability/presentation.

In this chapter, I have provided a full justification of why qualitative methods are better suited to my research questions than quantitative methods are. To ensure trustworthiness as I conducted this research, my supervisor and co-supervisor—both experienced researchers—were involved in debriefing sessions at all times during the study, especially the data collection and analysis phases. Before data were collected, my supervisors gave feedback on the topic guides to ensure that the questions were open ended, as intended, and would elicit good responses from the participants. In the present case study, each interview was documented using a digital voice recorder with high-quality sound detection functions. The researcher subsequently transcribed each interview.

Following the interview transcriptions/filed notes, I became more familiar with the content by reading and re-reading the transcripts/ filed notes while listening to the recordings. I sought help from my supervisor to hone my qualitative analysis skills. This took the form of each of us taking two transcripts to complete the initial stage of coding on independently. It was agreed that I would try to identify aspects of relevant fieldwork notes to add further depth and insight to the initial analysis of the transcripts. Coding was also discussed with the supervisors, who were able to suggest how the English language could be incorporated to express the key themes identified. Transcriptions are another principal component of qualitative interviewing methods that help ground the beginning researcher, acting as another foundation for data analysis (Barbour, 2001; Mays & Pope, 1995; Ritchie & Spencer, 2002). This means that reliability and rigour are crucial in ensuring that the research findings are founded on the collected data.

4.17 Conclusion

A qualitative case study informed by ethnographic methods was used to explore, describe and interpret the experiences of NGNs at one hospital in Saudi Arabia who were in the

initial 12 months of their first posts after entering the nursing workforce. Furthermore, the research examined the extent to which culture and social attitudes contributed to the NGNs' experiences and how they made sense of them. In the research, a case study approach informed by ethnographic methods were used to collect data through observation (field notes) with the NGNs. Data were also collected via semi-structured interviews with NGNs and HNs and analysed using Braun and Clarke's (2006) TA steps. Supervisors who are expert researchers were consulted and provided guidance at the various stages of the study to ensure trustworthiness.

CHAPTER FIVE: FINDINGS

5.1 Introduction

This chapter presents the findings from the interviews conducted with the female NGNs and HNs, together with those of the observations based on the fieldwork conducted with the NGNs at a hospital in a small city in northern SA. It is organised according to three themes, which reflect the personal, cultural, and structural barriers to nursing that arose during their first-time employment. These themes are: a) Difficult beginnings, b) Crossing boundaries, and c) Left behind.

The first theme, difficult *beginnings*, highlights a central conflict between the day-to-day realities of nursing, and the NGNs' initial assumptions about their professional roles and responsibilities. It focuses on the participants' disappointment with their new positions, situating this response in the context of the structural and cultural barriers to a successful transition to nursing. The second theme, *Crossing boundaries*, considers how socio-cultural beliefs about women and nursing establish boundaries for what is considered to be acceptable and unacceptable behaviour for NGNs. It also explores the dynamics in the hospital's multicultural environment, including the factors that facilitated estrangement between the Saudi and foreign nurses. Meanwhile, the third theme, *Left behind*, examines the interactions among the NGNs, HNs, physicians, patients, and other hospital staff. These relationships, which were coloured by gender, nationality, and social status, contributed to the NGNs' negative perceptions of hospital work. Whether alone or in combination, these three themes, and their related work-based challenges, motivated many NGNs to request transfers to other hospitals, or meant that they left nursing altogether.

The chapter commences with a detailed discussion of the first theme, *difficult beginnings*.

5.2 Theme 1: Difficult beginnings: Becoming a nurse in SA

In SA, nursing has traditionally been viewed as an extension of physician's work (Carty et al., 1998), rather than as a separate and vital occupation in itself. This view, among other factors, has resulted in the profession's low-profile and prestige, and in a distorted public awareness of nursing. For young women, the transition from NGN to qualified nurse is fraught with difficulty, as it involves adjusting to heightened responsibilities, as well as

coming to terms with misperceptions about the field. To explore this transition process further, this section employs six subthemes: Decision-making, Role ambiguity, Lack of clinical care, Emotional cost, Role minimisation, and Symbolic disregard.

The first subtheme, *Decision-making*, concerns the personal histories reported by the participants that lay behind their decision to practice nursing. As opposed to new nurses in other countries, Saudi NGNs do not always enter the profession voluntarily, a difference that plays a significant role in their adaptation to hospital nursing. The second subtheme, *Role ambiguity*, concerns how the lack of clarity regarding the scope of nursing intensifies NGNs' "transition shock" (Duchscher, 2008) and emotional response to nursing. Meanwhile, the third subtheme, *Lack of clinical experience*, examines the lack of clinical experience, and the differences between Saudi nursing curriculums and those in the United Kingdom (UK), together with their impact on the preparation for professional practice. The fourth subtheme, *Emotional cost*, explores the emotional toll of the transition experience that the participants reported was worsened due to the lack of support and supervision they encountered during their time at college, and the fact that, as NGNs, they were required to work independently, without support from the more experienced nurses in their workplace. The fifth subtheme, *Role minimisation*, considers how Saudi society's devaluation of nursing affects patient assumptions about the role of nurses, engendering a conflation of nursing and domestic work. This subtheme is periodically revisited in this chapter. Meanwhile, the final subtheme, *Symbolic disregard*, examines the issue of the absence of a hospital restaurant as a metaphor for the hospital's widespread indifference to NGNs' needs and experience.

5.2.1 Decision-making: The effect of parental pressure and grades

This subtheme discusses the experiences and reasons behind the NGN participants' choice of nursing as a career, the factors that influenced this decision, and the potential impact on their futures. It was evident that many of the NGNs participating in this research study did not make the choice to follow a nursing career freely, as some were influenced to train as nurses by their parents, or by other external pressures. In SA, parents exert a great deal of control over their children's career choices. For example, in my case, my father insisted that I study nursing, after hearing from a friend of his

daughter's enrolment in a nursing programme. While I was not forced to pursue this career, I chose to respect my father's wishes, although, as I soon discovered, I knew little about the practical realities of nursing. Similarly, many of this study's participants were pressured by their parents to study nursing. As the participants Samina and Mahad noted:

My parents were the ones who chose the profession for me. At first, I rejected the idea, but then I was convinced. (Lila)

[It was] *based on my father's desire. (Mahad)*

The decision to study nursing is also often a consequence of a poor academic performance, as standards for nursing programmes are less rigorous than for other health sciences fields. For example, the Faculty of Applied Health Sciences comprises several departments, including medicine, nutrition, and nursing. While all of the Faculty's first year students study the same modules, at the end of this preparatory period, the students are assigned to specific career tracks, based on their grade point averages. Those with the highest grades attend medical schools, whereas those with the lowest grades are directed to nursing.

During the interviews, several participants shared the fact that poor grades were the reason they attended nursing school, despite a preference for other courses of study. The following comments were typical:

My low grade in the preparation year meant that I had to go into nursing; this was my only opportunity. (Mona)

It was simply bad luck. First, I registered at science college, with studying medical laboratories as my aim, but because of my low grade in the preparation year, I was forced to study nursing. (Hapa)

I did not choose nursing from the outset. My first ambition was to be a nutritionist, but because of the preparatory year and the average [I achieved], I had to enter the nursing school. (Lama)

My own academic experience loosely mirrored that of the participants. After completing high school, I registered to study nursing at a local institute. At that time, the institute was unpopular due to its poor reputation, remote location, and relative independence from the area's main university. The institute, which granted diplomas after two-and-a-half years of study, was attended primarily by students who had been rejected from the four-year courses at the university. As a result, it constituted the last opportunity for individuals who were unable to progress because of their low grades. Unfortunately, I was not aware of these issues when I registered at the institute. Later, in a discussion with fellow students, I was asked why I had chosen to study nursing, given my impressive high school grades, and they stressed that under the same circumstances, they would have selected another field. As a result of their comments, I became concerned about my decision to study at the institute, and wished to quit the course as soon as possible. However, transferring from one field of study to another was difficult, so I continued with nursing, although I began to develop a negative view of the profession, based on this experience.

The results of this study showed that, while many of the participants were unhappy with nursing, not all were dissatisfied with their career choice. These NGNs claimed positive motivations for joining the profession. As Shawa observed:

The reason I chose it [nursing] was to fulfil the dream of my little brother who died before achieving it. So, I wanted to complete his dream and live the experience. *(Shawa)*

Another participant, Sma, explained that she developed the ambition to become a nurse independently, after watching American hospital dramas. She noted:

At first, I was curious about nursing. I had been watching TV programmes about nursing, and I wanted to understand how they balanced their professional and social lives. I wished to experience this for myself. Also, I like to help people when I help a patient and alleviate his pain, I thank God that I'm here to help him.' *(Sma)*

Sma's desire to "help people" is among the multiple reasons cited in the extant literature in the field, including in studies regarding Saudi women's decision to become nurses (Mebrouk, 2008). As noted, Sma's interest in nursing developed as a result of watching television programmes, and observing the tight-knit teams engaged in life-saving work.

Inspired by this image, she believed that nursing would be a meaningful and rewarding career. As the discussion chapter of this thesis explains, Sma's personal decision to pursue nursing appeared to strengthen her commitment to the profession, and her experience inspired the question of how the deliberate choice to purse nursing impacts the transition from university student to hospital nurse. To the best of my knowledge, no extant research has explored the relationship between the internal and external reasons for choosing nursing, and the subsequent transition experiences.

The next sub-section concerns the second subtheme, *Role ambiguity*, focusing on the 'shock' NGNs experience when they commence employment in a hospital service, and how this shock relates to the lack of awareness regarding nurse responsibilities. It also considers how the socio-cultural understanding of nursing contributed to the NGNs' reactions when they encountered unfamiliar and uncertain work conditions.

5.2.2 Role ambiguity: Contributions to 'reality shock'

The extant transitions literature suggests that the culture of professional nursing possesses its own meanings, norms, and expected behaviour. The reaction of NGNs to this culture was labelled "reality shock" by Kramer (1974), who charted the physical, intellectual, emotional, and developmental transformations accompanying first-time engagement with professional practice. In addition, Duchscher (2008) referred to the most intense period of adaptation as a time of "transition shock." This stage, which encompasses the first one to four months following workplace orientation, is rife with professional and emotional challenges, which can result in feelings of inadequacy, role uncertainty, and discontentment with the nursing career.

While the transition shock is based on shared responses to socialisation, it is also determined by situational factors and personal histories (ibid.), and in SA, it is complicated by the largely undefined scope of professional nursing, a field that lacks the practice standards common to other medical professions, such as medicine or dentistry (Aldossary, 2013) The absence of role legitimacy affects the transition process in specific ways, such as producing unclear codes of conduct for NGNs, hospital staff, and patients.

During the interviews conducted for this study, many of the NGNs suggested that they did not fully comprehend their daily responsibilities, including which actions might be considered negligent. As Noor commented:

Prior to being in nursing, I was unaware of it. I thought that it was the same as many jobs in the medical field, but I did not know exactly what being a nurse entailed. (Noor)

As she was new to nursing, Noor assumed that each member of the healthcare team would perform specific duties. For instance, she expected pharmacists to dispense medications, and laboratory technicians to transport blood samples to and from the department. However, she soon discovered that the realities of hospital work were, in practice, very different. She and the other NGNs found themselves conducting tasks normally attributed to other healthcare workers, such as: sending blood samples to the laboratory; securing wheelchairs; collecting pharmacy medication; shopping for patients' families; gathering staff from other departments; taking patients for X-rays; and accompanying patients to the dialysis unit. As she explained:

> *When I understood the responsibilities, I was shocked; it wasn't how I had imagined it [would be]. (Noor)*

Moreover, the study's participants came to understand that they were the only members of the healthcare team expected to conduct menial tasks, and to perform the work of others. This distortion of responsibilities, particularly in terms of how they were envisioned during training, created great discontent and resentment that was further fuelled by many of the NGNs' underlying disinterest in the nursing profession. As previously noted, I too became disillusioned with nursing, due to my reluctance to enter the field. Furthermore, I did not possess a thorough understanding of the nursing role, which later impeded my socialisation into the profession.

Instead of encountering disregard for their training, many new recruits expected that they would be valued by the hospital management for their skills. However, contrary to their expectations, they were loaded with responsibilities that were both beneath and beyond their abilities, causing many of the NGNs to doubt their ability to meet the professional standards (Duchscher, 2007), a topic that is discussed further later in this subsection. With regard to their reality shock, Rashda and Sma observed:

The everyday reality was different, as well as the people and leaders. I expected that there would be good behaviour and respect. However, when I got the job, I did not receive any appreciation from the HN and other staff, or respect, and they gave me responsibilities beyond my ability, which I did not expect. (Rashda)

I expected nursing to be a high-level job, as I had seen on TV, where everyone respects nurses, and nurses work as a team with the doctors and other health workers. The reality is quite different, however, as nurses are low in the hierarchy. (Sma)

As previously discussed, Sma had based her image of nursing on American television programmes that focus on the collegial relationships among nurses, doctors, and other professionals, as they worked together to save lives. For Sma, however, the off-screen reality proved different, and she was stunned by the treatment she received from her team members. This caused her to question nursing as a profession, although she eventually resolved to meet the challenge:

At first, I wondered why I had chosen nursing. Then I realised that this was not a dilemma, and that I should face the problems and find solutions to them. *(Sma)*

Sma's determination was not apparent among all the nurses interviewed, however. In contrast, Rashda observed that she was trapped in a hopeless situation:

If I could go back in time, I wouldn't choose nursing as a profession. *(Rashda)*

While many of the NGNs doubted or begrudged their duties, some of the HNs believed that their lack of enthusiasm affected their work, as exemplified by the following opinions:

I think they really didn't know what their responsibilities [would be]. Like, maybe, they just took the course without having prior knowledge about the work of a nurse. (HN2)

Some NGNs lack any interest, and I would ask them about choosing nursing as career. Are you really interested in your profession, or did you even think about doing this before going to nursing school? Or was there somebody who influenced you, your family or friends; because your friend became a nurse, you became a nurse as well. (HN4)

HN4 proceeded to explain:

In this country, they think it's easy to be employed, but they don't know what nursing all about, how much nurses sacrifice, how to take care of patients, or how to be concerned with the lives of the patients. (HN4)

The NGNs' limited knowledge of nursing likely reflected cultural attitudes towards the profession. First, as previously discussed, nursing is regarded as a low prestige occupation in SA, making it an unpopular career, compared with other healthcare professions. Second, nursing jobs have traditionally been held by foreign workers, and it is only recently that greater numbers of Saudis have entered the field. As discussed in the first chapter of this thesis, this change is due to Saudisation, a government plan developed in the 1990s to counteract unemployment, and to address expatriate/national work imbalances (Al-Mahmoud, Mullen and Spurgeon, 2012; Madhi and Barrientos, 2003). Thus, historically, there has been little public discussion or media representation of nursing, limiting outlets for Saudi nurses interested in sharing their experiences.

In addition to unfamiliarity with the nursing role, some of the participants in the present study felt short-changed in other ways, most notably in terms of clinical practice. This shortcoming, as the next subtheme discusses, stemmed from inadequate training, and was further complicated by the unique dynamics informing the NGN transition process in SA.

5.2.3 Lack of clinical practice: "It is completely different"

Concern regarding insufficient clinical practice is a consistent theme in the extant transitions literature, as is the fear of being outed as "clinically incompetent" (Duchscher, 2008; Benner et al., 2008). This was reflected in the present study as, for example, the NGNs often complained about the limited experience of practice during their fieldwork, particularly in certain spheres of patient care, including the specialised wards. During an informal conversation, one participant remarked that taking blood samples from patients, particularly those under three-years-old, made her extremely anxious. In addition, other NGNs expressed concern about the paediatric ward, commenting on their limited expertise in this area. This apprehension stemmed from difficulties managing young patients, who were often suffering from complicated conditions, and the fear that the children might be harmed due to clinical mistakes or parental oversights. In the

interviews, the NGNs attributed their general sense of unease to the challenges encountered in transferring their university-based knowledge and skills to clinical situations. As Sma remarked:

There is a big difference between what I have learnt, and what is practiced here in the hospital. What I learnt at university is not always accepted here. (Sma)

For example, Sma noted that the hospital's procedure for taking blood samples differed from that she had been taught at university. This gap in knowledge meant that she, and others among the participants, had to teach themselves how to conduct the task by observing and emulating the experienced nurses. Such demands meant that the NGNs felt that they were insufficiently prepared for employment, and, in the case of the paediatric ward, this assessment was accurate, since the vulnerability of the young patients limited hands-on training during their undergraduate schooling. As Mahad and Shawa noted:

At university, we studied complex and in-depth things in more detail, but when we got into the hospital, things were different. I came to the hospital as a beginner, as if I had not studied anything; they apply everything differently here. (Mahad)

I was shocked that what I studied in college was different from the work here in the hospital; it is completely different. (Shawa)

To a certain extent, the curriculum differences between the nursing programmes in SA and other countries explain the NGNs' deficiencies in clinical practice. For example, in the UK, 50% of the nursing course is theory, and 50% is clinical practice. Moreover, UK students commence their clinical practice early, and are often working full shifts before graduation. In contrast, Saudi students do not begin their clinical practice until the second semester of the second year and are engaged in practice just one day a week, for five hours at a time, under the supervision of the university preceptors.

For the HNs, the NGNs' lack of clinical practice was a topic of concern, and several advocated introducing a university programme to enhance their skills:

I think they lack skills experience from the time they are in the school… When it comes to the special concentration [required by nurses], maybe SA nurses need more motivation, and more practice in their skills and in their knowledge. They need a better introduction or orientation to prepare them to be a competent nurse, to be one of

the skilled nurses who can work in the unit. …Some of the nurses are knowledgeable, but when they are new, their skills are not sufficient to cope with the nursing profession. So, I want to be honest, I think they have a lack of skills experience from the time they are in school… they need more training, especially when they are in school. During their training, they have to learn. (HN4)

However, this view was not shared by all of the HNs. According to HN3, the NGNs usually arrived at the hospital with the necessary skills, although she wondered whether these could be supplemented with additional theoretical training:

I think they are skilful, and can perform the procedures as new staff satisfactorily, and they are willing to learn, so it's easy for them to become familiar with the procedures. But in terms of knowledge, I guess [they don't have] in-depth knowledge about the specific procedures or treatments, I guess because the bachelor's programme focuses more on skills, not much on theory. (HN3)

Nursing programmes in SA also differ from UK programmes in terms of the time spent on specialisations. In SA, nursing programmes are generalised, and students take courses in a range of specialties, including mental health, community health, or adult health. However, in the UK, there is greater focus on progressing towards a specialty. For example, some students concentrate on paediatric nursing throughout their education, and are therefore better prepared to work on these wards after graduation. In contrast, Saudi nursing students perform only short ward rotations, and are therefore deprived of the skills and confidence to work independently at the outset of their careers. Lengthening the duration of their ward rotations would be an important strategy for enhancing Saudi nursing programmes, and this issue is explored in more depth in the discussion chapter of this thesis.

When asked how nursing programmes in SA could be improved, the participants suggested a greater focus on practical skills, and especially on opportunities to apply these skills during training. Creating a more supportive environment might also help inexperienced NGNs to develop competencies, and build self-assurance (Maben, Latter and Macleod Clark, 2007; Roxburgh et al., 2010). Unfortunately, in the current situation in SA, NGNs are often blamed by HNs and administrators for the disparity between their abilities and the profession's real-world demands.

The next subsection examines the emotional cost of entry-level nursing, specifically that stemming from the fear, worry, and doubt that represented the sentiments most commonly experienced by the NGNs in this study as they conducted and reflected on their work responsibilities.

5.2.4 Emotional costs: "It is just so stressful for me"

Transitioning to professional nursing is exhausting for NGNs, requiring resilience and strength to manage the overwhelming emotions engendered by the process (Duchscher, 2008). The fear, anxiety, and doubt encountered erode well-being, as inexperienced nurses struggle to adapt to their work environments (ibid.; Kramer, 1974). Self-confidence, the belief in one's ability to accomplish a goal or task, is crucial during this stage of a career (Perry, 2011).

In this study, the participants identified working independently as an obstacle to accomplishing their work. While the NGNs were supervised throughout their undergraduate training, once in the workplace, direct supervision was rare, forcing them to persevere independently to fulfil tasks. As previously noted, the NGNs interviewed were frequently required to learn new skills, either over time or on the spot, which increased their performance anxiety, and undermined their self-confidence. Initially, some of the participants struggled to manage their time, and to address each patient's care requirements, in a single shift. Those assigned to wards with which they had limited clinical experience encountered the most difficulty coping with their caseloads, and consequently feared making errors or overlooking some aspect of care that might harm the patients. The participants often took these concerns home after their shifts, where they continued to worry about their capabilities. As Rashda commented:

When I get home, I think about how they [the staff] left me alone with many responsibilities. I worry that I might have forgotten to give a patient his treatment, or to complete his file, or that perhaps I didn't do my job efficiently. Usually, I wait for the next day to get back and make sure that everything is okay. (Rashda)

The participants also reported feelings of uncertainty, despite their initial confidence in their abilities, and as time progressed, the lack of support made them apprehensive about caring for patients. As Lama explained:

There is a big difference in many respects from being a student. I was getting a lot of support from my preceptor and I was confident, but now, as a nurse, all responsibility falls on me, and any mistake is not justifiable; it is just so stressful for me. (Lama)

Shawa expressed similar feelings:

The difference is big. As a student, it is more comfortable, and there is someone who is with you to tell you what should you do, and if that's wrong or right. While working as an independent nurse, you have more responsibility than you can handle, especially at the beginning of the work, when you have to take care of so many patients. Maybe I thought that because there are some things I don't know about, I would have someone with me, like a preceptor, to give me more self-confidence to work alone. (Shawa)

During the fieldwork observations, many stressful circumstances that challenged and demoralised NGNs were apparent, including intravenous (IV) cannula insertion, assisting patients with cerebral palsy or a tracheostomy, dressing wounds, and administering medication, particularly to children. In her interview, Lama discussed the emotional effect of treating individuals with cerebral palsy, both generally and during specialised interventions:

Sometimes, I cry, because it is very difficult to deal with them. It is stressful, as they have respiratory difficulties, and sometimes they have had a tracheostomy, and I don't have any experience in dealing with those patients. It is a very stressful situation. (Lama)

At one point during the fieldwork, an NGN, who was clearly anxious and unsure was observed preparing a dressing. During the procedure, she used too much gauze, as her hand shook continuously. Usually talkative and prone to laughter, on this occasion, she was completely quiet. She spent approximately 20 minutes on this task, although the patient was in pain, which increased her distress. When the NGN finally finished the task, she confided that she preferred working with experienced nurses when changing a

dressing, but was unable to that day, as they were all busy.

Observing the participants during the course of this research study affected me profoundly, as it resonated with my experience as a preceptor. During this time, I doubted my abilities in a range of areas, including critical situations that had not occurred during my course of study or internship. To a certain extent, the HNs who partook in this study understood the NGNs' lack of confidence. As one noted, student training procedures differ significantly from direct patient care:

Changing from being student at school to being a nurse here, it's not the same as in school, where you're only handling mannequins. You're inserting a cannula in a mannequin, or caring for a wound on a mannequin. So it's different. Like, real patients, with real situations, it's not a drill anymore… The main issue, or the main challenge they face is trusting themselves, trusting their judgment… They do not trust themselves, even when they actually know how to do it. (HN2)

Despite such displays of empathy, the HNs were routinely observed blaming the NGNs for failing to adapt to the hospital environment. This attitude contradicted the best practice identified in the extant transitions literature, which stressed the importance of guiding and encouraging NGNs as they incorporate their knowledge into professional practice (Kumaran and Carney, 2014). If applied, support and guidance would help Saudi NGNs to reduce their fear and stress levels, and perhaps to lower the attrition rate in the field.

The next section explores the perception of nursing, and of the status of the nursing profession in SA, which emanates from Saudi culture, in terms of it being deemed an inferior job, because it is a service profession. This demeaning view contributed to an already stressful transition period for the NGNs interviewed, and intensified their negative responses to hospital work.

5.2.5 Role minimisation: Being treated like a servant

The perception of nursing, and of the status of the nursing profession in SA emanates from Saudi culture, which considers it to be an unsuitable profession for females, because it is a service profession. In turn, this affects the dignity and reputation of Saudi females who enter the nursing profession, and exposes them to humiliation. This is considered critically, and in more detail, later in this thesis. In this chapter, the focus concerns the participants' inception as nurses, and their perception of being treated similarly to

domestic servants. In SA, nursing is also disparaged, due to its association with foreign nationals, who constitute approximately 50% of the nurses in the country (MOH, 2012). Saudis typically view foreign nurses as comparable to domestic servants, who are common in middle-class and upper-class homes. These servants perform domestic tasks, such as cleaning, childcare, care of the elderly, and driving, and are recruited into the country in the same way as foreign nurses (Alotaibi, 2008).

During the interviews, some of the NGNs complained that that they were treated like domestic workers by the patients, as well as by the wider healthcare community:

Sometimes, they treat me like a servant, and they ask me to take responsibility for everything. (Lama)

The perception regarding nurses, particularly by the elderly, is that they are basically servants. (Noor)

To the public, nursing duties may appear straightforward and simple, and easily accomplished without requiring a depth of knowledge or skill. As a result, patients and their attendants often assume that nurses exist to work for them. During the fieldwork both patients and their relatives were observed demanding personal services from the NGNs, such as looking after their children during appointments, ordering food from restaurants, carrying luggage, and charging mobile phones. This topic was explored with Rashda:

[Interviewer]: When that man [patient's relative] came to you [participant] and asked you to go and pay the restaurant [outside the hospital], and didn't ask his wife to do it, how did it make you feel?

[Participant]: Sad. It made me feel like I work in a restaurant, and I am here to take orders from people, like in a restaurant or a café. (Rashda)

In addition, Lama mentioned that the patients sometimes asked her to shop for them, assuming it to be part of her job:

They asked me to buy some of their groceries from the supermarket. They did not understand what is involved in my job; they think we have to do everything for them, and this is so disappointing. (Lama)

While some of the nurses genuinely wished to help their patients, at least on occasion, most of the patients did not appreciate these favours, and consider these additional tasks to be part of a nurse's job. In my hospital work, I experienced similar situations, and when I refused to accept these tasks, I was chided by the patients or their families. A refusal to do their bidding, no matter the request, was considered to be unacceptable, and was interpreted as either arrogance or laziness.

In many ways, the poorly defined job scope of nursing encourages the conflation of nursing with domestic service. To address this situation, policy makers and nursing training programmes must better clarify the role of nursing, which would help to legitimise the profession, and to facilitate NGNs' transition into practice. Also, because there is a need to improve public understanding of nursing more generally, a nationwide campaign to raise awareness, spearheaded by the Saudi government and media, would be constructive.

The negative perception of nursing is one of the greatest impediments to satisfactory working conditions for nurses (Lai et al., 2006). To my knowledge, the interaction between public perceptions of nursing, and the impact of this on NGNs' transitions has not been explored in the extant transitions literature.

5.2.6 Symbolic disregard: Lack of restaurant or café

This final subsection of the *New beginnings* theme exemplifies a clear manifestation of the disregard for nurses in the hospital in question: the absence of a restaurant or café on the premises. This absence was exacerbated by the logistical difficulties in ordering food to the hospital, a situation that is perplexing in a culture that places a significant degree of value on the ritualised food-sharing. Sma explained how the lack of an on-site restaurant or food supply affected her work, stating that she was often tired and hungry as a result, and sometimes unable to conduct her work effectively:

This is a very important issue. In the morning, the majority of the restaurants are closed, so you can't order food. In the evening, deliveries always arrive late, and at night, there are no restaurants available. The problem is that restaurants are not available all the time, and hunger can negatively affect my concentration. (Sma)

When I asked one of the HNs about how the staff could work without eating, she said that the nurses should bring food with them, or could have sweets in their pockets to

boost their energy:

The policies and procedures [that are explained to the NGNs when they are oriented] state how many minutes are allowed for the tea break, and the mail break. It is… 45 minutes. But we have to understand, as a nurse, that any time of the day can get busy, so we have to be prepared… You know that you're coming for duty, so get prepared, get something and bring with you: food that can help you, even chocolates in a packet, or candies with carbs or glucose that will help you. (HN1)

The lack of a restaurant in the hospital also created extra work for the nurses, because the patients often sought to enlist them to locate food. For example, during the fieldwork a participant recalled an incident that occurred the previous day. She explained that she and her colleague had ordered dinner from outside the hospital, and had requested the HN’s permission to eat in the nursing room. After 10 minutes, a man asked one of the Indian nurses on the ward how to locate a Saudi nurse. When the Indian nurse replied that they were eating their dinner in the nursing room, he asked if he could speak to them, so the Indian nurse knocked on the nursing room door, and when it opened, the man pushed inside, saw the nurses eating, and asked if the room was a restaurant, implying that eating in the hospital was unacceptable.

The participant expressed her surprise at the way the man had spoken, and explained that she responded by attempting to end the conversation by giving the patient the number of the restaurant that had delivered the food, suggesting that he call the restaurant himself if he required anything. After a few minutes, he returned and knocked on the door again. When the participant opened the door, he handed her some money and told her he wanted to order three chicken sandwiches and a Coca-Cola his wife. The participant responded angrily that he should order it himself, repeating this three times until the man left. After a few minutes, the restaurant called the nurse and told her that someone on the ward had ordered food and given her contact details. The participant explained that she was outraged by this, and explained that she had not ordered the food from the restaurant. She concluded by stating that she could not imagine how people had the audacity to think that nurses should conduct tasks such as ordering meals, and other jobs unrelated to nursing care for patients.

This exemplified and highlighted the burdens that NGNs experience daily when they are asked to perform tasks that are beyond their official responsibilities, adding tension and

unpleasantness to the work environment. As is evident in the subsequent sections of this chapter, disrespect for nurses' roles and time repeated across the different themes and subthemes, and consistently undermined the transition process for Saudi NGNs.

5.2.7 Summary

The issues discussed under the theme of *New beginnings* identified numerous personal, structural, and cultural conditions in SA that place NGNs, particularly females, at a disadvantage in the workplace. First, Saudi parents exercise significant influence over their children's careers, forcing many to pursue professions that are uninspiring to them. In addition, many are forced into nursing because of their poor academic grades. For NGNs, this is further complicated by the fact that the public is largely uninformed about their profession. Within Saudi society, service professions, such as nursing, remain unappreciated, and many patients treat nurses like servants, requiring them to complete tasks outside the remit of their jobs. These conditions create a formidable set of barriers that make the transition from new graduate to qualified nurse more challenging than in many other countries. Moreover, these impediments are tightly bound to cultural expectations and norms that prevent the easy reform of nursing education and training.

This chapter now turns to its next major theme: *Crossing boundaries*. This section explores the cultural barriers to nursing in a society stratified by gender, and considers the NGN participants' experiences within this socio-cultural context.

5.3 Theme 2: Crossing boundaries: Confronting cultural barriers to nursing

SA remains a deeply conservative society, despite recent efforts at modernisation (Long, 2005). As discussed in the introduction to this thesis, traditional customs, norms, and religious beliefs, many of which are national, although some are regional, shape daily interactions for men and women, in both public and private spaces (Gallagher and Searle, 1985). As the previous theme indicated, these notions of acceptable roles affect the work domain, and are central to defining the transition experience for new nurses.

This section concerns the theme, *Crossing boundaries*, discussing the study participants' experiences as they negotiated their transition to hospital life, and demonstrating that nursing in SA's conservative, patriarchal society is itself an act of transgression, since it continually threatens long held beliefs about women's autonomy and behaviour. Bound between two competing cultures, NGNs face numerous difficulties adjusting to the

expectations of their fellow staff members, while also balancing broader social norms and standards. This tension is often exacerbated by their families, who, although once supportive of their daughters' nursing careers, often begin to question, and eventually oppose the actual work demands of the daily nursing schedule. This situation is further complicated by patients' reactions to NGNs, whom they view as subordinate in status, both because they are female, and because of persistent misunderstandings of the nurse's role.

The theme with which this chapter is concerned is subdivided into five subthemes encompassing the cultural, largely gender-based, roadblocks to a successful NGN transition experience: Sex-segregation, Shift work, Transportation, Overflow work, and Lack of trust and respect for Saudi nurses. The first subtheme, *Gender-segregation*, concerns the familial and social disapproval of working in mixed-gender environments; this disapproval is aggravated further if, or when, NGNs are assigned to mixed-gender wards. The second subtheme, *Shift work*, discusses the problems NGNs experience when they are assigned night shifts, which violate temporal boundaries for female participation in the public/professional sphere. Meanwhile, the subtheme *Transportation* concerns the difficulties the participants experienced obtaining timely transportation to work, in the context of the legal restrictions on females driving at the time of the study. The next subtheme, *Overflow work*, explores the intersection between shift work and transportation dilemmas. This nexus extends work duties for nurses, who are obliged to stay at work beyond the time of their assigned shifts, in order to manage ward duties for colleagues detained by late drivers. The final subtheme, *Saudi nurses*, examines the cultural and structural barriers to trust and respect for Saudi nurses, and the preference of many patients for foreign nurses over Saudi nurses.

5.3.1 Gender-segregation: Keeping new nurses apart

This study originally aimed to explore the experiences of NGNs working on both female and male wards. However, on the day the fieldwork commenced on the male surgery ward, the male staff and patients clearly disapproved of the researcher's presence, and refused to partake in the data collection. It was therefore necessary to narrow the focus of the research to the female wards only. This experience exemplified the ongoing impact of gender-segregation on nursing. In general, hospital areas, such as surgical wards, are separated by gender, although the intensive care unit (ICU) and emergency Room (ER)

are two exceptions to this rule. Learning to negotiate these spaces, by choosing how or when to transgress boundaries, is an important part of the NGN transition experience, and one that is not shared by nurses in other countries.

From an early age, NGNs are exposed to SA's gender-segregation policies in a range of domains, including education. From primary school to college, female and male students are taught in separate classes by faculty members of the same sex. This includes all areas in the health sciences, such as medicine, nursing, and public health. Thus, NGNs commence their professional practice with little experience of mix-gender environments, and specifically in working one-on-one with men, whether hospital staff or patients. Moreover, NGNs are typically young women, fresh from nursing school, who have not yet married, or become mothers. Their youth and single-status distinguishes them from the older nurses, who have more experience interacting with men, both professionally and in private settings.

In conversations with the participants of this study, many shared their concerns about interacting with, and caring for male patients. Despite being an expected component of their job, the NGNs reported feeling uneasy about this behaviour, suggesting that it disrupted traditional gender relations, and reflected negatively on their moral standing as women. This latter, more abstract, concern was accompanied by anxiety about being respected for their professional skills by male patients. Mahad's comments were representative of this view:

I feel that the patient is feeling shy, and that if someone were to watch me taking care of the patient, he would have a bad impression of me, although I am trying to help the patient. (Mahad)

Whether single or married, parents and families often discouraged the NGNs from any male contact, despite their presence in the hospital. During the interviews, the participants remarked that it was not uncommon for their family members to comment disdainfully about the co-ed environments, though the responses to these statements varied among the participants. For example, as Samina reported:

One of my relatives asked me: How can you work in a place full of men? However, I did not answer her. (Lila)

Despite the argument about working in a mixed-gender environment, the work turned out to be decent like any other job as Shawa explained

My view that was built from people's words was that nursing is bad and usually there are mixing with men, but when I went into the practice I found it to be a decent work like any other. (Shawa)

One of the HNs also discussed parents' reactions to their daughters working in mixed-gender units:

There are some Saudi nurses that are assertive, and they are willing to work in a challenging area, like the Emergency Department especially. They want to work in an intensive area, but their family will refuse permission. …There is one member of staff, a very effective one, who was assigned to the ER, but her father refused to let her work in an emergency department, because of too much exposure to the people, especially men. Even though she didn't want to be transferred on another area, she didn't have any choice, so she was transferred to the paediatric ICU, where she is confined. The babies are there all day, and there is not so much exposure as in the ER. (HN3)

The HN continued, confiding that the NGN in question, with the help of other members of staff, persisted in treating male patients, actively disregarding her father's orders:

Some staff, also in the ICU, I think they tell their family that she is restricted to female patients, because if her father knew she is dealing with male patients, he will ask that she is transferred to another area, and that could be a problem, I think, for her. (HN3)

This story highlighted an important tension inherent in the younger female nurses' ability to conduct their nursing duties effectively. In many cases, parents continue to be responsible for their daughter's career, after initially urging them to choose nursing. After supporting them through their schooling and training, many are surprised by the actual requirements of professional nursing, such as tending male patients, which they consider to be disreputable. In response, these parents seek to extend their sphere of control into the workplace, by seeking to convince their daughters to behave in specific ways, or by pressuring the hospital administration to alter their ward assignments. This tendency appeared repeatedly in the subsequent subsections of this chapter, including in the next subtheme, *Shift work*, further complicating the NGNs' efforts to negotiate their

workplace.

5.3.2 Shift work: Barriers to work and home life

Since hospital nursing involves 24-hour, round-the-clock care for patients, it is organised in shifts throughout the day to ensure a full coverage. As a regular part of their duties, nurses are expected to adhere to this system by working the shifts they are assigned. For the NGNs, who are newly familiarising themselves with hospital procedures, their shifts do not always end on time. For example, it often takes up to two hours for new nurses to complete their responsibilities, before they become more adept at time management.

As the hospital's focus is seamless patient care, prompt arrival for shift work is an important job requirement. However, in SA, at the time when this study was conducted, women did not possess the right to drive, and were therefore dependent on others, specifically male relatives or family drivers, to take them to and from work. For a number of reasons that are discussed below, these transportations were not always reliable, and this compromised the NGNs' ability to report to work on time.

Moreover, night shifts posed significant challenges to the NGNs, whose families were not always supportive of the extra time required to complete their nursing assignments, or the time of day, particularly overnight, when the shifts occurred. In general, the parents expected their daughters to work shorter hours, or only during the day. An HN described the clash between normative expectations for women, and the requirements of professional nursing:

The culture is not that supportive of working at night, or in the afternoon, or coming home late. Yes, there are changes now, and it is more accepted than before, but there are still difficulties. A downside [of nursing] is taking different shifts, and long working hours, as you don't have a specific time when you finish work. (HN2)

The study's NGNs linked their family's disapproval of shift work, especially night shifts, with the limited cultural understanding of the professional demands of nursing. As Shawa and Hapa explained:

Night shifts are a special situation in our society. It is assumed in our society that there should be morning and evening shifts, without night shifts. (Shawa)

My father thinks that Saudi nurses should only work morning shifts. (Hapa)

In addition, one participant was concerned that nursing and marriage were inevitably incompatible. This, in turn, affected her attitude towards marriage, and ultimately, she felt that Saudi women were not suited to the demands of professional nursing.

In Saudi culture, women are not supposed to be nurses, firstly because of mixing [male and female], secondly because of the system of shifts, and thirdly because of communication with men… Nursing is a very hard job, and it's beyond a Saudi woman's ability, since she won't find time for her husband, children, family, and personal life. (Rashda)

Most of the NGNs interviewed found shift work disruptive to their personal and social lives. In addition to describing the stress induced by shift work, which affected their overall well-being, they noted that the long hours, and constant thoughts of work, affected their relationships with their friends and family. Sma remarked:

As a nurse, I work in three shifts: morning, evening, and night. Therefore, I have to delay other duties for my holidays. Sometimes, I have to make a schedule to help me finish my duties. My relationships with my family, friends, and wider society are also affected, as I do not have enough time for them. (Sma)

The other NGNs reported similar views, commenting that shift work isolated them from their friends and relatives. As Shawa explained:

Yes, it hinders me a lot, and I don't know how to balance my career and my personal life, for example: do I make time for family, or do personal work? (Shawa)

Mahad concurred with Shawa, complaining that she had no time to relax or tend to personal and interpersonal matters, which created feelings of loneliness:

There is no balance in my life. I feel that my life is irregular. From work to sleep and then back to work again. I forget family visits, weekends, and events. I may have to work the days of Eid. I do not even accomplish any housework on my working days, and I fear the idea of marriage, because I don't have time. (Mahad)

Shawa and Mahad's comments reflected the findings in the extant literature in the field, which indicated that unpredictable shift work that requires nurses to fluctuate between night and day shifts on a regular basis impacts negatively on NGNs' morale and job satisfaction (Duchscher, 2012; Gifkins et al., 2017).

Despite these similarities in the transition experience between Saudi NGNs and new nurses in other parts of the world, the participants in this study struggled to manage their heightened work demands. In their case, the culture of nursing, including overnight shifts, was complicated by the traditional Saudi views of women, which made the long hours and making the work-life imbalances common to all NGNs significantly more burdensome. Moreover, there were found to be stark differences in work-life balance between Saudi and non-Saudi nurses. While Saudi NGNs were constrained by social mores, foreign nurses had far greater freedom, and were more easily able to incorporate overnight shifts into their schedules. Furthermore, the foreign nurses tended to live nearby the hospital, which reduced the distance they were required to travel to work, and subsequently allowed them more personal time. The issue of travel to work is linked to another social constraint on Saudi nurses, namely control over transportation to and from work, which is explored under the next subtheme.

5.3.3 Transportation dilemmas: Getting to work on time

As stated previously, at the time of conducting the fieldwork for this research study, in SA, women were not legally allowed to drive. Furthermore, they were unable to access secure, dependable public transportation, since most Saudi cities lack the necessary infrastructure. As a result, the NGNs often relied on male relatives for transport, which created difficulties getting to and from work, especially for shifts outside standard working hours. Moreover, for the NGNs living in villages located significant distances from the hospital, using drivers to take them into the city was their only option. As Hapa explained:

I live 80km from the city, and I really face big problems with transportation. I wish I could drive. (Hapa)

Unlike Hapa, not all of the NGNs interviewed had access to family drivers, or other forms of private transportation, such as commercial taxis, which were located unevenly across the city. Once again, this created problems meeting work demands. As one HN acknowledged:

They arrive late, because of their driver. They complain that their driver was not on time, and then there was no one to take them. Not all Saudis have drivers, who should be a family member, like their brother or their husband. (HN4)

Moreover, for the NGNs with drivers, punctuality also was a concern, and during the fieldwork, drivers were regularly observed failing to arrive on time. While this was never the NGNs' fault, the nursing administration office refused to accept this reason for their lateness, punitively cutting salaries as a result. Rashda explained:

Another problem is the lateness of transport, because women cannot drive. This is something beyond my control. If you are late, no one will excuse you. You must be there on time, and they will not accept lateness, even if it is not your fault. (Rashda)

Due to the negative repercussions, the fear of late arrival at the hospital contributed to the stress experienced by the NGNs during their transition. This challenge was another example of the differences in transition experiences between Saudi NGNs and that of nurses in other countries, who can more easily access public transportation, or drive their own cars to work.

Moreover, the NGNs interviewed in this study reported the fact that there was a further complication involved in their transportation to the hospital: conflicting schedules with the male family members responsible for driving them to work. In these cases, the men were not always able, or amenable, to changing their plans to accommodate the NGNs. As Sma explained:

I face real difficulties with transportation to get to my workplace; sometimes I am grateful that I can find someone to take me to work on time. (Sma)

Given their travel difficulties, it's unsurprising that many of the NGNs interviewed felt that the hospital should help them to address the issue, preferably by providing transportation for staff members. As Mona suggested:

It would be better if the hospitals help us with our transportation, and provide us with a bus to collect us from our home; even if this was only for night shifts, it would be very helpful. (NGN9 Mona)

Fortunately, recent changes in SA law mean that women are now able to drive, which will help to resolve this problem. Moreover, as the discussion chapter explains, improvements in infrastructure planning and development would also help nurses to deal with the transportation barriers, lessening their stress, and increasing their job satisfaction. The reform of the driving laws should also help to minimise the strain associated with the next subtheme, *Overflow work*, which involves the extra duties

associated with the extended shift hours resulting from the fact that NGNs are often required to wait for their colleagues to overcome their transportation difficulties and arrive at work, before they are able to end their shift.

5.3.4 Overflow work: Shift demands and transportation problems

Another challenge for reported by the NGNs in this study was overflow work, specifically that around the time of shift changes. While workload is a concern for new nurses in all countries, the shift work and transportation problems that are specific to SA create difficulties in transferring effortlessly from one shift to another. This issue creates a build-up in caseloads of patients with varying needs, as the NGNs are required to stay late to provide cover for nurses delayed by transportation issues, as well as to relay critical information to them on their arrival. During the fieldwork with the NGNs, the following exchange was observed:

Participant 2: I think we will be late leaving work today, and will stay until 1:00am, instead of leaving at 11:30pm, as there is a lot of work. There are not many nurses on the other shift, and some of them will arrive late. This means we must stay beyond the usual time of the shift change. …we should explain the procedure for each patient to our colleagues on the night shift before leaving.

*I asked if it was permissible for them to leave at 11:30pm, and Participant 2 replied that they can leave at 11:30pm, but this will cause problems for the nurses on the next shift. She added that sometimes she arrives at work late, so she wants her colleagues to wait for her, otherwise she will experience problems with a lack of awareness of important details about the patients and events in the previous shift, and she is still a new nurse. (*Observations)

The pressures associated with shift changes added to the frustration expressed by the NGNs in the previous section, as it increased their burden of unexpected nursing responsibilities. With shifts extending by an hour or more, the daily physical and emotional demands of nursing were intensified, leading to greater exhaustion and dissatisfaction with working conditions. Overflow work also threatened to upset work-life balance. Moreover, in an already strained environment, where relations with colleagues and patients were often on edge, prolonged shifts potentially made relations worse and threatened to compromise patient care. For overflow work occurring at the start of over-

night shifts, NGNs on the earlier shifts, who carefully avoided later hours due to family pressure, risked condemnation for failure to conform to cultural expectations regarding the role of working women (e.g. the need to return home in the evening).

In the next section of this chapter, which explores the communication dynamics between the NGNs and hospital staff, the fallout from the stress of the heavy workloads, particularly on hospital relationships, is a key focus. Meanwhile, the final subtheme of *Crossing boundaries*, *Foreign nurses*, considers the cultural constraints imposed on Saudi NGNs' relationships with foreign nurses. These nurses are recruited to SA to address ongoing nursing shortages, including the lack of female nurses on male wards. Due to a combination of factors, including social bias against Saudi nurses, they are treated more favourably than their Saudi peers.

5.3.5 **Foreign Nurses*: Lack of trust and respect***

Profound cultural differences create a tenuous relationship between Saudi NGNs and foreign nurses. These dissimilarities in ethnicity, language, social status, and nursing experience establish a firm cultural boundary that is rarely tested or transgressed, and serves to hinder the Saudi NGNs' transition experience. In addition, the distrust between Saudi and foreign nurses has its origins in the gender imbalances in Saudi society, as foreign nurses have historically been recruited to the country due to the persistent biases against Saudi women and work.

There are multiple reasons for the divide between Saudi and foreign nurses. First, the perception of nursing in Saudi society, which is largely negative, affects the view of the respective capabilities of the national and foreign nurses. Among patients, the longstanding cultural view of nursing as a lower status occupation, akin to domestic servitude, predisposes patients to mistrust Saudi nurses. As discussed under the first theme in this section, the role of nursing remains ambiguous, and is not fully understood by most Saudis.

In addition, suspicions about the quality of Saudi nurses' training also persist, although much has been done in recent decades to improve nursing education in the country. While Saudi nurses previously graduated from institutes with inadequate teaching programmes (Al-Ahmadi, 2014), receiving diplomas in just two-and-a-half years,

standards have recently been tightened, and four-year courses are now the norm. However, since recruitment of foreign nurses is restricted to qualified nurses with a minimum of four years' experience, Saudi NGNs begin their transition period at a disadvantage, compared to foreign nurses, who possess more developed skills and competencies. These factors mean that Saudi patients are more inclined to trust their care to foreign nurses. When interviewed, HN3 supported this view:

Basically, I think some patients refuse to accept some of the Saudi staff nurses. Before, we didn't have bachelors' qualifications, and there is a huge difference between a graduate with a bachelor's, and one with a diploma, because of their curricula. So, [the patients] have created a notion that Saudis are not that competent, compared with non-Saudis, so some refuse [to be cared for by a Saudi nurse]. But nowadays, they're more confident that the Saudi staff will take care of them, because they understand them more easily; I mean, they can't communicate with a non-Saudi that easily. They have also observed that the Saudi staff are also doing well, and providing good care, so they are much more confident now, compared with before. (HN3)

In addition, Sma reported that even her mother believed that foreign nurses were better trained and more efficient than Saudi nurses:

My mother believed that Saudi nurses could not work as well as foreign nurses, meaning that she thought that foreign nurses were better than us. *(Sma)*

The perception that Saudi nurses are unapproachable, because Saudi nurses are less likely to obey patient orders than foreign nurses, also contributes to the patient preference for foreign nurses. As one of the HNs explained:

I guess [it's] because of cultural factors. However, I am a Saudi, you are a Saudi patient, so do not just ask me to do like this, like that. (HN4)

One reason why foreign nurses may be more willing to acquiesce to patient demands, even when they are not part of their jobs, is their interest in retaining their nursing positions. When foreign nurses are employed in SA, they receive a number of benefits, including housing, food, and a living wage (Aldossary, et al., 2008; Mitchell, 2009). These bonuses mean what the living and working conditions in SA are superior to those in many other countries. In contrast, Saudi nurses, who are hired through the Saudisation programme, perform their responsibilities, and do not comply with all patient requests.

The differences in culture, language, and skills was also found to contribute to a lack of cooperation between staff in the working environment, as staff of the same nationality separated themselves from those of other nationalities. This self-segregation left the Saudi NGNs feeling marginalised, as Rashda explained:

It is an environment of cliques, an environment where there is no help, and an environment where you have to depend on yourself; there is no partnership or help. Unfortunately, the job environment is very poor. An environment of cliques means, for example, if there are three Saudi nurses, they stick together, and it is the same for foreign nurses. Unfortunately, the environment is bad and frustrating. (Rashda)

During the fieldwork, the nurses were observed congregated in small groups, with the Filipino nurses sitting apart from the Saudi nurses, who also isolated themselves. This divide may have been due, in part, to the Saudisation programme, which is intended to introduce more qualified Saudi citizens to replace the foreign workers, an objective that may be perceived as threatening by the foreign nurses (Madhi and Barrientos, 2003; Al-Mahmoud, 2012).

From the participants' perspective, the foreign nurses' exclusion of the Saudi nurses denied the NGNs the opportunity to prove themselves, and to participate in more interesting cases, as well as maintaining the foreign nurses' advantage in terms of skills and experience. These types of initiatives could facilitate the transformation of the current competitive environment into a more respectful, multicultural workplace that is beneficial to both the Saudi and foreign members of staff, and the fostering of a more collegial and cooperative setting might also have a positive impact on the NGNs' transition experience.

5.3.6 Summary

The theme of this section, *Crossing boundaries*, incorporated a discussion of various cultural pressures that create roadblocks to a smooth transition experience for NGNs en route to becoming registered nurses. The subthemes in this section examined how traditional beliefs, particularly gender norms, act both independently and together to constrain NGNs' autonomy at work. Moreover, it explained how efforts to ignore cultural standards concerning gender segregation and work hours for women sometimes backfires, as families intervene to demand that the hospital administrators make changes to their daughters' ward assignments or schedules.

A lack of public transportation, and, at the time of this fieldwork, the regulations against women driving, meant that the NGNs were dependent on private or family drivers, or male relatives, to get to work. The NGNs interviewed reported that these transportation sources were not always reliable, causing delays for the participants, and resulting in punitive salary reductions. Moreover, the transportation barriers that kept the NGNs from punctual arrival at work placed a burden of extra work on the nurses on the preceding shift, who were required to stay past the end of their working day to cover for their detained colleagues. Finally, the cultural divisions between Saudi and foreign nurses was reported to promote a negative, competitive environment that strengthened the foreign nurses' advantages in clinical skills, and hindered the NGNs' learning and development during their transition experience.

The next section explores the theme of *Left behind*, which develops many of the issues raised in the previous sections of this chapter, but includes a broader focus that explores a wide spectrum of interpersonal relations among hospital staff, patients, and relatives,

together with their impact on NGNs' transition experience, a process that frequently culminates in the nurses' desire to leave nursing entirely.

5.4 Theme 3. Left behind: "No one supports or helps us"

In SA, nursing has historically been perceived as a low status occupation, and even today, the stigma associated with nursing remains profound (Miller-Rosser, Chapman and Francis, 2006). Cultural barriers to nursing, particularly for women, dissuade many Saudis from entering the profession, and despite government efforts to recruit Saudi nationals (Al-Omar, 2004; Tumulty, 2001), the country continues to rely on foreign nurses to staff its hospitals. These topics were introduced under this chapter's first theme, and explored in greater depth under the second theme. This section elaborates further on these issues, in order to discuss the role they played in shaping the relationships of this study's participants with other hospital personnel, exploring how the perceived low position of NGNs in the hospital hierarchy contributed to significant communication problems, misunderstandings, resentment, and lack of confidence among the participants.

This section is divided into six subthemes. The first, *Teamwork among nursing colleagues*, focuses on communication problems, and the lack of cooperation between NGNs and more experienced nurses, which the HNs in this study tended to attribute to the NGNs. The second subtheme, *The Impact of Heavy Workloads*, explores how heavy workloads, often resulting from limited teamwork among the hospital's staff, affected the interactions with other nurses and patients, and resulted in a tense work environment that promoted verbal disagreements. The next subtheme, *Missing preceptor support*, continues the examination of how poor teamwork affected the NGNs' performance, particularly the impact of insufficient preceptorship, instruction, and feedback from experienced staff regarding opportunities to learn and grow professionally during the transition period. The fourth subtheme, *Doctor-nurse communication*, examines power dynamics between the doctors and nurses, together with their negative impact on the NGNs' transition experience. The fifth subtheme, *NGN-patient communication*, develops the issues of authority and autonomy by analysing how disrespect and distrust defined the nurse-patient relationship for the study participants, and the final subtheme, *Intention to leave*, explores the ultimate outcome of imbalanced co-worker and patient relationships: the desire to leave clinical nursing.

5.4.1 Teamwork among nursing colleagues: Welcome to the jungle

The participants in this study frequently voiced concerns about the hospital's lack of collegiality, particularly between the NGNs and other nurses. They shared the fact that they felt side-lined by the other healthcare team members, and that, rather than being part of a greater whole, they often worked alone to provide patient care. As Hapa stated:

I used to think that nurses collaborated, and nursing was a piece of cake, but it is not like that; you have to depend on yourself, as everyone is busy, they have a lot of work to do. (Hapa)

Rashda agreed with Hapa's assessment:

Once, a doctor wrote down a treatment, but it was unclear. When I asked about the treatment, no one could read it to me. When patients need something, I cannot find anyone to ask for help. In addition, if I do not know something related to a treatment, no one will help me. I feel I am really lost. (Rashda)

Sma also complained about the lack of cooperation among her nursing colleagues, noting that it often resulted in feelings of helplessness that affected her general well-being:

Unfortunately, no one supports us or helps us, and if there is no collaboration, the work cannot be carried out. For example, when you get tired, who will support you? There will be nobody to help you. This causes psychological and physical pressure, and prevents me from asking for help. (Sma)

The work environment was described by Shawa as 'a jungle', in which, she believed, NGNs would lack their colleagues' support until they had achieved more seniority:

There is no teamwork here. I blame the heads of department and senior nurses, because they should help the new nurses. Until you're independent and powerful here, everyone works for himself; I feel like I'm working in a jungle. (Shawa)

During my internship, I suffered from physiological symptoms arising from similar workplace tension. I often experienced severe headaches, and on one occasion, the headache was so extreme that I was unable to transfer a patient to the dialysis department, where I knew the crowds and noise would make it worse. When I asked my colleagues to help me transfer the patient, every one of them refused, arguing that they were busy with their own patients, even though there were few patients on the ward at

the time. I learned from this incident that help from fellow nurses was rare. As a result, I was very angry, especially because I was usually quick to assist other nurses. I remember visiting the nursing office (administration) to complain, but I received little empathy there, so I asked for permission to leave and go home. In response, one of the heads of the department, who did not believe that I was too tired to remain at work, insisted on taking me to the emergency department for a physical examination, in order to obtain evidence of my condition. Once we arrived, my vital signs and blood pressure were taken, and the results showed that I had low blood pressure, due to fatigue and exhaustion. At this point, she finally granted me sick leave, but the incident left its mark. Once home, I cried profusely, and remained anxious and angry with the way they handled my illness. Fortunately, I possessed resilience, and was able to persevere with work, but this is not always the case with new nurses.

During the fieldwork observations for this study, the NGNs were heard making several comments regarding poor communication from the heads of departments. For instance, one participant described the events that occurred with a department head during a morning shift. She started to describe the shift by saying that the head department on the morning shift, told them that she would be making a complaint about the afternoon shift nurses because one of them had left the hospital to buy some items from the market, which is not allowed She then asked the morning shift nurses about the incident, but they all denied that it had happened. However, the department head went ahead and filed a report with the hospital administration, and the administration subsequently requested the attendance of the nurses in question to investigate the complaint. The participant concerned expressed her anger about the way the department head handled the original complaint from the afternoon shift's HN, complaining that it was not dealt with fairly, and that the HN should have asked the other nurses their perspective before filing her report with the hospital administration. The participant also suggested that the event occurred because the HN did not like the nurses in question, explaining that she worked with them as a staff nurse, before she was assigned to her current position as head of the department. The participant believed that her replacement was appointed through nepotism, and not on merit, attributing the new HN's employment to 'wasta,' which is an Arabic term meaning nepotism or favouritism based on power and connections (Fawzi & Almarshed, 2013). While nepotism is technically against Saudi law,

in reality many positions are acquired this way in SA and other Middle Eastern countries.

Another example of poor communication between the HNs and NGNs was provided by Rashda, who attempted to speak with the director of nursing about a transfer to another hospital, but whose request was ignored:

… I applied for a transfer to a different hospital, but when I tried to introduce myself, they told me to get out the office. (Rashda)

In Rashda's opinion, her request was denied because the administration did not want her to consider leaving the hospital.

While most of the participants were unhappy with the support they received from their colleagues, some did experience successful multidisciplinary teamwork in certain wards. They credited this teamwork with making them feel more comfortable and assured about their work, noting that it also facilitated socialisation, and helped them to learn more about the workplace. The following comments made by Sma and Lila were typical:

At the hospital, the previous HN treated all the staff equally. She was the only one who gave me a chance to prove myself. (Sma)

Lots here support me, like the HN and other staff. I have not asked for help from the nursing office, but if I did so, they would certainly not refuse. (Lila)

However, the HNs interviewed did not necessarily agree with the NGNs' concerns regarding a lack of help on the wards. For example, one of the HNs suggested that the work environment was built on respect, appreciation, and cooperation:

They are respectful, cordial. They are also cooperative, and they have this, you know, professional relationship across the healthcare team. They have to have due respect at all times, because we are working here as a team, and we cannot work alone; we need the other healthcare providers to help us in completing our work. (HN)

Another HN blamed the NGNs for their predicament, claiming that perceptions of exclusion and unfair treatment were unfounded:

….This feeling of potential victimisation comes from the NGNs' heads …they should consider the challenges for NGNs to improve their self-confidence, and trust in themselves. (HN1)

She added that the NGNs lacked sufficient challenges to aid them in adjusting to their

new careers, and to boost their self-confidence and faith in their abilities.

Only one of the HNs recognised that the environment was challenging for the NGNs:

One of the obstacles faced by the NGNs is shyness, because they are new to the work environment, and they find it challenging to adapt to this environment when they are no longer students, and are independent nurses responsible for their own actions. (HN4)

According to Duchscher et al. (2008), poor relationships with colleagues, dependence on others for help, and a lack of support are the most commonly cited problems reported by NGNs during their initial 12 months in the job. The importance of nurturing cooperative and respectful relationships between NGNs and other nurses during the transition period was reported by the participants in the present study. For example, Rashda noted:

Collaboration with staff, good leadership, respect, and more instructions would make the transition to work as a new nurse easier. *(Rashda)*

However, instead of cooperation, most of the NGNs interviewed found themselves facing the transition-related challenges alone. Addressing these issues would greatly ease NGNs' transition into the professional work environment, thus contributing to an improved mood and morale in the working environment and increasing work efficiency.

As the next subtheme discusses, the stress and dissatisfaction reported by the NGNs was compounded by another facet of their transition experience: heavy workloads. The constant nature of the work caused tense relationships with their colleagues and patients, and not infrequently, flared tempers, and verbal sparring on the ward.

5.4.2 The Impact of Heavy Workloads

Several of the participants in this study commented that their heavy workloads resulted in a tension-riddled workplace, which affected everyone's mood. Moreover, a number of the participants discussed the fact that the workload of an average working day meant that they did not have sufficient time to tend to their patients. As a result, they were often unhappy about their inability to meet all of the patients' needs, which resulted in negative emotions. The majority of the participants recognised that numerous responsibilities decreased the amount of time they spent with patients, which occasionally resulted in the patients feeling stressed or upset, due to feeling ignored or

under-informed.

For example, Rashda explained that her heavy workload hindered her ability to respond to queries from patients:

The pressure of work makes me unable to deal with the patients, the other members of staff, or with the leaders. This is because of work pressures and the fact that I have to take on responsibilities that are beyond my ability. When I must deal with four critical cases at the end of a shift, there is no time to open a file for each. At the end of the shift, patients come and ask me about their conditions, but I tell them I don't know. I didn't have time to check because I was busy. When I finish with one or two patients, there will be things that I did not accomplish, and this makes the patients angry. To deal with such situations, I tell the patients that I did not leave them, I was just busy. (Rashda)

While the heavy workload and time pressure caused most of the NGNs frustration, one, Sma, expressed satisfaction with being able to juggle all her responsibilities successfully. She noted:

I enjoy working under pressure, as it challenges me to organise my time between work, patients, and medications. I see other staff who do not organise their time, and who cannot finish their work. Unlike them, I consider work pressure as something positive that can motivate me. (Sma)

Meanwhile, another participant, Lila, suggested that the standards of care were adversely impacted when the strain on the ward caused quarrels among the nurses:

I feel worried about the pressure of work. I work nervously, and I may raise my voice to one of the nurses without being conscious of doing so …and they may respond to me. That eventually leads to quarrels. (Llia)

During the fieldwork on the female wards for this study, these kinds of arguments were observed frequently. To most non-Saudis, this type of interaction would probably appear to be inappropriate; however, it was unremarkable, and not unexpected in a pressurised Saudi workplace, although the behaviour would be viewed as unprofessional in other countries, such as the UK, and be censured as a result.

According to Duchscher (2008), workload demands are one of the most commonly cited reasons for NGNs' difficulty transitioning to the hospital environment. However, the HNs

interviewed for the present study did not validate the NGN participants' opinion that they suffered from a demanding workload, arguing that the nurses' workloads were reasonable and responsive to staff capacity and patient needs:

The workload of the NGNs is very fair. They are not allowed to have more assignments until they finish their orientation, unless they are competent… The scheduling or the planning of the schedule is based on the needs of the patient, and the nurse/patient ratio. The HNs determine it, because they're familiar with the status or the situation in their area. It depends on the patient census, patient acuity, the procedures being done, and the scope of the area. (HN1)

When questioned about the inadequate number of nurses during shifts, the HN explained the policy for staff shortages:

We have a policy that if we lack staff, the nurse provider on duty is informed. Of course, it is the responsibility of the HNs to check the staffing, to ensure that there is proper coverage for all shifts, and we have the policy of on-call staff. In case there is a shortage, they will be recalled. First, the supervisor will be there to assist them. Maybe she has staff available on the other units who are cross-trained, or in this area who are competent cross-trained, and so qualified to work in this area. So, staffing shortages are managed based on the policies. (HN1)

Another HN stated that responsibilities were assigned according to the nurses' abilities:

First …it is based on competency, under evaluation. After that, the load that is given to them is fair, within their limit. They cannot do, for example, a charge duty, that is too much of a load. Or we cannot give them more patients, because there is a nurse-patient relationship here, and they are new, and only just getting familiar with the policies, the procedures. So, they are given a chance to adapt to the policies, the work environment, and everything else here. (HN3)

In contrast to the views expressed by the HNs, the fieldwork observation conducted or this study suggested that NGNs were responsible for the same number of patients as experienced nurses. For example, if five nurses were on duty in a ward of 30 patients, two of them would be NGNs. According to Hapa, there were many occasions on which nurses had to take on more patients, in order to meet the load:

Sometimes a nurse takes over 12 patients, because of the lack of nurses, and a large number of patients. (Hapa)

One HN was sensitive to the NGNs' grievances, and stressed that hiring more nurses was a high priority:

Hopefully in the future, somebody might see this. They must increase the number of staff, increase the encouragement of Saudis to take up nursing, especially in the medical field, because I have seen that the flow of patients is too much, and so you need nurses. You can see that you have to motivate the young, and that they have to go on nursing, because there are lots of patients waiting for care. (HN4)

Next subtheme addresses the absence of preceptor support, an oversight stemming from the lack of a specific and enforceable policy concerning preceptorship, a process that is part of the transition experience at many hospitals around the world.

5.4.3 Lack of preceptor support: "You have to face tough realities"

This subtheme highlights the importance of encouraging and assisting NGNs, together with creating respect and appreciation for them, in order to ease their transition. In order to do so, it focuses on another area in which the NGNs interviewed in this study reported that they lacked support: preceptors. In a hospital, a preceptor is understood to be any experienced nurse requested by the HN to help the NGNs, when necessary, during their first three months of placement. However, at the hospital in question, there was no formal process of assigning a guide or mentor to the new nurses to ease transition to a unit, as there is elsewhere. According to one participant, Sma, the preceptors, in this case the experienced nurses, spent just a few minutes with NGNs each day, which was not sufficient to offer support, feedback, or instruction:

I felt that we did not get enough attention. Over three months, we had a nurse as a preceptor, but she was not available all the time. She could only give you 10 minutes of her time, although I had hoped that she would be there all through the shift, especially at the beginning of our work. (Sma)

Like Sma, most of the participants felt that a preceptor should provide supervision throughout a shift, especially during the early stage of their clinical work. Other participants suggested that the support of a preceptor, who is an expert in the field, would help to facilitate the transition into clinical practice by improving new nurses' skills

and competency levels. The following comments from Rashda and Shawa were typical:

Collaboration, good leadership, respect, and more instruction from preceptors would make the transition to working as a nurse easier. Now, I feel that I am a student more than a nurse. Unfortunately, you have to face tough realities. *(Rashda)*

There should be a preceptor with the NGN when she is assigned to her place of work, in addition to training courses and programmes for each department, because they are different from just a general workshop, which is not of benefit. *(Shawa)*

At the hospital, the NGNs were offered a series of courses when they first arrived at their placement. However, these classes, such as general lectures on nursing ethics, provided little in the way of clinical instruction. As a result, the participants felt that it would have been a better use of time to provide courses that introduced them to their new departments, explained the role of the preceptors, and discussed topics directly related to their work.

However, while the NGNs were disappointed with the preceptor-NGN relationship, the HNs viewed the interactions as largely positive:

There is a good relationship. Yes, some of the NGNs have difficulties with not trusting themselves, and they are sometimes not confident. However, we have a good relationship with them if we start with them from the beginning, telling them you have to approach your preceptor. The preceptor takes the responsibility to approach [the NGN], asking if they have questions or doubts, any time they want. However, issues arise when the NGN does not have a good approach to their preceptor. (HN2)

Another HN expressed a similar opinion:

We will inform you [NGNs] of anything you're not clear about; you can ask the preceptors freely, and you don't have to be afraid of anything or anyone. But it is better to ask questions, or raise your doubts, so that we can improve your work, and then prevent any errors for our patients. *(HN1)*

Regardless of the HNs' claims, during the fieldwork observations, there was an apparent lack of support from the preceptors, and the NGNs were consistently observed working alone, without supervision, which made the fact that the HNs held the NGNs accountable for their unsatisfactory relationship with their preceptors perplexing. Only one HN had an

opinion that diverged from that of the others, as she noted that NGN-preceptor interactions were largely unsatisfying and uninformative:

There are so many negative factors in this relationship. It's maybe because of a lack of communication. Then there are some who feel disappointed, especially in their area of assignment. Sometimes, you will receive some complaint that the HN is not teaching them, the senior nurse [preceptor] is not teaching them. (HN4)

The uncertainty and insecurity expressed by the NGNs reflected those that I experienced, even as a preceptor. During that time, there were several nursing procedures that I did not know, or did not have sufficient training or experience in to supervise the students. There was, however, another preceptor who helped me in the position, which bolstered my self-confidence, and translated into better preceptorship of the students, and better application of my clinical skills.

As Duchscher (2008) highlighted in her work on transition stage theory, NGNs feel abandoned when they lack experienced nurses to guide them in unfamiliar, unexpected, or unpredictable situations. Moreover, other researchers also demonstrated that a lack of support from preceptors inhibits learning, and negatively impacts the transition experience (Azimian, Negarandeh and; Duchscher, 2008; Pleshkan, 2006; Thomes, 2003). Considering these insights, it is likely that the presence of highly skilled and accessible preceptors lowers the risk of medical error, and improves the speed and efficiency of new nurses' learning processes, ultimately creating an environment that encourages a productive transition experience.

The next subtheme explores the position of the nurses and doctors in the hierarchy of the hospital that was this study's focus. The study found that, in most cases, the doctors preferred to deal with the expert nurses, and did not spend time with the NGNs. In more extreme cases, they engaged in harsh treatment of the NGNs, creating feelings of resentment and powerlessness among the study participants.

5.4.4 Doctor-nurse communication: "They view me as an inferior"

Doctors are another group in a hospital who have a significant influence on nurses' transition experiences. According to the participants in this study, the doctors at their hospital sometimes demonstrated a lack of respect for the new nurses, appearing to

marginalise the NGNs, and preferring to interact with the experienced nurses. This negatively impacted the confidence of the new nurses. During the fieldwork, several barriers to the doctor-NGN relationship were observed, including the absence of a clear procedure regarding nurse-doctor communication regarding patient needs. For example, when patients required medication, or some other form of care, the NGNs sometimes found it difficult to locate or reach the doctors. As recent graduates, there were many skilled tasks that the NGNs could not perform without permission, or a signature from a doctor. For example, during the fieldwork, a participant was observed attempting to reach and update a physician on a patient's health, specifically regarding his history of hypertension, and the use of anti-hypertensive medication. Despite multiple attempts to discuss the matter, the participant was unable to contact the doctor, and became upset about the difficulty involved in trying to start a patient on medication, a relatively uncomplicated procedure. Throughout the period of fieldwork at the hospital, the impact of these communication gaps was apparent; it wasted a considerable amount of time, and left the participants feeling distressed and discouraged.

At times during the field-work observations, I felt anxious and concerned that patients who required urgent care would not have their treatment administered, since the doctor had not yet given permission for the NGN to proceed. While the hospital policy dictated that such situations, in which a patient's life was threatened, must be reported to the head of department, there was a need for a clearer mechanism for managing such emergency cases when the doctor is not in the department. Implementing such a system would secure patient safety more effectively, and save the NGNs valuable time and concern, ultimately creating a more positive transition experience.

The NGNs' difficulties calling or locating doctors were exacerbated when they did not know the doctors responsible for their patients. In addition, the participants complained that some of the doctors entered the patient requests onto the computer database at the end of their shift, thus delaying work for the NGNs. In fact, some of the NGNs reported that the nurses often preferred to complete the doctors' work for them, rather than waste time trying to locate them. As a result, the workloads tended to snowball, and the NGNs were forced to improvise to manage their workflow. The following observation occurred during one visit to the hospital:

We sat at reception for about five minutes, and the NGN tried to call the doctor to

tell him about the patient, who had been complaining of abdominal pain in the afternoon, and wanted to let the doctor know, but there was no response from the doctor. He had told the NGN her in a previous call that he would come to the ward at 4:30 pm, but he had still not arrived at 6:17 pm, and the participant was nervous and stressed. She reported this to the HN as I finished my observation. I do not know what happened later. (Observations)

Doctors also contributed to the participants' stress levels, due to their maltreatment of the NGNs. For example, they would often disregard the NGNs when working with them, depriving the participants of their time and encouragement. The doctors were also disinterested in helping the inexperienced NGNs, who had not yet mastered certain terminology or skills, in order to improve their competence by providing explanations or clarifications of a required procedure. Typically, when the doctors encountered the inexperienced NGNs, they asked that they were replaced with more experienced nurses. This rejection damaged the new nurses' confidence, and slowed their professional development during their transition experience. As Hapa noted:

I feel I am not used to working with doctors, especially in front of the patients, because they use many medical orders and expressions that are new to me, which makes me embarrassed, because I don't get what the doctor means. *(Hapa)*

In addition, Rashda explained why the doctors preferred to work with the more experienced nurses:

They are used to working with the experienced nurses, who are faster than me because of their experience in the department, and they can understand all the procedures, expressions, and analyses that the doctors ask for. But I am new here, and sometimes I need to ask the doctor what he means, so he raises his voice, asking the HN to teach me properly, and that happens in front of the patients, which makes me upset. Then he says, 'Didn't you study this and that?' but I don't reply; it's not reasonable that I should remember all of what I studied, and I am sure that even the doctor needed help when he started. *(Rashda)*

During the fieldwork, many incidents were observed that supported the NGNs' concerns about interacting with the doctors. For example, one day some of the doctors were heard

complaining about the presence of a new nurse for a number of reasons, including her lack of familiarity with particular blood tests ordered by a doctor. In this case, the doctor's response was to bypass the NGN altogether, and to ask the head of department to send an experienced nurse, rather than to take a few moments to explain the procedure.

Given the hospital's strict hierarchy, the head of the department usually sided with the doctor, apologising and sending a new nurse. This behaviour was clearly disempowering for the nurses, particularly when it occurred in the presence of patients and colleagues. It appeared that the HN was unaware of how her consistent support of the doctors undermined the confidence of the new nurses. One participant explained that when a certain doctor was on the ward, she would ask the head of the department to send an expert nurse, instead of her, as the doctor in question had a reputation for treating the NGNs' harshly; he was always impatient, raised his voice often, and rebuked them in front of their patients and colleagues.

Some of the nurses implied that the Saudi culture's association of nurses with servants also negatively affected the nurse-doctor relationship. As Rashda stated:

We had a doctor in the hospital who treated Saudi nurses badly, and considered them to be nothing. Although he was not a Saudi, he was familiar with our society. (NGN1 Rashda)

On the wards, it was not uncommon for doctors to treat the nurses as inferiors required to obey orders, even if there was no obvious reason for a specific action. For instance, one doctor asked a participant to repeat an electrocardiogram (ECG), even though the previous test produced normal results. When asked why he wished it to be repeated, he responded that there was no particular reason, other than that he thought the NGN should redo the test. In the interviews, the participants also explained that when under pressure from a heavy workload, the doctors would deflect their frustration onto the nurses. This demonstrated the power dynamics among the hospital staff, and the NGNs quickly recognised that, as nurses, they were unable to refuse a doctor's request, given their low status. As Mona explained:

In my opinion, nurses are low status within the hospital. Doctors are very high status, and they have a high self-esteem. Nurses are a bit different. Not everyone, but

many. It's about authority amongst the nurses; they don't have very much authority within the hospital. (Mona)

Sma and Hapa agreed with Mona's opinion:

Nurses are low in the hierarchy… In regard to doctors, they look at me as an inferior. (Sma)

Doctors are considered to be everything, and nurses are considered to be nothing. I noticed this during my internship, and became more sure of it once I was employed. (Hapa)

Hapa continued that the majority of people believe that nurses are merely the doctor's assistant, taking orders to complete their work, and never acting autonomously.

This dynamic was exemplified in an incident that occurred during the observation of one of the participants. The NGN in question was scolded by a doctor in the presence of her patient, because she brought a smaller medical gauze than was required. The doctor snatched the gauze from her as she tried to hand it to him. The participant subsequently remained silent throughout the procedure. When she returned to the reception desk, she was upset and reported the doctor's actions to her colleague. When asked about the incident, she said that it made her feel ashamed, particularly because she was being treated harshly in the presence of a patient, and it resulted in her subsequent silence because she was afraid of the doctor.

In addition, during the fieldwork observations, another participant reported feeling extremely frustrated with the way the new nurses were treated, blaming the doctors' dominance, which made doctors the final authority on patient-related matters.

The lack of a clear hospital policy recognising the NGNs' concerns, and allowing them to make a complaint against a doctor, was another issue that intensified the workplace pressures for the participants. In order to better understand these dynamics, the comment regarding the doctors' 'dominance' was explored further, and in an interview with HN1, she was asked about the interactions between the doctors and the NGNs. Her reply was as follows:

It is a challenge for them [the NGNs], in terms of how to deal with the other medical staff, and the other members of the workforce or healthcare team at the hospital.

(HN1)

She considered it to be the NGNs' responsibility to proactively discuss any problems with the physician, adding:

Some of the NGNs are very good with the others, like the doctors, they are open with them, they can ask questions. But again, there is hesitancy, because they are not yet familiar with the doctor, so they are hesitant about asking questions. Alternatively, they might have the impression that a particular doctor, or member of the medical staff, is strict. (HN1)

On every occasion, the HNs held the NGNs responsible for their communication difficulties with the doctors, and were indifferent to the idea that the doctors might make mistakes, or act inappropriately with the nurses, exhibiting a lack of awareness that the NGNs' poor working relationships with the doctors hindered their transition to competent staff nurses. For example, during one interview, an HN described an incident involving what she perceived to be an example of an NGN's inappropriate attitude and poor communication skills:

There is one time that I remember when one staff member actually complained to the doctor, 'If you're not going to come here, I will report you and your salary will be cut'. I think she just intended to inform the physician that he should do his work, but the delivery of the message is also important, right? Though the intention was good, how she delivered it was not acceptable, so the physician complained about her instead. If we ever receive such complaints, we need to provide counselling, so the nurse will not repeat the behaviour, and will be more aware of how she talks to others. *(HN3)*

This kind of disagreement between the NGNs and doctors may have been a result of the lack of clear protection or a protocol. According to the participants, on occasion, the nurses did raise their voice; however, in the majority of cases, it was the doctors who became verbally abusive with the NGNs, and other hospital staff. Another HN explained that it was a challenge for the NGNs to deal with the doctors, or other colleagues and members of the healthcare teams at the hospital:

The first challenge would be that they felt shy, because they are just adapting, adjusting, so the challenge is to start adjusting to the work environment with the people around you, and the system. And the new graduates are no longer students. (HN4)

Despite what they perceived to be their often demeaning relationships with the doctors, many of the NGNs believed that their role as nurses was the most important in terms of patient care; in their view, the other healthcare professionals could not function without them. As one participant stated, the doctors give the orders, but the nurses use their skills to apply the orders to the patient.

The doctor is worth nothing without the nurse. (Lila)

The disproportionate degree of power held by the doctors and the other staff in the hospital setting is also a topic of discussion in the extant transitions literature. For example, according to Duchscher (2012), the majority of NGNs feel that nurses are at the bottom of their hospital's hierarchy of authority. In order to address this imbalance, more should be done to correct the power differentials between doctors and nurses, which constitute a negative influence on the work environment, and on the transition experience. One way in which this issue might be addressed is for the nursing office to be reconstituted as a source of strength and support for the nurses, rather than simply as an entity that reinforces the doctors' authority over the nurses.

The next subtheme explores the dynamics between nurses and patients, which this study found are largely defined by conflicts around power and control. This push-and-pull affects the communication between NGNs and patients, undermines NGNs' patience and well-being, and occasionally threatens patient safety, as patients attempt to force the NGNs to perform behaviours that are not in their best interest.

5.4.5 NGN-patient communication

The nurse-patient relationship is the backbone of the nursing profession, and is based on mutual trust and respect. However, these qualities were found to be absent in many of the nurse-patient relationships at the hospital that was the focus of this study. This resulted in poor communication between the two parties that was reinforced by factors such as heavy workloads, time constraints, and patients' partiality to foreign nurses, as discussed previously.

During an interview, one participant explained that some patients expect the nurses to meet all of their needs quickly, even though the nurses have other priorities; this causes misunderstandings and, at times, arguments with the patients, as was witnessed during the fieldwork. In one instance, many patients were observed demanding that a single

nurse take care of them and respond to their questions, unaware that she also had other patients, and more urgent responsibilities. Moreover, during the fieldwork in the Emergency Department, a doctor was observed asking one of the participants to measure a patient's blood-sugar level at 12 pm, but the patient asked to change the timing and do it at 11 am instead. When the participant was unable to comply with the patient's request, because she was busy with patient files, the patient remained at the reception desk and repeated their demand. However, the participant continued to refuse, arguing that the patient's condition was stable. This resulted in the patient seeking the head of the department to request a new nurse, although the administration ultimately rejected the request.

Hospital visiting hours were found to be especially challenging for the NGNs. These were long timespans during which it was not uncommon for a patient to receive between 10 and 20 visitors, mainly family members. During the visiting times, the visitors constantly requested information, and confronted the nurses about the procedures being administered to the patients, such as laboratory tests or changes in intravenous fluid. The following is an excerpt from the notes taken during the observations in the paediatric ward:

Around 4:58 p.m. We were in reception, where a 10-year-old boy arrived and told us that his brother had taken off the IV cannula on his hand, which was now bleeding. The participant grabbed some cotton swabs and ran quickly to attend the patient. When we arrived, we found the IV cannula in place, and nothing had happened. The participant looked at the boy and asked why he had lied, as there was no blood. She told him this kind of thing is not a joke, and that the unnecessary alarm had scared her, and she looked at the boy angrily and raised her voice. The boy replied that the infusion was not working, and he knew if he told the truth no one would have come to attend to the problem, but by raising an alarm, he ensured that someone would come to solve this problem. The participant looked at him and told him that there are other patients to see, that she was busy, and that this was not an urgent issue, so there was no need to lie. The participant addressed the problem, and it was clear from her response and voice when speaking to the boy that she was angry. We returned to reception, where the participant was still angry about this case, and said it is not acceptable that the child had lied.

As noted under the first theme, many Saudis lack a basic understanding of what nursing

entails. For example, they are unaware of the full range of nurses' responsibilities, believing that attending to patient demands is the nurse's only task. As a result, patients are often impatient when their requests are not immediately acknowledged, and sometimes, the nurses receive a flurry of requests within a short period of time, which creates an unpleasant and stressful environment.

A number of other factors also adversely affect the nurse-patient relationship. For example, many of the participants complained that they were burdened by requests for medical information from patients and their family members, even though they did not possess the qualifications to provide a meaningful answer. They explained that having to define their role to patients was stressful, and left them feeling anxious and overstretched. In addition, the NGNs were aware that if they provided an incorrect response to a medical question, they could be held responsible for any negative outcome in the patient's status, or in the relationship between the NGN and the patient. These situations were observed frequently, especially in the Emergency Department, a hectic department in which there was no time to argue over non-essential matters. The following example taken from the observation notes is illustrative of this situation:

When we were talking, four patients approached the participant to ask about some blood test results, and every time she replied that she needed more time. One set of blood test results did appear, and she told the family that she would call the doctor to examine the results, and discuss the results with them. She went to tell the doctor about the results, but she could not find a doctor, and so she then informed the patient that she would have to wait. The patient asked about the results, and she [the participant] replied that she was not allowed to discuss them with him, and that the doctor had to talk to him about them. (Observation)

While it was not possible to record the patient's response, this extract exemplifies the communication issues that the nurses faced at the hospital, where they were frequently bombarded with questions and demands during their time on the wards. Indeed, another such incident occurred when a patient asked Shawa to change her bed, a job that did not fall under Shawa's remit.

There was a stubborn patient. I took her to a spare room, and I had prepared the bed before I took her to bed, but she rejected it and wanted to change it. The bed she wanted had been allocated to another patient, and her face went red with anger and she

called her family over. Her big brother came and shouted at me, I tried to make him understand how the placement and numbers of beds are important, and are related to patient priority, but he didn't understand, and the problem escalated until they called the nursing director. It took a lot of time and effort, and was physically exhausting, especially for me as a new nurse, because I didn't know what I should do. (Shawa)

This type of incident is disruptive and inconvenient for other patients on the ward, but more importantly, switching a patient's bed can be a serious safety concern, since it could result in misidentifying the patient, and administering the incorrect medicine. While there was no hospital policy in place to prevent these events from occurring, even when there are established protocols, NGNs risk making mistakes.

As previously noted, the participants in this study reported that many patients preferred to receive care from foreign nurses, rather than Saudi staff members. This was due to several reasons, including the perception that foreign nurses are more responsive to patients' requests, including those unrelated to nursing. In addition, the foreign nurses were perceived as more efficient workers than the Saudi nationals. These factors worsened the already difficult dynamics between the Saudi NGNs and their patients. As an HN explained:

In terms of the relationship with the patient, yeah, there is a difficulty in communicating with them. As an example, in an area like the dialysis unit, a patient comes into the unit every other day. They prefer the senior international staff, the more experienced staff, to prick them, to insert the cannula. In addition, they think that Saudi nurses are not as efficient, or as good as the others. You cannot change the culture of people here. In general, they will always look for other nationalities, because they have heard stories of Saudis and how they work. Their preference will always be Filipinos, because Filipinos are more attentive. They are more caring. That is what I have been hearing from patients. (HN1)

However, while many negative aspects of the relationship between the patients and Saudi nurses were reported, this relationship was not always untrusting. In fact, many of the participants mentioned that conversing with the patients, rather than simply focusing on their functional responsibilities, positively affected their interactions in general. They noted that the more time they allocated to the patients, the more the patients viewed them as knowledgeable and trustworthy. As Noor observed:

When the shift has fewer patients, I can communicate with individuals and talk to them, and I see that this pleases them a lot, and improves my relationship with them. (Noor)

The communication between the NGNs and the patients was affected by many factors, including work-based pressures, and the patients' confusion about the purpose of nursing. In addition, the patients' preference for foreign nurses harmed the interactions between the patients and the NGNs, and undermined the NGNs' confidence and transition into practice. While the Saudi nurses shared a common language with the patients, this did not typically forge good relations between the two, since many foreign nurses also speak Arabic.

To date, this chapter has presented the range of barriers to nursing discussed by the participants in their interviews, and in conversations during the fieldwork. As noted previously, these obstacles can contribute to NGNs' dissatisfaction with nursing, and can ultimately induce some to choose another occupation entirely. The next subtheme discusses this issue in more detail.

5.4.6 Intention to leave: "The work, for me, is like a prison"

The multiple pressures of hospital nursing was found to impact on the NGNs' mental well-being, and to destabilise their personal and professional lives. The constant worry, coupled with long hours and heavy workloads, isolated many from their friends and family, and prevented them from a achieving a balanced, rewarding work- and home-life. These hardships, which defined the transition period, meant that many of the NGNs involved in this study became disillusioned with nursing as a career. As Shawa noted at the end of her interview:

I used to work to fulfil a dream, but now I'm working for the salary… The work, for me, is like a prison. (Shawa)

During the course of discussions with the participants, and with other NGNs on the wards at the hospital that was the focus of this study, many revealed that they intended to transfer to another department, or to leave the profession entirely. The NGNs mainly blamed the hospital's management for their dissatisfaction, citing a management style that left them feeling voiceless and disconnected from the decision making processes. They also criticised the administrators for their lack of support and recognition. Overall,

the participants believed that the nursing profession in SA remains undervalued by society, and within the healthcare profession itself, and that these views contributed significantly to their decision to leave the profession. As Rashda noted:

This will affect my choice to continue as a nurse, or to change my profession. I may move to work in another department with more respect and less of a workload. The social view of the low status of nursing is very important, and it is affecting my choice to continue as a nurse. *(Rashda)*

Rashda's comments resonated with my nursing experience, as I realised during my training period that the profession was not respected or appreciated by the community. This belief was the key reason behind my wish to work at a university, rather than to become a practicing nurse.

Another participant, Mona, stated that an important factor behind her desire to leave nursing was the lack of support and guidance for new nurses. She argued that supervision by experienced nurses would have made her feel more confident about working with patients, and less fearful about making mistakes. As she remarked:

Support and guidance are important factors in the desire of the employee to stay and develop himself, but I have not had that. I feel that I am lost, and I am always stressed and worried. I think a lot about changing my workplace and moving to a different job where there is cooperation between [the members of the team. (Mona)

In addition, Sma shared that she wished to move to an administrative position, in order that she could help to improve the status of nursing in SA, but that before doing this, she needed to gain work experience to develop herself professionally:

hope to occupy an administrative position, which I will use to improve the nursing system. Before this, however, I hope to learn a lot, which will help me bring about change. (Sma)

It can be argued that the extent of the dissatisfaction and alienation among the NGNs is alarming in a career that is the foundation of quality healthcare. In order to address this problem, the Saudi healthcare industry should actively pursue policies to support new nurses. These efforts should include fostering a cooperative and respectful culture that is committed to engaged learning for NGNs in their initial weeks and months at work. Such actions would improve retention rates, and eventually encourage more young women,

who are enthusiastic about working in the field, to become nurses.

5.5 Summary

This chapter explored the three separate themes that emerged from the interviews and field research conducted for this study, each of which related to the NGN transition experience in the first 12 months of entry into permanent hospital positions. The first theme explored the difficulties that NGNs face as they begin their nursing careers in SA. The second theme addressed the wider social and cultural factors that challenge women in nursing, and circumscribe their role. Meanwhile, the final theme investigated the interpersonal dynamics in the hospital workplace, together with their impact on NGNs' relationships with their patients and superiors.

CHAPTER SIX: DISCUSSION

6.1 Introduction

In this chapter, I critically discuss the main themes and subthemes explored in the findings chapter. To that end, I have situated these themes within the existing literature to provide context for the Saudi NGN transition experience. This approach allows for greater analysis of the findings, connecting those findings with prior and pertinent research and generating suggestions to improve the transition process. Unfortunately, due to the lack of professional standards/code of practice for the nursing profession in SA, it was not possible to compare the study's findings against these types of guidelines.

The titles for the main themes are as follows: difficult beginnings, crossing boundaries and left behind. Through each theme, I examine the major impediments NGNs face when they transition to nursing, and I pay close attention to the personal, socio-cultural and structural forces influencing this process.

Having established the foundation for this chapter's analysis, I now present the first category: Difficult beginnings.

6.2 Difficult Beginnings

Through this theme, I consider the reasons why participants decided to study nursing and how the intention to study nursing informed their transition experience. As in the findings chapter, here I explore how parental and academic pressure influences the decision to become a nurse. Through this theme, I also focus on NGNs' initial exposure to hospital work, a period when NGNs must grapple with the pressures of their new environment while meeting prescribed milestones. Among the many difficulties that surface during this phase are the following: reality shock, inadequate preparation for clinical practice, emotional distress and negative interactions with patients who treat NGNs as inferiors akin to domestic servants. How NGNs manage these difficulties affects their evolving identities as nurses and their long-term commitment to the field (Laschinger, Finegan, Shamian & Wilk, 2001). During this discussion, I draw on relevant transition theory and empirical work to provide a critical analysis of the study's findings,

and I offer evidence-based suggestions to improve the transition period.

6.2.1 Decision Making

This study's findings indicate that for most NGNs, nursing was not a career of choice.

Instead, participants were compelled to study nursing for two main reasons: their parents' influence and poor grades. Within Saudi culture, parents exert significant control over their children's academic pursuits, particularly as those pursuits relate to future careers, and children typically comply with their parents' wishes. In addition, the decision to become a nurse is often based on poor academic performance in high school, which bars students from studying other health sciences fields with more stringent entry requirements. In the current study, only one participant, Sma, was inspired to become a nurse on her own, having watched American television dramas and becoming fascinated with the profession. Conversely, the other participants expressed regret and disappointment ('bad luck') that they had been unable to pursue preferred career choice.

Overall, this study's findings confirm results from previous research showing that Saudi nurses/NGNs begin university with little motivation to study nursing (Alamri, Rasheed & Alfawzan, 2006; Al-Omar, 2004). These results also support studies that found limited interest in the profession among Saudi high school or college students (Alamri et al., 2006; Al-Omar, 2004; Hayes et al., 2006; Jackson & Gary, 1991; Tumulty, 2001). For example, in a 1991 survey of high school and university students, Jackson and Gary ranked nursing last as a suitable occupation for women. Reasons for this low ranking included the type of work, insufficient salaries and long working hours (Tumulty, 2001).

Almost 15 years after Jackson and Gary's (1991) study, research on high school students in Riyadh found that just 5.2% of 479 study participants were interested in becoming a nurse (Al-Omar, 2004). Similarly, a literature review focusing on undergraduate perceptions of nursing documented that few Saudi secondary school students intended to pursue a nursing career (Hayes et al., 2006). Personal and cultural factors determined disinterest in nursing, including nursing's negative reputation in Saudi society, cultural and community perceptions of nursing, long working hours, mixed-gender work environments and poor working conditions, e.g. night shifts (Hayes et al., 2006).

Research from Western countries suggests that many nurses in those cultures also

choose to study nursing because of poor grades (Cohen et al., 2004; Lai et al., 2006). Moreover, students with higher grades, particularly women, tend to reject nursing in favour of other fields (Cohen et al., 2004; Dockery and Barns, 2005). Common reasons for disinterest in nursing included low salaries, lack of respect and physically challenging work (Brodie et al., 2004; Cohen et al., 2004; Hallam, 2002; Tseng, Wang & Weng, 2013). Furthermore, studies from non-Western nations significantly overlap with the Western literature on students' interest in nursing. These studies indicate that reluctance to pursue nursing is related to perceptions of nursing as a physically demanding job (Al-Kandari & Lew, 2005), an underpaid profession (Liaw et al., 2016) and a field associated with poor academic ability (Liaw et al., 2016; Neilson & McNally, 2013).

Researchers have also identified motivators for studying nursing in Western and non-Western countries. Across cultures, a key reason for choosing a career in nursing is altruism, specifically the desire to help and care for others (Buerhaus, Donelan, Norman & Dittus, 2005; Dombeck, 2003; Halperin & Mashiach-Eizenberg, 2013; Law & Arthur, 2003; MacIntosh, 2003; Mimura et al., 2009; Neilson & McNally, 2012). An example of this phenomenon from the current study involves the participant Sma, who purposefully entered the profession to provide patient care and found satisfaction in this endeavour as an NGN: 'When I help a patient and alleviate his pain, I thank God that I'm here to help him.'

Some studies have pointed to the role of cultural systems in influencing the decision to pursue nursing. For example, while Western students are more likely to choose careers based on their own interests or decisions (in keeping with more individualistic cultures), Asian students are more likely to make decisions based on their parents' expectations (Oettingen & Zosuls, 2006). The effect of social attitudes on students' intent to pursue nursing was explored in a recent qualitative study on Singaporean health care students (Liew et al., 2016). This research highlighted several (negative) social influences on the decision to study nursing, including gender roles (specifically perceptions of nursing as 'women's work'), the poor image of nursing in Singaporean society and parental objections to entering the field. These findings overlap considerably with the themes of this study and suggest that there may be interesting parallels in attitudes towards nursing among more traditional cultures, even when they are geographically and socially distinct.

Cross-cultural research also underscores the benefit of structural approaches to addressing the lack of interest in nursing and negative images of the profession. For instance, in a Kuwaiti study on attitudes towards nursing among female high school students, 19% of participants stated that they would consider nursing as a future occupation (Al-Kandari & Lew, 2005). This percentage is significantly higher than in Saudi Arabian surveys and is largely due to the Kuwaiti government's policy of paying citizens $1,000 to $1,500 a month to attract and retain them in the nursing profession (Al-Kandari & Lew, 2005).

Altogether, this study's NGNs studied nursing for several of the reasons identified in the international literature, including parental pressure, poor academic performance and perceptions of nursing as less rigorous than other fields. To the extent that cultural forces, e.g. negative views of nursing, influence nursing in Saudi Arabia, many of these forces are in place even before young women and men enter nursing school, and these forces subsequently shape the transition process in powerful ways.

Newton et al. (2009) suggested that a relationship exists between the intent to become a nurse and the motivation to work in the field. While they did not develop this proposition in their study, it offers an interesting point of departure when framing the relationship between participants' original reasons for studying nursing and their experiences as their careers progress.

For example, Sma shared her views on the transition experience, as had the other participants, but she stood out for one reason: she was still passionate about nursing. While most of the others were disappointed with their jobs or regretted their nursing studies, Sma was adamant about the importance and meaning of her work, and while other participants were thinking of leaving nursing or transferring to another department, Sma intended to stay in her current position. Moreover, she hoped to one day occupy an administrative position, where she planned to use her role to improve the nursing system. This commitment to the profession reflects the positive nature of Sma's transition process. While her story alone is not proof of a meaningful relationship between intent and motivation, her experience, contrasted with that of other NGNs, is notable and suggests that this is a potentially rich area for future Saudi nursing research. Sma's story also underscores the need to present nursing as a more attractive occupation

by changing culturally based preconceptions about the field.

6.2.2 Role Ambiguity

My research supports prior studies suggesting that new nurses are largely unprepared for their responsibilities as professional nurses, resulting in role ambiguity. This mismatch between the idealised notions of new graduates and the actual culture of nursing leads to a period of shock, which has been labelled 'reality shock' (Kramer, 1974) and 'transition shock' (Duchscher, 2008) in nursing literature. This shock phase follows an early 'honeymoon' period (Schmaleberg & Kramer, 1976), and as reality shock sets in, bewilderment, loss, doubt and confusion soon develop due to misapprehensions about the nature of nurses' daily tasks and inadequate clinical training for the job (Clark & Holmes, 2007; Duchscher, 2008; Kramer, 1974; Oermann & Garvin, 2002; O'Shea & Kelly, 2007; Rochester & Kilstoff, 2004; Ross & Clifford, 2002).

Like NGNs in other settings, participants in the present study were surprised to find that their daily responsibilities did not match their original expectations about professional nursing. For example, participants were taken aback by the division of labour among the hospital staff, which was not as neatly delineated as they had been taught to expect. Rather than focusing solely on bedside patient care, for instance, participants found themselves taking on tasks ascribed to other health care workers, such as: sending blood samples to the laboratory; securing wheelchairs; collecting pharmacy medication; shopping for patients' families; gathering staff from other departments; taking patients for X-rays; and accompanying patients to the dialysis unit. Participants viewed these jobs as menial, and as time went on, their resentment at being asked to perform them grew.

The NGN's surprise at these unexpected tasks can be further understood by applying Van Gennep's (1960) "rites of passage." An anthropologist, Van Gennep, studied transitional rituals ("rites of passage") across cultures, observing that they were typically composed of three successive stages: separation (when the individual or group is removed from a previous state); transition (a liminal phase); and incorporation (marked by integration into a new state). In particular, Van Gennep's schema have influenced significant NGN transitions theories (e.g. Duchscher, 2008), and have been used to identify rituals that mark the socialisation process (Barton, 2007; Cantrell & Browne, 2006; Draper et al., 2009; Holland, 1999; Nash et al., 2009; Tradewell, 1996). This process ends with the

adoption of a firm identity and commitment to nursing (Tradewell, 1996).

The liminal period in Van Gennep's framework – which coincides with reality and transition shock - occurs when a nurse has separated from his/her previous student role, but has not yet assumed the nursing role. Due to its transitory state, "the attributes of liminality… are necessarily ambiguous" (Turner, 1969); this uncertainty is reflected in the role ambiguity experienced by NGNs' when they are tasked with "menial" jobs contrary to their expectations. While successful socialisation means that new nurses will eventually leave this liminal period to enter the incorporation state, negative feelings – such as marginalisation or disillusionment– threaten to derail this journey, particularly in the Saudi hospital environment, which lacks incentives and structures to ameliorate job dissatisfaction. The lack of a code of practice for nursing, as discussed previously, may also contribute to the lack of clarity concerning job assignments for NGNs

According to Schmalenberg and Kramer (1976), the reality shock phase comprises four main features: moral outrage, rejection, fatigue and perceptual distortion. Moral outrage involves a reaction to the new work environment's values, which clash with nursing school ideals. It also reflects NGNs' anger at the injustice of having been put in such an awkward position in the first place.

With new nurses in this study, moral outrage compounded under the ill-defined scope of nursing in Saudi Arabia, which hinders role legitimacy (Aldossary, 2013). As described by Machin and Stevenson (1997), role legitimacy involves recognition of formalised guidelines and defined areas of practice by high-level, authoritative bodies, thus conveying stature to a profession. Non-formalised role legitimacy includes 'greyer' areas of practice, typically at the community or occupational level, as different groups negotiate to determine where practice boundaries are drawn. Role legitimacy also extends to groups outside particular disciplines, including the public, who help define the field's roles and their meaning. With NGNs in the present study, lack of clarity in their daily work and social perceptions of nursing undermined role legitimacy. Ultimately, a lack of role legitimacy impacted NGNs' personal and professional lives, affecting self-perception, potential nursing identities and relations with colleagues, superiors and family members.

In transition theory, as expressed by Schmalenberg and Kramer (1976) and Duchscher

(2008), the shock phase is a temporary stop along a continuum towards full socialisation into professional nursing. Within Schmalenberg and Kramer (1976) model, for example, NGNs typically push through reality shock to the recovery phase and eventually arrive at the resolution phase, where they realise a nursing identity. These models largely rest on the assumption that the transition process is sealed off from external pressures and takes place entirely within the hospital culture, ignoring socio-cultural factors impacting the process. Additionally, for many of the NGNs in this study, role conflict (Keller, 1975; Rizzo, House & Lirtzman, 1970) was prolonged or unresolved, complicating what is presented as a linear model of professional socialisation in the literature. These oversights suggest that to understand the transition process more completely, the experiences of NGNs in non-Western cultures (such as those discussed in this thesis) should be integrated into existing explanatory models.

On a practical level, research indicates that satisfaction with the transition phase significantly affects intent to remain in nursing (Laschinger & Smith, 2013; Phillips, Esterman & Kenny, 2015). However, as a result of the factors described above (and others discussed in this chapter) the participants' initial response to nursing was largely disappointment, intensified by an original disinterest in the profession (Laschinger & Smith, 2013; Phillips et al., 2015). In the Saudi Arabian context, strong negativity at the start of the transition process warns of subsequent discontentment and possible intent to leave the profession altogether.

6.2.3 Limited Clinical Practice

This study's findings indicate that NGN participants felt unprepared for their first positions as nurses, particularly regarding clinical skills. In addition, NGNs often worried about their lack of clinical experience, whether taking blood or caring for patients in specialised wards, such as the paediatric unit. Placed in these positions, undertrained NGNs were anxious and afraid of making mistakes or harming patients.

This type of discomfort stems from what the nursing literature refers to as the 'theory–practice gap' (Greenwood, 2000b), which arises due to the disconnect between nursing education and the realities of clinical practice. In much of the nursing literature, the theory–practice gap is considered the principal cause of the reality shock phase of the transition period (Charnley, 1999; Duchscher, 2001; Evans, 2001; Heslop et al., 2001;

Kelly, 1996; 1998; Kilstoff & Rochester, 2004; Maben et al., 2006; Oermann & Garvin, 2002; Ross & Clifford, 2002). In this study, NGNs were forced to teach themselves how to perform unfamiliar tasks, usually by emulating senior nurses, most of whom had no time to assist or supervise the new nurses due to their own patient loads. At an emotional level, the NGNs' lack of clinical experience left them feeling incompetent and disoriented. Ultimately, they blamed their undergraduate education for failing to train them to meet the demands of their current job. Specifically, the NGNs pointed to a lack of clinical training or experiential learning during nursing programmes as the major cause of their theory–practice gap.

This perception is largely accurate. As discussed in the findings chapter, nursing courses in Saudi Arabia spend less time on clinical specialisation than comparable courses in other countries do, including the UK, where a competency-based curriculum emphasises experiential learning in addition to theoretical instruction (Nursing and Midwifery Council, 2019). Moreover, at the beginning of their formal education, U.K. nursing students engage in a period of supervised clinical practice to prepare for their futures as registered nurses (Ousey, 2011; UKCC, 1999). Conversely, Saudi nursing students begin clinical practice much later in the educational process and are engaged in clinical rotations for a shorter duration (Al Mutair, 2015).

There are several explanations why Saudi Arabia's nursing curriculum overlooks clinical practice. First, compared to the West, formalised nursing education in Saudi Arabia is recent, beginning in 1960 and developing rapidly throughout the next several decades, particularly with the introduction of the Saudisation plan (Tumulty, 2001). This was followed by a major overhaul of the higher education system in 2006, establishing 18 new universities, each with schools of health science and/or nursing (MOHE, 2014). Current figures from the MOH suggest that there has been a slight uptick in the recruitment of Saudi students to nursing, but significant barriers remain (as this study explores).

Moreover, the Saudi nursing workforce still largely comprises foreign nurses, and Saudi-trained nurses (some of whom have studied abroad with government sponsorship) have only recently begun to move into leadership positions in the profession (Alboliteeh, Magarey & Wiechula, 2017; Almaki, Fitzgerald & Clark, 2011; Al-Yami, Galdas & Watson, 2018). Each of these factors – inchoate professionalisation, dependence on foreign nurses

and fewer Saudi nurses in administrative or educational roles – potentially puts less pressure on colleges and universities to adjust their nursing curriculums to meet the competency-based instruction currently implemented in the West.

6.2.4 Emotional Costs

This study's NGNs described a range of emotional reactions – doubt, uncertainty, fear and anxiety – to the demands of hospital work. This role strain (Hardy & Hardy, 1998) was brought on by stressors such as time constraints, unfamiliar clinical tasks and heavy patient loads (Scott, 2008), which tested the NGNs' ability to complete tasks during their shifts while providing satisfactory care. As novices (Benner, 1982), participants assigned to specialised wards found it especially difficult to manage their caseloads. Thus, they were fearful of making mistakes and harming patients based on limited knowledge and skills (Clark & Springer, 2012; Duchscher, 2001; Gerrish, 2000; Wangensteen et al., 2008), and this uncertainty eroded their confidence over time. For example, as noted in the findings chapter, NGNs went about their tasks with trepidation and great caution, especially tasks that challenged their skills, such as dressing wounds, assisting patients with cerebral palsy and administering medication to children.

Participants were surprised by how the transition process affected their energy, time and evolving professional identity. The emotional responses, such as worry and distress, NGNs encountering were impossible for the new nurses to leave behind at the end of their shifts. Instead they carried their concerns home with them, where possible errors obsessed them.

When I get home, I think about how they [the staff] left me alone with many responsibilities. I worry that I might have forgotten to give a patient his treatment, or to complete his file, or that perhaps I didn't do my job efficiently. Usually, I wait for the next day to get back and make sure that everything is okay. (Rashda)

Existing transition research lends support to the findings of this study, both in terms of the stressors associated with transition shock and the stressors' psychological and emotional consequences (Casey, Fink, Krugman & Probst, 2004; Duchscher, 2009; Kelly & Ahern, 2009; Lee et al., 2013). For example, Lavoie-Tremblay et al. (2008) argued that psycho-social dimensions of the workplace, e.g. jobs strain or decision latitude, as well as

heavy workloads, time restrictions and complexities of patient care can lead to psychological and cognitive problems for NGNs. For this study's participants, these challenges were especially burdensome, exacerbating a difficult transition process already underway due to ambivalence about their career choice and concerns about their inadequate undergraduate preparation for nursing.

Beyond the pressures, worries and exhaustion brought on by role strain, the NGNs found themselves working alone, without assistance or guidance, a situation at odds with their undergraduate experience, when an instructor routinely supervised them. In addition, head nurses were generally unresponsive to the participants' complaints, claiming in their interviews that working relationships in the wards were collegial, helpful and respectful. The head nurses' main grievance involved the need to take on more work when collaborating with NGNS, leaving the former disgruntled about the extra burden. This attitude added to the difficulties of the participants' transition process and threatened to derail it. These issues are explored in greater detail in the third section of this chapter, which focuses on communication and relationships.

Within the nursing literature, high stress levels during the transition process have been shown to contribute to high turnover rates during the first year of practice (Casey et al., 2004; Duchscher, 2009). Burnout and psychological distress from cumbersome workloads, time pressures and role ambiguity or role conflicts are also associated with high attrition rates (Barnett & Brennan, 1995; Bowles & Candela, 2005; Gould & Fontenla, 2006; Jasper, 1996; Karasek, 1979; Scott et al., 2008). Placed within the context of these findings, the participants' profound emotional difficulties help to explain the high attrition rate among nurses in Saudi Arabia.

6.2.5 Role Minimisation

Participants in the present study experienced troubled relationships with patients and their families. One of the most difficult issues for the NGNs was dealing with persistent patient demands that were well outside the scope of nursing. As reported in the findings chapter, nurses were routinely asked to perform extraneous chores for patients and their relatives, such as providing childcare during appointments, going supermarket shopping or ordering food from nearby restaurants. This treatment angered and hurt the study's participants while further complicating role ambiguity and creating disillusionment with

their nursing career.

Participants blamed this treatment on Saudi society's negative perception of nursing and public misunderstandings about the responsibilities of nursing, which are viewed as basic and unskilled (Saied et al., 2016). As discussed previously in the first chapter of thesis, the poor image of nursing in Saudi Arabia is based on traditional norms (Almutairi & McCarthy, 2012; Gazzaz, 2009), including prohibitions against women working in the public sphere (Aboul-Enein, 2002). Historically, nurses were expected to provide very basic physical and emotional support for patients, reflecting their low social status (Tumulty, 2011). This conception of nursing as unskilled labour has endured so that, even today, nurses are equated with servants or maids (Alboliteeh, 2015; Al-Sad, 2007; Miller-Rosser, Chapman & Francis, 2006). As the current study demonstrates, this perception is easily translated into an assumption that NGNs should obey all orders, no matter how trivial the order may be, or risk wrath and condemnation.

These historical biases are strengthened through the association of nursing with foreign labour. In Saudi Arabia, and across other Arab Gulf states, little distinction is made between chores done by domestic workers and those performed by nurses, since both are recruited to the country in the same manner (Al Awaisi, 2012; Al-Kandari & Ajao, 1998; Alotaibi, 2008; Stevens & Walker, 1993). Because the majority of Saudis born between 1970 and 1990 were raised with domestic workers, the patients' behaviour likely triggered a reaction in the NGNs rooted in class dynamics. Aware of the association between nursing and maid's work (Al-Omar, 2004; Lamadah & Sayed, 2014; Mebrouk, 2008), the participants found it difficult to carry out what they perceived as humiliating tasks. Consequently, they felt embarrassed by their career, which was already a source of internal conflict for most, given their reluctance to enter the profession in the first place.

The nursing literature suggests that interpersonal relationships affect job satisfaction and retention rates (Wilson, Squires, Widger, Cranley & Tourangeau, 2008). Survey research conducted in developing countries, e.g. Pakistan and Lebanon, found a relationship between lack of respect and poor job satisfaction (Bahalkani et al., 2011; Kumar et al., 2013; Yaktin et al., 2003). Qualitative studies in countries such as Oman (Al Awaisi, 2012) and Pakistan (Hamid et al., 2013) indicate that lack of respect from patients is a prevalent concern tied to nurses' job dissatisfaction and a desire to leave the profession.

6.3 Crossing Boundaries

Saudi Arabia is a society in flux, as rapid socio-economic development coincides with longstanding conservative beliefs and values. For the study's NGN participants, who are young women in their 20s, this juxtaposition of the old with the new creates several challenges to nursing work. One of the greatest barriers to a successful transition process is gender dynamics. As discussed in the previous chapter, the social structure of gender in Saudi Arabia circumscribes the role of new nurses in unique and powerful ways. Patriarchal values, gender stereotypes and social and legal restrictions create barriers to full participation in the profession and perpetuate its low social status. To assert autonomy as a nurse, specifically an NGN, is to test the boundaries of normative female behaviour and to invite social and familial condemnation. It also involves negotiating the expectations of team members and patients while balancing broader social norms. The possibility of cultural transgression, and the constraints against it, exist in several spheres of nursing work: sex segregation, night shifts (and work–life balance) and transportation from/ to the hospital.

In NGNs' relationships with foreign nurses, cultural norms present challenges to creating a collegial work environment. The boundaries between the two sets of nurses result in marginalisation and exclusion for NGNs, with little opportunity to transcend these divides. The following sections explore these cultural boundaries and explain how they play out in different domains of hospital life.

6.3.1 Sex Segregation

My research indicates that attitudes towards male and female roles, particularly normative beliefs about sex segregation, influence the NGN transition process. Although Saudi society is experiencing rapid change, mixed-gender settings are still considered unacceptable in most circumstances, and this social disapproval extends to mixed-gender health care work (Alawi & Mujahid, 1982; Alboliteeh, 2017; Al-Johari, 2001; El-Sanabary, 1993; Gazzaz, 2009; Hamdi & Al-Hyder, 1995; Jackson & Gary, 1991; Meleis & Hasan, 1980; Miller-Ross et al. 2006). From childhood, boys and girls in Saudi Arabia are educated separately, and this segregation continues through college education, when male and female students attend separate classes with instructors of the same sex (Alqallaf, 2017; Alwedinani, 2016; Baki, 2004). Therefore, until NGNs begin their nursing

career, they have been kept apart from men who are not relatives, making their introduction to the mixed-gender hospital environment its own form of culture shock.

In the present study, NGNs reported ambivalent feelings about working alongside and treating men. Having accepted the culture's strict gender guidelines, some struggled to reconcile their exposure to mixed-gender environments with long-held ideas about interactions between men and women. At the same time, they wished that male patients would treat them with respect and recognise their skills. Several participants mentioned that despite their initial trepidation about working in a mixed-gender environment, the work turned out to be 'ordinary' and 'decent', as in other settings. Others observed that while they occasionally encountered criticism from relatives for interacting with men, they tried to ignore or dismiss these comments. However, several NGNs discussed how social disapproval of nursing may cause some NGNs to leave the profession, particularly since the demanding hours and working conditions are incompatible with marriage in a society where women remain solely responsible for domestic matters.

To date, research on gender in Saudi nursing has been scarce. In a study conducted on job satisfaction and working conditions at Saudi hospitals, El-Gilany and Al-Wehady (2001) found that most of the female nurses would not accept working with male patient. In qualitative work by Gazzaz (2009), female nurses reported struggling with social disapproval from family and friends who were concerned with work in a mixed-gender environment. Ten years after Gazzaz's study, the participants in the present study perceived their experiences in similar and, in some cases, distinct ways. For example, in their interviews, the NGNs frequently relayed that other Saudis viewed their career as 'bad' or 'impolite', and several of those other Saudis suggested that nursing was 'not suitable' for married women. These words imply that participants were aware that, as nurses, they were transgressing boundaries meant to uphold traditional ideas about gender roles.

Based on terms such as 'not suitable', the NGNs' remarks can be interpreted as proof that they have internalised the negative cultural meanings attached to nursing, although they never directly expressed this. Nevertheless, the participants' use of words such as 'decent' to refer to nursing arguably indicates that prevailing social attitudes have less traction than in the past. For example, the HN's story in the findings chapter has a

conventional beginning: an NGN's father demanded that the administration move his daughter out of a mixed-gender ICU unit. However, it also has an intriguing ending: without her father knowing, the NGN continued to work with male patients while being supported by her colleagues. To a degree, then, some NGNs in this study consciously resisted social norms, whether by dismissing social judgements meant to shame them or by directly defying constraints that disapproving family members placed on them. Moreover, the NGNs' need to negotiate familial/parental disapproval of mixed-gender environments is itself a powerful example of the tension between changing social attitudes and normative expectations for women, when in many cases, parents were responsible for encouraging their daughters to attend nursing school in the first place.

A final point is important to provide context for the issue of sex segregation. Unlike Saudi nurses, foreign nurses mix freely with patients of both sexes. As a result of these behaviours, foreign nurses are perceived as cultural outsiders within Saudi society (Almutairi & McCarthy, 2012), threatening the social organisation of gender in nursing (Mebrouk, 2008) within a health care system that relies on foreign nurses . Because foreign nurses are viewed as immodest (Miller-Rosser et al., 2006), this judgement is often extended to Saudi nurses (Almutairi & McCarthy, 2012), harming their reputation in the process.

For the participants in this study, social disapproval of nursing based on gender norms adds another negative dimension to the transition process. Managing external concerns about their profession is potentially exhausting and may add to doubts about their nursing career. Until social attitudes change, these issues remain as barriers to job satisfaction and full socialisation into professional nursing.

From a patient care perspective, there are advantages to easing hospital-based sex segregation. In particular, it could help improve communication between male and female nurses, who currently gather in separate staff rooms and recreational areas (Mebrouk, 2008). With the ability to share information about cases more easily, the quality of patient care would improve.

6.3.2 Shift Work

My research findings suggest that hospital shift work, specifically night shifts, is another

barrier to nursing and an issue that hinders the NGN transition process. Descriptions of negative socio-cultural attitudes towards night shifts occurred in most of the interviews. From a traditional viewpoint, shift work and work away from home in the evening tests proscriptions against women's involvement in the public domain (Miller-Rosser et al., 2009), especially during hours when women are expected to be at home with their families.

In their interviews, participants expressed frustration with the disconnect between the work demands, including night shifts, and their parents' expectations about women's roles. As with sex segregation, participants found this outlook restricting and resented its interference with their professional responsibilities. However, NGNs' usual recourse in these situations was to request a transfer to a different department that excluded evening and night shifts, an action that runs counter to the culture of nursing, in which shift hours are rotated to distribute their burden (West, Boughton & Byrnes, 2009).

This study's findings corroborate past research on the conflict between shift work and cultural norms in Saudi Arabia (Alotaibi, Paliadelis & Valenzuela, 2016; Felemban et al., 2014). Moreover, as in my research, Gazzaz (2009) found that Saudi nurses regularly contend with family objections to night shifts, caring for male patients, long hours and weekend work. Studies conducted in other more conservative, family-oriented cultures, such as Iran and Hong Kong, also indicate that staff nurses contend with negative images of nursing and family conflicts because of night shifts (Emani & Nasrabadi, 2007; Foong, 1999; Nasrabadi et al., 2009; Nickbakht, Nasrabadi & Emani, 2006; Yam & Rossiter, 2000). To date, the literature has largely ignored the role of socio-cultural forces on the NGN transition process, although some limited work does acknowledge that stress during this time is connected to personal relationships outside of work (Casey et al., 2004; Duchscher, 2008; Rydon et al., 2008). This study's findings add an important insight to understandings about the transition process and suggest that more cross-cultural work is needed.

NGNs in this study found shift work to be physically and emotionally draining, with significant effects on their personal lives, a finding consistent with the nursing literature on the transition process (Kapborg & Fischbein, 1998; Maben & Macleod Clark, 1998). For most, it was the first time that they had worked these hours, making the transition

experience especially gruelling.

Participants attributed their emotional stress and physical health issues, such as poor eating patterns and difficulty sleeping, to shift work. In addition, participants noted that the time demands of shift work and persistent thoughts about work negatively impacted their relationships with family and friends. Some NGNs also complained about loneliness since their work schedules kept them from attending to interpersonal matters.

Overall, these negative impacts correspond with international findings, showing that shift work has deleterious effects on physical, mental and social well-being for nurses throughout their careers (Chee et al., 2004; Fukuda et al., 1999; Geliebter et al., 2000; Hughes & Stone, 2004; & Zhao & Turner, 2008). The literature suggests that the emotional difficulties associated with shift work should be an expected part of the transition period, since NGNs are mourning the loss of the fixed academic schedule (Boswell et al., 2004). NGNs in this study also complained about a loss of freedom from responsibilities that defined life as a student.

Research indicates that a work–life balance encourages greater job satisfaction, commitment, productivity, retention and loyalty. For example, prior studies have shown that job turnover and absenteeism can be reduced when employees are satisfied with work conditions (Nabe-Nielsen, Sibly, Forchhammer, Forbes & Topping, 2010; Whittard & Burgess, 2007). Furthermore, Azeem and Akhtar (2014) found that conflict between work and personal life creates work-related stress among health care employees, and as Shanafelt et al. (2012) asserted, people who spend excessive amounts of time at work are at a higher risk of experiencing familial conflict and higher levels of burnout. Thus, given the obvious benefits to employees and organisations, it is in the best interest of management to introduce policies that support an effective work–life balance for NGNs, a recommendation that has already been advocated in the literature on the NGN transition process (Boswell et al., 2004; Halfer & Graft, 2006).

6.3.3 Transportation Dilemmas and Overflow Work

At the time of this study, Saudi women were not permitted to drive, and safe and reliable public transportation was not available. Consequently, NGNs were entirely dependent on family drivers or male relatives to get them to work, a dilemma that caused particular

difficulties for participants living in more remote villages. This constraint snowballed into significant work-related issues. For instance, late arrival to shifts resulted in punitive measures, such as reductions in wages, with no consideration of the barriers preventing punctuality. These findings corroborate existing research which has cited transportation as a major impediment to nursing in Saudi Arabia (Al-Rabiah, 1994; AlYami & Watson, 2001; El-Gilany & Al-Wehady, 2001; El-Sanabary, 2003; Lamadah & Sayed, 2014).

Transportation issues were also the catalyst for family conflicts, creating even more pressure for NGNs. Thus, many new nurses ask for day shifts to combine their job with family responsibilities (Tamim, Hejaili, Jamal, Al Shamsi & Al Sayyari, 2010). Almalki et al. (2012) suggested that many registered nurses prefer to work in administrative positions since this type of employment is more convenient and family friendly. Finally, women's ability to drive to work in other Arab and Muslim countries has been identified as a key determinant of job satisfaction (Felemban et al., 2014; Van Rooyen, Telford-Smith & Strümpher, 2010). Several participants in this study emphasised that their transition process would be made much easier if they had the ability to drive to work.

Transportation barriers also create what this study terms 'overflow work', which lengthens the time between shift changes. While long shifts are an issue for nurses in all countries, shift work and transportation barriers combine to produce an extra burden for Saudi NGNs. Overflow work develops as NGNs prolong their shift hours to wait for colleagues detained by transportation problems. The pressures associated with shift changes fueled additional frustrations among NGNs already disgruntled with work conditions. In particular, the extended shift hours increased NGNs' workload (e.g. paperwork, patient care, etc.), exacerbating existing emotional and physical fatigue and threatening work-life balance (Banakhar, 2017; Stimpfel et al., 2012). Moreover, research suggests that nurses who work shifts of 10 hours or longer are up to 2 ½ times more likely than nurses working short shifts to experience burnout and job dissatisfaction (Dall'Ora et al., 2015; Stimpfel et al., 2012). Specifically, within the Saudi Arabian context, where high levels of stress and negative work conditions routinely create tensions among nurses (as discussed previously), overflow work has the potential to compound the problem.

Overflow work also threatens to jeopardise patient care. Indeed, studies demonstrate that prolonged shift hours can harm patient safety by increasing nursing errors (Rogers et

al., 2004; Trinkoff et al., 2007; Stimpfel et al., 2013). In addition, the evidence suggests that extended shift hours lower patient satisfaction with quality of care (Stimpfel et al., 2012). However, beyond the potential negative impacts on NGN well-being, working conditions and patient safety, overflow work further complicates gender dynamics in nursing. As already noted, many Saudi (female) NGNs intentionally work during the day, in order to comply with gendered expectations regarding employment outside the home. Overflow work, which carries daytime shifts over into evening/night-time hours, risks provoking family objections and producing negative consequences for NGNs.

Foreign Nurses

In Saudi Arabia, foreign nurses comprise almost 50% of the profession's workforce (MOH, 2012) and come from over 40 countries worldwide (Aboul-Einen, 2002; Abu-Zinadeh, 2006; Marrone, 1999), creating a mix of religions, cultures, experiences and ethnic backgrounds among the country's nursing staff. This diversity complicates the transition process, and many NGNs struggle to fit into this unfamiliar environment. Ultimately, this struggle affects relationships with colleagues and patients, shaping the new nurses' professional identity.

While the government's investment in nursing programmes has increased since Saudisation, improving courses and lengthening the time to obtain a degree, distrust of Saudi nurses' skills remains among patients and wider Saudi society (Aboul-Enein, 2002; AlYami & Watson, 2014). The fact that foreign nurses are recruited at later stages in their careers, giving them more experience than many new Saudi nurses have, further separates the two sets of nurses. As participants shared in their interviews, negative comparisons between Saudi and foreign nurses in terms of capability and experience served to undermine their confidence and sense of self-efficacy (Bozionelos, 2009).

Participants also suggested that patients and their families preferred foreign nurses because they were seen as more pliable and responsive. As the findings chapter suggested, foreign nurses may be motivated to act more solicitously to maintain their jobs, which have favourable salaries and living conditions. Whatever the reason, this behaviour perpetuates negative perceptions of Saudi nurses.

Given differences in culture, language and skills, the hospital's nurses tended to self-segregate into groups of the same nationality. Because of this behaviour, participants expressed concern about the lack of collegiality between Saudi and foreign nurses, suggesting that they could not depend on foreign nurses to support them during their shifts. NGNs also felt that their marginalisation by foreign nurses kept them from opportunities to work on more engaging cases and to showcase their skills, engendering frustration among NGNs. In the transition literature, researchers have explored the effects of uncongenial and unsupportive work environments on NGNs, showing that experienced nurses' exclusionary behaviour results in irritation, depression and helplessness among NGNs (Bjerknes & Bjørk, 2012; Casey et al., 2004; Duchscher, 2009).

In this study, three of the four HNs interviewed were foreign nurses. While they did not express directly that Saudi NGNs failed to measure up to foreign nurses, they often discounted participants' feelings about heavy workloads, lack of support and disrespect by patients and staff. In this way, HNs shared similar attitudes with foreign nurses in a study conducted by Lovering (1996), who found that non-Saudi nurses tended to view Saudi nurses as spoiled or undependable because of their requests for day shifts, more flexible working hours or leaves to attend to family matters. Lovering, a former foreign director of nursing, also noted discriminatory hiring practices against Saudi nurses, especially in hospitals where non-Saudi administrators dominated management. However, with more Saudis assuming management roles over the more than 20 years since Lovering's work, hiring decisions may now be more equitable.

Within the NGN literature, unsatisfactory relationships with peer nurses are one of the reasons provided to explain high attrition rates among new nurses (MacKusick & Minick, 2010). When cultural stereotypes and biases confound these relationships, it is reasonable to assume that dissatisfaction with colleagues and/or intent to leave the profession increases. While none of this study's participants expressed intent to leave nursing based on their relationships with foreign nurses, issues related to foreign nurses have been documented in Saudi studies as a reason why nurses eventually exit the profession. For example, in a quantitative pilot study, Aldiabat et al. (2016) examined motivations to leave bedside nursing among 46 nurses: 83% rated 'society's perception of non-Saudi nurses as more skilled than Saudi nurses' as high or very high among their reasons for quitting their jobs. A significant number of respondents also reported that

they were motivated to abandon bedside nursing because of the disparity in salaries and benefits between Saudi and foreign nurses.

To date, there is limited research that explicitly explores the relationship between a host country and foreign nurses from the perspective of the local nursing staff. Alternatively, there is a much larger body of literature on mechanisms to empower foreign nurses. Due to this omission, this study presents an account that can hopefully enrich the existing literature and provide direction for future research in this area.

These studies suggest that one way to improve communication between Saudi and non-Saudi nurses might be to implement cultural competency programmes. The aim of these programmes is to increase awareness about the connection between culture and nursing in different contexts and to promote sensitivity to issues that arise in diverse workplaces (Johnstone, 2008). Such initiatives, initiated by management and educators (Johnstone, 2008; Leininger, 1991; Littlewood & Yousef, 2000), should begin during nursing courses and continue during orientation and throughout hospital employment. This type of curriculum and engagement may help to mitigate self-segregation and marginalisation, encouraging NGNs to overcome their feelings of inadequacy, thus improving quality care in Saudi hospitals and potentially improving the transition process for those newly hired at such medical facilities.

6.4 Left Behind

Positive interpersonal relationships with colleagues are critical to the transition process for NGNs (Chen et al., 2001; Delaney, 2003; Duchscher, 2008; 2009; Dyess & Sherman, 2009; Ross & Clifford, 2002). These bonds support a work environment into which new nurses must successfully integrate over time if they are to flourish in their new career. When these relationships are unconstructive or worse, damaging, it not only impairs the transition process but increases the chances that a new nurse will choose to leave the profession. To a significant extent, the hospital hierarchy shapes these relationships. At the end of a long chain of command, NGNs are susceptible to problematic behaviour from their superiors, whether it involves indifference, disregard or maltreatment. This can result in communication problems, mix-ups and disputes with senior nurses, doctors and managers, leading to increased timidity, depression, anxiety and resentment among NGNs.

New nurses must also manage relationships with their patients. Given negative social attitudes towards nursing in Saudi Arabia, these too involve struggles over authority, respect and trust, as this fractious dynamic comes to define nurse–patient relationships. These relationships are also emotionally draining for NGNs, adding to the ongoing strain of the transition process.

To understand these relationships and to appreciate how they are maintained, it is useful to place them within the larger organisational structure that provides lesser or greater degrees of social support to its employees. In the context of this study, negative relationships among staff are sustained as the hospital lacks the structural resources to provide employees with access to their own empowerment (Kanter, 1979; Laschinger et al., 2004). As I explore in this section of the chapter, the fallout from this structural oversight drastically affects the work environment, specifically the interactions within it, and threatens the success of the NGN transition process.

6.4.1 Teamwork among Nursing Colleagues

An ongoing area of concern for this study's NGNs is the lack of collaboration with other hospital staff (Kramer & Schmalenberg, 2003). In general, participants felt pushed aside by their co-workers, including senior nurses, doctors and administrators, and consigned to practise alone, without supervision or support. Repeatedly, participants stated that they felt abandoned by colleagues in an environment where questions were not asked because no one was willing, available or free to answer them. As a result, NGNs worried about experiencing exhaustion or encountering situations beyond their abilities during their shifts because they felt certain no one would be there to assist them. As one participant put it in the findings chapter:

There is no teamwork here. I blame the heads of department and senior nurses, because they should help the new nurses. Until you're independent and powerful here, everyone works for himself; I feel like I'm working in a jungle. (NGN4 Shawa)

Some NGNs reported that their treatment by head nurses and nurse managers was stressful and, at times, demoralising (Daiski, 2004). They relayed stories about administrators ignoring their requests for transfers or firing them; they also talked about being blamed for mistakes they did not make and being yelled at by nurse managers in

front of patients and colleagues for situations that were not in their control. This and other types of harsh behaviour were reported in previous research on NGNs (Duchscher, 2009; Dyess & Sherman, 2009; Ebrahimi et al., 2016; Lee et al., 2013) For example, in a Taiwanese study by Lee et al. (2013), the authors observed that senior nurses regularly criticised new nurses in an overt and public manner. Lee et al. argued that in contrast to the West, this treatment of NGNs is considered acceptable and viewed as a 'learning experience' in a Chinese culture that emphasises collective (rather than individualistic) values and adherence to authority. Lee et al. also found that, despite being normative, the harsh behaviour of senior nurses was dispiriting and disempowering for NGNs. Because Saudi Arabia is a collectivist society as well (Harbi, Thursfield & Bright, 2017; Hofstede, 1980), this may help to contextualise the abuse that participants experienced and explain why it was permitted.

These experiences are in keeping with a broader literature on horizontal violence in the nursing profession, including bullying and verbal aggression in Western countries (Dyess & Sherman, 2009; Farrell, 1997; McKenna et al., 2003; Rydon et al., 2008; Salt et al., 2008) and in developing nations, such as Pakistan and Turkey (Lee & Saeed, 2001; Yildirim & Yildirim, 2007). While there is no universal definition of workplace bullying, it is generally distinguished from ordinary co-worker conflict because bullying is a repetitious conflict. Workplace bullying is also related to power; the victim of horizontal violence cannot end the conflict because the victim is subordinate to the bully (Leymann, 1996; Lutgen-Sandvik et al., 2007). Examples of bullying include belittling comments, humiliation, constant criticism, unfair accusation, social isolation and refusal to acknowledge a person (Johnson, 2009). Many of these behaviours were recollected and described in interviews with the participants or observed during my fieldwork. These issues are discussed in more detail in the upcoming section on NGN–doctor relationships.

Studies of NGN experiences are increasingly showing that social support is an important factor in the transition period (Beecroft et al., 2008; Evans, 2001; Rydon et al., 2008; Wangensteen et al., 2008; Zinsmeister & Schafer, 2009). For example, in a study by Wangensteen et al. (2008), NGNs suggested that constructive feedback from head nurses played an important role in facilitating the transition process. However, as previously described in this chapter, HNs interviewed for the current study largely ignored NGN complaints, feeling that they had to do more work when collaborating with NGNs. This

finding aligns with a recent study examining experienced licensed nurses' perceptions of NGNs, in which senior nurses reported feeling frustrated with new nurses. The experienced nurses viewed new nurses as untrustworthy, lazy, argumentative and overly sensitive to criticism (Ebrahimi et al., 2016).

While bullying is the action of an individual or a group, the structure of an organisation reinforces this behaviour. Thus, solutions to horizontal violence rest in identifying and removing workplace features that allow bullying to persist (Hutchinson et al., 2006; Lewis, 2006). A study conducted in Kuwait has particular relevance to this research (Alotaib, 2008) In two sets of exit interviews with foreign nurses who had resigned from their positions in public hospitals, the respondents reported conflict with nursing managers, whom they viewed as uncooperative and uninterested in the staff nurses' concerns, e.g. there were no staff meetings as a regular part of the hospital routine. In addition, nurses argued that nursing managers were largely concerned with the needs of hospital managers, who had little to no experience in clinical practice. As a result, in their view, a bureaucracy out of touch with actual clinical staff determined the work goals. The study ended with a recommendation to replace nursing managers with less hierarchical and more interactive modes of communication (Alotaib, 2008).

Nursing research points to the importance of empowerment and autonomy in job satisfaction and retention rates (Bergquist, 2018; Breau et al., 2014; Kanter, 1993; Laschinger et al., 2001; 2004; Wagner, 2010). Kanter (1979) argued that empowered workers are highly motivated, satisfied and engaged with their work. This empowerment enables them to meet work-related goals, experience better work outcomes and extend empowerment to others, thus increasing organisational effectiveness. Conversely, employees who feel powerless experience greater disengagement from their work and less commitment to the organisation. They are also at greater risk of occupational burnout (Maslach & Leiter, 1997). In a study on NGNs, Cho et al. (2006) found that empowerment contributed positively to NGNs' work life, which in turn reduced perceptions of emotional exhaustion.

Within Saudi health care organisations education programmes within hospitals to ensure that NGNs can handle those added responsibilities autonomously. These efforts could help to increase nurses' standing among colleagues and provide space for them to

function autonomously. As with empowerment, multiple studies suggest that autonomous work raises nurses' job satisfaction (Athey et al., 2016; Han, Trinkoff & Gurses, 2015; Laschinger & Fida, 2015), reduces feelings of helplessness and enhances decision-making abilities (Spence, Laschinger, Zhu & Read, 2016).

One successful model encouraging nurses' autonomy is the 'magnet hospital'. Hospital organisations are awarded magnet status by the American Nurses' Credentialing Centre (ANCC) based on set criteria for high-quality patient care and for excellence, expertise and innovation in nursing practice. Nurses in magnet facilities have described their culture as supportive of autonomous practice (Kramer & Schmalenberg, 2003). Research has also shown that the nurses employed in magnet hospitals enjoy greater job satisfaction and provide superior patient care (Horrigan, 2016; Manojlovich & Laschinger, 2007).

6.4.2 The Impact of Heavy Workloads

Heavy workloads were widely seen as a source of stress for participants. NGNs reported that work demands caused fatigue and a fear that they would not be able complete all their duties during assigned shifts. These concerns align with prior research on the transition process (McVicar, 2003) and suggest that NGNs' extensive workloads are detrimental to patient care, especially in terms of meeting patients' emotional needs (Duffield et al., 2011). For example, in the present study, some participants felt that their heavy workload kept them from promptly responding to patients' questions.

NGNs felt especially overwhelmed by patient questions concerning prognoses, tests results, discharge dates and other matters. This in turn offended patients because they assumed that their needs were being overlooked. This finding supports previous studies highlighting that communications with patients and their relatives creates stress during the transition process (Ellerton & Gregor, 2003; Schoessler & Waldo, 2006).

Researchers have found that harried NGNs tend to eschew personal connections with patients to focus on more concrete tasks (Ellerton & Gregor, 2003). As McCarthy et al. (2007) suggested, nursing workloads involve direct and indirect patient care, with the latter including care planning, non-nursing activities and invisible care, such as emotional support. For this study's participants, competing work demands made it difficult to

prioritise patient well-being, thus depriving patients of needed attention and keeping participants from engaging in this aspect of nursing care.

Participants also reported that they spent excessive amounts of time on tasks unrelated to nursing. These tasks included taking care of paperwork for doctors, accompanying patients to other departments and dealing with hospital bureaucracy. As Duffield and O'Brien-Pallas (2003) noted, these sorts of duties indicate that organisational culture depends on NGNs to compensate for staff shortages. As a result of these expectations, this study's participants experienced greater stress (Atefi, Abdullah, Wong & Mazlom, 2014) and eventually grew resentful (Harrison & Nixon, 2002).

Several participants noted that constant pressure from heavy workloads made the hospital's staff extremely short-tempered. As a result, it was not unusual for arguments to break out among the nursing staff. While such conduct would be viewed as unprofessional in a Western context, it was commonplace in the Saudi work environment and took time away from patient care. This finding is not mentioned in the existing transition literature; thus, previous studies have overlooked a potential threat to quality of care and workplace efficiency in Saudi Arabia and other cultures where such behaviour is commonplace.

Participants identified nursing shortages as key determinants of their heavy workloads and as drivers of stress and anxiety, a finding which corroborates other studies on nursing in Western nations (Applebaum, Fowler, Fiedler, Osinubi & Robson, 2010; Watson, Deary, Thompson & Li, 2008) and in Saudi Arabia (Almalki et al., 2011; Romyn et al., 2009). A recruitment embargo on staffing in the MOH was also considered a reason for widespread understaffing in SA (Aldossary et al., 2008; Janiszewski Goodin, 2003). The high patient-to-nurse ratio meant that NGNs were compelled to take on patients with very different needs, despite their underdeveloped clinical skills. Many participants felt that this compromised patient care.

As extensive research has shown, heavy workloads frequently result in burnout, causing nurses to end their contracts or change their profession (Bowles & Candela, 2005; Gould & Fontenla, 2006; Greenglass, Burke & Fiksenbaum, 2001; Kalliath & Morris, 2002). Alternatively, smaller workloads have been shown to enhance job satisfaction and promote the mental well-being of nurses and patients (Healy & McKay, 2000). When

nurses become worn down by excessive work demands and decide to leave nursing, this results in even fewer nurses on staff and puts more pressure on remaining nurses (McCarthy, Tyrrell & Lehane, 2007).

Laschinger and Leiter (2006) argued that sound nursing management is critical to improve the work environment for nurses and to enhance the care they provide. Yet, in this study, the senior nurses and HNs were insistent that stressful working conditions were intrinsic to nursing. Consequently, NGN objections to burdensome responsibilities were dismissed as unwarranted. These findings are comparable to results from research showing that NGN complaints about heavy workloads did not affect managers at a hospital in Oman (Al Awaisi, 2012).

6.4.3 Lack of Preceptor Support

Another area where participants felt unsupported was their relationship with preceptors. At the hospital in this study, no official process existed to assign preceptors to NGNs, unlike at many other hospitals, where preceptors are a designated resource during the transition process. Instead, experienced nurses functioned as preceptors; however, despite the title, the former spent very little time helping NGNs to improve their clinical knowledge and skills. Participants contrasted the lack of preceptor supervision during the transition process with the consistent input they received from preceptors during their studying period. Throughout the interviews, participants noted the effects that lack of preceptor support had on their self-confidence, sense of teamwork and belonging, and development of professional competencies.

These findings correspond with research documenting that poor preceptor support and poor teaching skills hinder the transition process (Hautala, Saylor & O'Leary-Kelley, 2007; Rush, Adamack, Gordon & Janke, 2014). For example, research shows that inconsistent preceptor support is stressful for NGNs and leaves them feeling lost, confused and disoriented at work (Clark & Holmes, 2007; Gerrish, 2000). Lack of preceptor support has also been found to hinder NGNs' adaptation to their new role (Clark & Holmes, 2007; Gerrish, 2000; Goh & Watt, 2003; Ross & Clifford, 2000; Zinsmeister & Schafer, 2009) and impede the formation of trusting relationships (Mårtensson, Engström, Mamhidir & Kristofferzon, 2013). Moreover, the absence of preceptors causes NGNs to feel more insecure on unfamiliar wards (Suen & Chow, 2011), potentially affecting patient care.

Conversely, studies have shown that a continuous relationship between preceptors and NGNs helps to build trusting relationships, improve continuity of learning and bolster self-confidence (Callaghan et al., 2009).

The absence of preceptor supervision further demonstrates the damaging effect that poor social and educational support across the hospital has on the NGN transition process. This structural issue requires attention at multiple levels, as previously discussed. In terms of the poor relationship between NGNs and preceptors, several steps could be taken to improve communication and learning. First, to the extent possible, preceptors should be released from certain obligations, thus reducing occupational stress for preceptors and making them more physically and mentally available to new nurses (Clark & Holmes, 2007). Finally, if these changes are not possible, NGNs should be given more support from colleagues to integrate into the health care team and become less reliant on preceptors' assistance and advice.

6.4.4 Doctor–Nurse Communication

This study highlights a relationship between doctors and NGNs rooted in power dynamics between superiors and subordinates. Similarly, asymmetrical doctor–nurse relationships have been identified in the transition literature and are considered one reason for dissatisfaction with nursing as a profession (Daiski, 2004; Rosenstein, 2002; Rosenstein & O'Daniel, 2005; Rowe & Sherlock, 2005). Based on the study findings, I identified three key factors informing the doctor–nurse relationship. Together or alone, these factors harmed doctor–nurse interactions, reinforced doctors' authority and disempowered female NGNs, leaving them frustrated, hesitant and/or helpless. The factors included poor communication, lack of respect for NGNs' clinical skills and maltreatment and bullying. While these behaviours were common, it is important to note that they diverge from existing professional standards/codes of practice for medical professionals (i.e. doctors) in SA. Current standards/codes encourage respectful interactions with medical colleagues, including nurses, and prohibit abusive or disrespectful actions (Aldossary et al., 2008).

First, staff communication with doctors was difficult due to the absence of clear hospital policies dictating appropriate channels to contact physicians. For instance, participants often had difficulty locating doctors for permission to administer treatment to patients.

This could result in significant delays in patient care, particularly since NGNs could not perform certain tasks without doctors' approval. As discussed in the findings chapter, there were several occasions during my fieldwork when I became concerned that a patient might not receive urgent care because a doctor could not be reached for permission to administer medication or to perform a procedure.

In addition, doctors would often enter relevant patient information into the hospital computer system only at the end of their shifts, thus postponing communication with NGNs and creating a backlog of cases; in some cases, nurses preferred to take on doctors' work rather than trying to locate doctors, but this too caused workloads to snowball. Overall, these findings correspond with the literature showing that doctor–nurse communication is often poor (Rosenstein & Daniel, 2005), leading to low job satisfaction scores among nurses, increased risk of adverse events and poor patient outcomes (Manojlovich, 2005; Rosenstein, 2002; Utriainen & Kyngäs, 2009).

Second, doctors were often dismissive of NGNs' need for clinical practice and their existing clinical abilities. When working with doctors, participants were often ignored or replaced with more experienced nurses. As a result, NGNs were denied the opportunity to increase their knowledge or hone their clinical skills. In addition, the physicians' actions left the NGNs feeling that they were not trusted, undercutting their self-confidence. Moreover, in many of the interviews, NGNs shared that the doctors' behaviour made them feel 'inferior', and other participants stated that the doctors treated them like servants, thus reinforcing the association between nursing and domestic service discussed earlier in the chapter. Doctors also expected nurses to follow their orders, regardless of whether the orders were necessary or relevant to a particular situation, an experience the NGNs found humiliating, both because of the behaviour and because their response was to comply.

The dynamics between NGNs and doctors in the hospital may be better understood by situating them within existing research on hierarchical power in health care. For example, extensive literature exists examining the relationship between men's historical dominance in health care and socialised gender roles (Dombeck, 1997; Stein, 1967; Taylor-Seehafer, 1998; Warelow, 1996). Some of the older literature (Stein, 1967) focuses on the perpetuation of subordinate (gender) roles reinforced via interactions between

nurses and doctors, during which nurses deferred to physicians' authority. More recently, Warelow (1996) has written that nurses are complicit in their own subjugation through a discursive idealisation of the doctor–nurse relationship that elides power differentials. Within this frame, hierarchical authority, originally constructed via gender norms and roles, continues to influence the doctor–nurse relationship, even though women are now a part of the medical profession.

This view has now become outdated, and contemporary scholars tend to interpret nurses' agency as constrained within a patriarchal system (Ogren, 2001). This perspective is useful to understand why NGNs feel powerless to respond to what they receive as unjust treatment from doctors and why their (forced) passivity serves to re-establish doctors' authority (Aroskar, Moldow & Good, 2004; Ketola, 2009; Manojlovich, 2007). Given the lack of support from senior colleagues and administrators already discussed in this chapter, this also helps explain their reluctance to question or challenge doctors.

Lee et al.'s (2013) research on Taiwanese NGNs provides context for NGNs' passive behaviour when confronted with doctors' inconsiderate treatment. The authors observed that the overarching pattern of the NGN transition process in Taiwan involved constant 'struggling to become an insider'. This desire to conform led NGNs to 'mask themselves' and 'hide their true feelings' as a form of self-protection to avoid conflicts and negative situations. In many ways, the participants' passivity in the present study matches the behaviour of the NGNs in Lee et al.'s study.

Third, doctors sometimes resorted to verbal abuse when frustrated by NGNs' behaviour, insulting, belittling or intimidating them in front of colleagues and patients.

As discussed earlier in this chapter, research has addressed bullying in the hospital environment as well as the mental and physical symptoms it causes, such as depression, anxiety, mistrust, headaches and hypertension (Farrell, 1999; McKenna et al., 2003). Moreover, as Dyess and Sherman (2009) pointed out, conflict with medical professionals can be career threatening. Within the literature on nursing in Saudi Arabia, bullying in doctor–nurse relationships has received particular attention (Alkorashy & Al Moalad, 2016; Alswaid, 2014; Aslaqri, 2014), pointing to a pervasive problem. This study's findings support that research and offer greater insight into how bullying and abuse negatively affect the NGN transition process. The importance and scope of this issue suggests that

additional research in this area would be beneficial to improve nurses' status in the Saudi health care system.

6.4.5 NGN–Patient Communication

The NGN–patient relationship in this study was constrained due to poor communication as well as mistrust and disrespect for Saudi nurses. Participants complained that the patients and their relatives had little trust in their work and failed to give them sufficient respect (Lamadah & Sayed, 2014). As discussed previously, the NGNs suggested that this disdain stemmed from a societal view of nurses as domestic servants and misunderstandings about the professional responsibilities of nurses. This finding in line with (Crowe, 2000) Nurses were seen by patients as a disempowered and subservient group of people who carried out the orders of doctors.

Throughout the day, and especially during long and crowded visiting hours, patients and their relatives expected immediate responses to their requests (sometimes demands) and questions about medical procedures, even though NGNs' other tasks took precedence over these concerns. As a result, participants reported feeling anxious and overwhelmed at having to explain the nurses' role to patients, while hoping to clear up confusion and lessen the insistent demands. The fact that NGNs would be held responsible for any negative outcome if they provided erroneous medical advice also generated stress during shifts.

In this study, patients and their relatives trusted the skills of foreign nurses more than those of Saudi nurses. Patients viewed foreign nurses as more experienced in nursing, more efficient at their jobs and more agreeable to dealing with both medical and non-medical matters. This perception served to further complicate the NGN–foreign nurse relationship previously discussed in this chapter.

Responses to the patient's demeaning conduct varied among participants. At times, the reaction was resistance to the demands, leading to fights between nurses and patients, and their relatives in some cases. However, continual pressure from patients and their relatives also required self-control to avoid constant conflict.

If nurses are to gain respect and enjoy positive working conditions, the general attitude towards nurses in Saudi Arabia must change. Failing to address this need may hinder the success of Saudisation by disincentivising women (and men) from joining the profession. Saudi society should thus be better informed about the role of nurses. This could be accomplished through government and nursing authority initiatives that highlight nurses' clinical skills and knowledge (Al-Mahmoud, Mullen & Spurgeon, 2012). Another viable means to reshape the public image of nursing would be to implement a television campaign that emphasises the compatibility of nursing with Islam, e.g. the story of the first Muslim nurse, who received the blessing of the prophet. Finally, efforts to improve the status of nursing must occur within the profession itself, instituting reforms that enhance the agency of practising nurses.

6.4.6 Intention to Leave

The many transition difficulties outlined in this chapter had cumulative, negative effects on NGNs' physical and mental well-being as well as their personal and professional relationships. These challenges came from within the hospital, including long hours, heavy workloads, lack of supervision or social support, social isolation and interpersonal conflicts. In addition to these pressures, the NGNs struggled to deal with external stressors, such as transportation barriers, social disapproval of nursing and family objections to (night) shift hours and work on mixed-gender wards. Given the weight and hardship of the transition process, it is not surprising that many NGNs in this study were disillusioned with their career.

The NGNs largely held the hospital's management accountable for their dissatisfaction. This is consistent with research showing that poor managerial policies contribute to stress, low morale and high turnover rates among nurses (Pineau Stam, Spence Laschinger, Regan & Wong, 2015). It also reflects findings in the Saudi literature that (poor) leadership and management styles are determinants of turnover and intention among nurses (Abualrub & Alghamdi, 2012; Al-Ahmadi, 2014; Suliman, 2009).

The nursing literature offers several explanations for these administrative failures. For example, Tingleff and Gildberg (2014) suggested that poor support from management prevents the theory–practice gap from closing during the transition process, an outcome corresponding with this study's findings, as participants' experienced little supervision,

instruction or opportunity to develop their clinical skills. Freeman, Morrow, Cameron and McCullough (2016) maintained that problems develop when nursing conditions do not coincide with the wider organisational culture. In the case of the study participants, my research indicates that lack of support and respect for NGNs reflects an organisational culture that values hierarchy and perpetuation of the status quo over the needs of the hospital's new nurses.

A recent systematic review of research on nurse turnover in Saudi Arabia found a range of turnover rates across studies of varying design and rigour (Falatah & Salem, 2018). Within this literature, the highest turnover intention rate was 60% (Al-Ahmadi, 2014), and the lowest was 17% (Zaghloul et al., 2008). In terms of NGNs, one prior study provided a turnover rate of 50% (Abu-Zinadah, 2006). While it is difficult to know the precise turnover rate among Saudi nurses, there is clearly a need to address this issue and the widespread discontent with nursing that fuels it. Innovative programmes are needed that create more robust, supportive and responsive hospital policies. Possible approaches include peer-link programmes with other NGNs, providing emotional and professional support networks, and sufficient training from preceptors, allowing NGNs to function on hospital wards (Henderson & Eaton, 2013; Rush et al., 2013).

6.5 Conclusion

The preceding pages have discussed the Saudi NGN transition experience within the context of existing theories and empirical research on the transition process. Overall, the transition period for the study's participants includes many of the same conditions, barriers, stressors and outcomes described in the transition literature and, in some cases, Saudi research. However, cultural, structural and personal influences also shape a transition process specific to Saudi Arabia. To address many of these issues, the next chapter discusses recommendations to help improve the transition process, paving the ways for increased job satisfaction among new nurses, higher retention rates and higher-quality care for patients.

CHAPTER SEVEN: STRENGTHS AND LIMITATIONS, CONCLUSION, RECOMMENDATIONS

7.1 Introduction

This study examines the lived experiences of Newly Graduated Nurses (NGNs) working at KKH in Hail, SA. It is the first study to elevate the voices of NGNs to explain the transition process from recent graduate to registered nurse. As part of the analysis, the thoughts, feelings, and views of study participants were situated within the cultural and structural forces affecting nursing in contemporary Saudi society. The current chapter outlines the study's conclusions and presents a series of data-driven recommendations to improve the NGN transition experience in order to increase job satisfaction and increase retention rates amidst the ongoing nursing shortage.

7.2 Strengths and Limitations of Current Study

To enable policy-makers, educators and administrators to assess these recommendations, this section describes the various strengths and limitations of this study. First, this study's qualitative research design limits the generalisability of the findings. To obtain respondents for this study, purposive sampling was used, resulting in nine NGNs and four HNs. As Liamputtong and Serry (2013) note, small sample sizes in qualitative work can restrict the researcher's ability to draw inferences and conclusions from the data. In this case, the sample is somewhat small, but the information provided by respondents is supplemented and substantiated by the author's ethnographic field notes (which will be discussed shortly).

Next, the study's use of a non-probability sampling technique may have increased the risk of sampling bias, limiting the representativeness of my sample and the generalisability of the findings (Etikan, Musa, and Alkassim, 2016). However, the author intentionally chose a research design with a smaller sample because it offered several advantages, including increased validity and the opportunity for thick description of participants' experiences. This approach also facilitated the conducting of interviews in person, and personally transcribing them, requiring full engagement with all aspects of data collection, and

helping to ensure the quality of the data. In addition, Liamputtong and Serry (2013) argue that this method is beneficial, because it reassures the participants that the sensitive information they share is valued and will be treated respectfully.

In addition, the ability to generalise findings was not the primary aim of the study; its main objective was to conduct an initial investigation into the lived experiences of Saudi NGNs and to provide information that could be used to improve their transition process. This approach is supported by Groleau, Zelkowitz, and Cabral (2009), who contend that the main objective of qualitative research is to influence policy-making to improve individuals' health and welfare of. Purposive sampling was also a useful method, because it enabled the author to obtain in-depth data about NGN's experiences across various hospital sectors.

Another design limitation involves the study's use of a self-selected sample, which is associated with inherent bias (Tongco, 2007). Herein, it is important to note that the findings represent only the experiences of those nurses who agreed to participate in the interviews, as they were willing, comfortable and able to share their views. However, because the participants were self-selected, they were highly motivated and interested in sharing their experiences, helping to keep the interviews focused and contributing to the quality of the data (Etikan et al., 2016).

This study was conducted by one person, making it limited in scope, due to time and budgetary constraints. The study was also restricted geographically, since the data was collected from a small pool of participants at one hospital in SA, rather than across hospitals, communities or wider regions, another limitation on the generalisability of the findings. On the other hand, several scholars, including Freeman, DeMarrais, Preissle, Roulston, and St. Pierre (2007), Crewel (2009, 2014) and Merriam (2009), have pointed out that focusing on a single hospital provides an in-depth case study, which may produce data that is valuable in its specificity.

As the findings are based on a case study, they might not reflect the experiences of NGNs in other hospitals, states or nations or NGNs who began their careers in settings other than a hospital. Moreover, the study's recommendations for practice might not be relevant to all institutions, since undergraduate nursing education and orientation procedures vary considerably. The study's findings may also be limited due to the

sensitive subjects included in the interviews. Even though their anonymity was assured, some nurses failed to be entirely forthcoming about topics; particularly foreign nurses, who might have felt inhibited about sharing their honest opinions with a Saudi interviewer.

One of the interview questions may also have affected the study's findings. The question asked the participants how well their undergraduate education had prepared them for clinical practice. To answer this, the participants had to engage in subjective interpretation of it, exercising a certain degree of recall, influenced by several factors. However, Pannucci and Wilkins (2010) suggest that recall is an unreliable indicator of curriculum quality, because it is affected by a range of variables, including attendance, concentration, interest and learning and teaching styles. In the current case, however, this warning does not apply, since it is not concerned with curriculum assessment, but rather perceptions of readiness for nursing practice based on undergraduate education.

In qualitative research, the researcher acts as the primary data collection instrument (Creswell, 2014; Miles et al., 2014). Throughout all the stages of this study, the author made a concerted effort to remain as open-minded and objective as possible. This involved setting aside personal preconceptions and bias when interviewing the participants or observing activities or behaviours at the hospital. The author also made field notes after each interview as a reflexive mechanism when considering thoughts and feelings about what had transpired.

Throughout the data collection process, the author brought professional credibility and authority to each interview. This was based on an in-depth knowledge of the literature, as well as personal experience as an NGN and hospital nurse. The fact that all the interviews lasted for an agreed time limit, while several lasted longer, reflects the author's interviewing skills and ability to make participants feel sufficiently comfortable and secure to express their views honestly.

The qualitative case study approach used in this research, combining semi-structured interviews with fieldwork observations, allowed for continual clarification of concepts and an ongoing analysis of data. Applying different data collection methods strengthened the findings of the study.

The ethnographic approach in this study enabled the author to observe and communicate with participants in real time. During this period, it was apparent that the author's presence might interfere with data collection. Every effort was thus made to be personable and respectful to encourage participation and to reduce wariness or anxiety concerning the researcher's presence. The field-based approach also generated new data as participants raised new issues each day and allowed the author to follow up on interviews. Moreover, it provided time to establish a rapport with participants before their interviews. Finally, the use of ethnography facilitated an in depth understanding of the nurses' views and the NGN experiences, as the accounts that they provided were both vivid and highly perceptive, leading to much richer data than could be obtained from interviews alone.

Following completion of the data collection process, close attention was paid to performing rigorous data analysis. Writing up the data was particularly difficult, but a step-by-step method allowed the author to produce descriptions of the participants' experiences that were clear and analytically-informed. Consistent reference to the data was made during this phase to ensure that the participants' accounts were not misrepresented or altered by personal interpretations. Two supervisors acted as experts during the research process and helped to confirm, interpret and verify the findings. This collaborative process was extremely useful when reaching conclusions regarding the consensus. Moreover, during the data analysis process, the author again consulted the supervisors to ensure that they agreed with the approach to thematic coding, which provided reassurance about the credibility, dependability and confirmability of the research findings.

Finally, this study provides data on NGN's lived experiences in SA. It supplements these findings with information about the status of nursing and nursing work in SA, and provides greater insight into how culture shapes the transition process for new nurses working in countries in the Arabian Gulf. The study was conducted during a time of pronounced economic, social and political change. As such, it established baseline knowledge that could provide a point of comparison for future studies under similar or different circumstances. While several previous studies have cited the poor image and low status of nurses as explanations for the acute shortage of Saudi nurses, this study updates these findings and places them in the context of current social conditions.

Finally, this study provides a response to the nursing shortage crisis that fully voices the concerns and experiences of Saudi nurses.

7.3 Conclusion

This study presents a comprehensive overview of the daily challenges faced by Saudi nurses, particularly NGNs. The researcher is sincerely grateful to the participants for their contributions; without their participation, the study would not have been possible.

The Saudi NGN transition process shares many features with the equivalent process in the West. However, Saudi NGNs encounter a range of cultural and social challenges that are not present in other countries, shaping their experiences in a culturally distinct manner. Specifically, this research highlights the many ways in which NGNs are experientially affected by the low social status of nursing in SA; both in the hospital workplace and in wider Saudi society. It specifically links negative working conditions and lack of prestige with historical (mis)conceptions about nursing, persistent cultural norms opposing women's labour force participation, and widespread unfamiliarity with the purpose and practice of nursing.

A major finding of this study is that there is a persistent substantial theory-practice gap between NGNs' abstract knowledge at the start of their career, and the actual demands and expectations of daily nursing. As NGNs feel ill-prepared for their first jobs (Casey et al., 2004; Pfaff, Baxter, Jack, & Ploeg, 2014), they lack confidence throughout the transition process, which creates a cascading effect on mental and physical well-being, and professional interactions and relationships. Specifically, participants described how their lack of preparation and self-assurance compromised their ability to address various day-to-day workplace situations (i.e. high-pressure rapid response situations, and communication with doctors, patients, and preceptors). They attributed this uncertainty to the theory-practice gap discussed above, stressing that their education, particularly in the context of clinical practice, did not equip them for the practical demands of their new positions (Chang & Hancock, 2003; Duchscher, 2001, 2008, 2009; 2012; Kramer, 1974; Morrow, 2008).

Furthermore, the absence of an official support system, or issues platform in the hospital exacerbated participants' insecurities during the transition process, eroding their (still

fragile) professional identities. These reactions further contributed to occupational stress and lowered morale and job satisfaction. Heavy workloads and long working hours, which are inherent to nursing, also fostered discontent.

The study's data suggests that the workplace is structured around issues of power and autonomy (i.e. the capacity to experience professional empowerment). Furthermore, the participants argued that their needs and opinions were subordinate to the interests of patients, doctors and administrators. For example, the asymmetry of the nurse-doctor relationship was a principal concern for NGNs, who described its negative impact on effective communication and patient care. Other issues affecting the participants' autonomy included sex-segregation, particularly barriers to working with male patients, night shifts and transportation challenges. These concerns created conflict within families, particularly parents, who disapproved of women working in mixed-gender environments or on overnight shifts.

Finally, the study's findings tentatively suggest an association between an intent to study nursing and the motivation to work as a nurse (Newton et al., 2009). This potential relationship is illustrated by taking a closer look at one participant's story (Sma), and comparing it to the other participants' reasons for studying nursing and their subsequent transition experiences.

The following section draws on the study's findings to provide recommendations to improve nursing education and practice. The recommendations are intended for the government and nursing policy-makers, managers and educators in SA.

7.4 Implications and Recommendation

To date, a suite of reform programmes, including Saudisation, have been implemented to address shortcomings in nursing education, recruitment, work environment and retention. At the same time, increasing numbers of Saudi nursing students are opting to study overseas (Ministry of Higher Education, 2014), bringing this training home with them to practice in Saudi healthcare settings. These initiatives been commendable in terms of recruiting and developing professional, empowered, and leadership-ready Saudi nurses.

Despite these advances, the process of remediation has been complex and time-consuming and has not kept pace with rising public demand for healthcare services. This situation prompts concern that the current nursing workforce, which is still developing, will be unable to cope with these pressures. While it is tempting to wait for greater experience and professional growth among Saudi nurses, there is no guarantee that time alone will be adequate to address nursing's remaining educational and occupational challenges.

This study has documented the many reasons for Saudi NGNs' dissatisfaction with their training and work environment and has explained their ramifications for the practice of nursing and health care in general. Taken together, this research points to the immediate need to engage in thoughtful planning and targeted strategies to rectify this situation.

7.4.1 Saudi Government

Future economic and social plans for SA are set out in the "Saudi Vision 2030". This plan focuses on economic diversification, private sector investment, trade expansion, and employment opportunities for Saudi citizens. It also outlines several goals for the healthcare sector. To meet these objectives, the Saudi government needs to implement strategies to improve the image of professional nursing. Broadly speaking, this should be achieved by promoting the crucial role nurses play in the healthcare community, as well as wider society. Ultimately, this approach would help address the goals of the MOH' Saudisation programme and reduce the need for expatriate nurses. This would then also enable the delivery of culturally relevant care to native Saudi citizens. Thus, the study offers the following recommendations for the Saudi government:

- Saudi nationals need to be educated and made aware of what nurses do and how their work contributes to maintaining individual and social well-being. This focus includes descriptions of the roles male and female nurses play in mixed-gender settings.
- Media-based information and recruitment campaigns could help to improve the public perception of nursing. These initiatives could include TV and radio shows, press articles and online resources.
- The media must disseminate this information widely to encourage young men and women in local communities to study and work as nurses.

- Intensive, consistent and positive media campaigns are essential to increasing community respect for nurses and the nursing profession, especially at public hospitals. To achieve this end, doctors and other health professionals must act as advocates for their colleagues. Evidence of increased collaborative work between nurses and other healthcare professional could also help raise the status of nursing.

While it will take time to alter Saudi socio-cultural beliefs about nursing and improve the profession's public image, such programmes should eventually have a positive impact, resulting in more Saudis making informed decisions about whether to enter and remain in nursing. Furthermore, a favourable shift in perceptions of nursing should help foster better working environments and promote interdisciplinary respect for nursing.

Finally, a government agency should be established to promote the interests of nurses and ensure their status in the medical community. This entity could address national nursing issues, including ongoing challenges during the NGN transition period. One of the organisations currently working on these issues is the Saudi Society for the Nursing Profession.

7.4.2 Nursing Policymakers

A better understanding of the NGN transition period, as well as the needs of experienced nurses, is crucial to ensuring safe and high-quality patient care. These insights could help lay the foundation for nursing infrastructure that supports nurses at all stages of professional development and acts as a safeguard against high attrition rates. In their discussion of the nursing crisis, the Joint Commission (2008) stressed that teamwork is at the heart of good nursing relationships and patient care. With this in mind, the following recommendations are made to nursing policymakers to help create a culture of collaboration:

- MoH managers must act as leaders and provide support to new nurses during the transition period. Supervisory skills are also key to motivating employees and improving overall work performance.

- To clarify issues of accountability and authority, there must be a robust description of job responsibilities and nursing hierarchy in the areas of practical nursing and nursing education. Codifying and disseminating this information should allow NGNs

to assess the stages of the nursing career and identify routes to promotion.

- A more cooperative relationship should exist between nurse managers and NGNs. Hospital nursing managers should monitor wards closely and communicate openly with ward NGNs. As part of this strategy, nurse managers should meet regularly with NGNs to discuss their transition period and to identify solutions to adjustment issues.

- Nursing managers should establish a formal system for NGNs to share their opinions and air their grievances. Ideally, this would involve formal and informal meetings with senior management.

- In order to retain existing staff, there must be greater investment of resources into mechanisms to support the orientation and integration of new nurses into healthcare environments.

- Traditional processes for on-boarding new nurses into health care organisations must be re-evaluated and modified to include strategies that help NGNS improve communication skills and develop confidence in their abilities and knowledge. In addition, managers should put into place practices aimed at preventing the mistreatment of new nurses by patients and other workplace staff. These efforts would help promote an environment of excellence and equality within the healthcare organisation.

7.4.3 Colleges of Nursing and Education

This study's findings indicate that current nursing curricula do not adequately prepare NGNs for practical nursing. In particular, the absence of experiential learning leaves new nurses hesitant to converse with physicians, patients and families and concerned about their ability to provide appropriate patient care. Previous studies have emphasised that efforts to address these issues should focus on strengthening NGNs' support systems, confidence and competencies (Fero et al., 2008; Marshburn et al., 2009; Roth et al., 2011; Ulrich et al., 2010). Based on these empirical insights, the following recommendations are made for the Colleges of Nursing and Education:

- It is crucial that NGNs are given meaningful clinical rotation experiences that accurately demonstrate how health care systems operate in real-life scenarios.

- To this end, universities and hospitals should improve standards of cooperation and communication to provide student nurses with access to clinical rotation opportunities.

- In contrast to the Saudi system, the British Nursing and Midwifery Council's Nursing Education Programme aims to achieve a balance in its curriculum between theoretical and practical training approaches, a practice that is standard in many Western countries (Vanlaere & Gastmans, 2007). Using these programmes as a guide, Saudi university curricula should be amended to reflect a balance between theoretical and practical training, with more practical placements. These placements should be longer in duration and expose students to the complexities of nursing practice. For example, full-shift work should be introduced at an early point in this clinical experience.

- Clinical experience should provide student nurses with opportunities to gain workplace communication skills (i.e. briefing doctors about abnormal laboratory results and providing verbal end-of-shift reports to primary nurses).

- Nursing education should incorporate practical simulations to provide student nurses with a non-threatening environment in which to develop problem-solving, clinical judgment, and technical nursing skills. Such simulations would allow student nurses to build confidence by learning from their mistakes.

- Student engagement with a simulated high-pressure rapid response and medication error situation would provide the knowledge necessary to avoid or respond to such scenarios in real-world contexts.

- Simulated experiences should also be used to provide student nurses with the opportunity to practice dialoguing with patients and families.

- Undergraduate programmes should educate nursing students in culturally competent care standards (as practiced in the West) so they can address the culturally specific needs of patients and colleagues.

- Finally, undergraduate programmes should provide opportunities for inter-professional learning.

7.4.4 The Work Environment

This study's participants reported that their workplace was largely unsupportive, and at times, even hostile. A large body of evidence suggests a significant link between negative work environments and high staff turnover (Almalki, FitzGerald, & Clark, 2011). Based on this association, the following recommendations are made to improve working conditions for NGNs:

- The internal culture of Saudi hospitals should be restructured to recognise and reflect the specific cultural needs of Saudi nurses and patients. Managers should also be responsive to suggestions from nurses to reform these policies.

- Decision-makers should make greater efforts to consider the culturally specific needs of, and challenges faced by, Saudi nurses when developing or implementing large-scale policy reforms concerning gender segregation and night shifts. These issues are also important for managers to consider when scheduling duties that might contravene Saudi cultural or gender norms, such as night shifts and care outside the hospital.

- Part-time employment opportunities should be provided to the meet the needs of Saudi nurses, particularly working mothers, who find it difficult to balance work and home responsibilities.

- Incentive-based strategies (such as part-time/flexible work arrangements; localised working opportunities; smooth transitions back into work; professional development and financial opportunities) should be implemented to recruit ex-nurses throughout the Kingdom.

7.4.5 Nursing Research

Whilst conducting this research, it became apparent that a gap in empirical knowledge exists with regard to the perceptions and experiences of Saudi nurses, as well as the current status of the nursing profession. Promoting more local research would allow nurses to advance the nursing profession, increase knowledge about nursing conditions, and improve nursing practices and health care provision in SA.

Moving forward, Saudi nursing organisations and policymakers should actively seek out

detailed evidence-based knowledge about nursing, and use this information to inform and implement cultural reforms in the Kingdom (Harne-Britner & Schafer, 2009). With these aims in mind, the following recommendations are made regarding future nursing research:

- Future studies should focus on how specific work settings affect graduates' performance and confidence levels as well as how this knowledge can improve staff retention and quality of care.

- There is a need for a longitudinal study to explore the differences in graduates' attitudes concerning job satisfaction, stress, and confidence at work. Using qualitative methods, researchers could gain greater depth insight into nurse managers' and nurse colleagues' opinions on these issues and use these insights to implement support systems for graduate nurses.

- Researchers should examine existing support initiatives in Saudi hospitals to identify the most effective approaches to assisting NGNs during their transition period. This information on best practices could serve as the basis for recommendations to policy makers and nursing leaders charged with instituting or enhancing comprehensive support programmes.

- Researchers should explore possible ways to alter undergraduate nursing programmes to instil professional confidence in NGNs. This might include a study focusing on the effect of clinical group sizes (for example groups of four to five versus eight to ten students) on student nurses' confidence.

- To supplement the current study, which focused on NGNs in one Saudi hospital, future research should focus on NGNs' experiences building confidence in other hospitals or healthcare settings in SA.

- Future intervention research should assess the effectiveness of organisational support measures targeting NGNs' learning, adaptation and satisfaction during their transition period.

- Researchers should investigate how formal preceptorship programmes can be improved to provide greater educational benefit and support to NGNs.

- Researchers should conduct long-term studies to assess and follow up on NGNs' intentions to remain at or leave their workplaces in order to help address NGN job satisfaction and retention rates.

- Researchers should develop the tools necessary to conceptualise and analyse the (interactive) effects of the multiple determinants affecting the NGN transition process. These determinants include Saudi culture, working conditions, and (perceptions of) the social status of nursing in SA.

- Researchers should examine how public perceptions and the social status of nursing impact nursing practices and patient care.

- As SA's healthcare services will remain dependent on foreign nurses for the near future, researchers should analyse that ways in which the presence of foreign nurses affects the quality of Saudi nursing practices and care delivery, as well as the status of nursing in SA.

- Finally, researchers should collate and evaluate information concerning foreign nurses' perceptions of the culturally specific needs of Saudi patients. Then the results of this study could be used to determine best practices when introducing newly recruited foreign nurses to Saudi healthcare and culture.

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APPENDICES

APPENDIX 1: Invitation Letter

You are receiving this letter as you have been identified by the senior nurse in the hospital as being a new graduate nurse.

I am a full time PhD student at the University of Salford, England.
I am currently recruiting participants for a research study that aims to explore, describe and interpret the experiences of NGNs in first destination posts in Saudi Arabia. The study will be conducted by myself, XXXXXXXXX, a full time PhD student at the University of Salford in the UK. You were selected as you are employed as a newly qualified nurse at XXXXXX Hospital.

Please find enclosed an information sheet that offers more detail about the study and what you might expect should you consent to participate.

If you would like to participate in this study contact me on: Mobile

Phone:XXXXX
or
Email:XXXXXX

Kind Regards,

XXXXXXX PhD student, University of Salford
Thank You

APPENDIX 2: Consent Form for New Graduate Nurse

Title of study: Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

Name of Researcher: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and delete yes or no, as applicable in the box on the right hand side.

1. I confirm that I have read and understand the study information sheet version , dated …., for the above study. I have had the opportunity to consider the information and ask questions which have been answered satisfactorily. — Yes/No

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 rights being affected. — Yes/No

3. If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is xxxxxx — Yes/No

4. I agree to participate by being observed in practice and being interviewed. — Yes/No

5. I understand that my personal details will be kept confidential and not revealed to people outside the research team. However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to you or another, the researcher will have to share that information with the appropriate authorities. — Yes/No

6. I understand that my anonymised data will be used in the (researcher's thesis/ research report) other academic publications and conferences presentations. — Yes/No

7. I agree to take part in the study: — Yes/No

__________________________ _ ___________ **Name of participant**
Date **Signature**

___________________________ ____________________ ___________________
Name of person taking consent **Date** **Signature**

APPENDIX 3: Consent Form for Head and Experienced Nurse

Title of study: Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

Name of Researcher: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Please complete and sign this form **after** you have read and understood the study information sheet. Read the statements below and yes or no, as applicable in the box on the right hand side.

Statement	
1. I confirm that I have read and understand the study information sheet version , dated …., for the above study. I have had opportunity to consider the information and ask questions which have been answered satisfactorily.	Yes/No
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 rights being affected.	Yes/No
3. If I do decide to withdraw I understand that the information I have given, up to the point of withdrawal, may be used in the research. The timeframe for withdrawal is xxxxxx	Yes/No
4. I agree to participate by (Please add – e.g. – by being interviewed, participating in a focus group, etc.)	Yes/No
5. I understand that my personal details will be kept confidential and not revealed to people outside the research team. [If appropriate -However, I am aware that if I reveal anything related to criminal activity and/or something that is harmful to self or other, the researcher will have to share that information with the appropriate authorities]	Yes/No
6. I understand that my anonymised data will be used in the (researcher's thesis/ research report) other academic publications and conferences presentations.	Yes/No
7. I agree to take part in the study:	Yes/No

______________________	______________________	______________________
Name of participant	**Date**	**Signature**
______________________	______________________	______________________
Name of person taking consent	**Date**	**Signature**

APPENDIX 4: Poster

INFORMATION FOR PARENTS AND RELATIVES ON (Insert name of ward or department as appropriate)
THE EXPERIENCES OF NEWLY QUALIFIED GRADUATE NURSES

There is a research study taking place on (insert name of ward or department). This involves a female researcher observing the work of new graduate nurses. The focus of the observations is on new graduate nurses as they care for you or your relative. None of your or your relative's personal details will be collected, recorded or reported.

It is hoped that the results from the study will help this and other hospitals to reduce the number of new graduate nurses leaving the profession.

Please let the ward staff know if you would like more information or do not want your care to be observed as part of this study.

Your decision will be respected and will not impact on your current or future care in any way.

APPENDIX 5: Participant information sheet (New Graduate Nurse)

Title of study: Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

Name of Researcher: xxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxxx

Invitation paragraph

Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

What is the purpose of the study?

The purpose of this study is twofold; to explore, describe and interpret the experiences of newly graduate nurses in Saudi Arabia during the initial 6 months in their first destination posts; and to examine the part that culture and social attitudes play in their experiences. I am undertaking this study to fulfil the requirements of a PhD qualification at the University of Salford, UK

Why have I been invited to take part?

I have been given permission to approach you to take part in this study by senior staff at the hospital. You are invited to be a participant as you are employed as a new graduate nurse and you are in the first 6 months of your employment in the XXXXXXXXXX Hospital.

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?

I would like to observe you in practice on a number of occasions. This will be agreed with you in advance. The observations will last between 2 – 4 hours at any one time. I would also like to talk to you about what I have observed and ask you to tell me more about your interpretations of my observations. I would also interview you on two occasions or more if you wish to talk to me about other things. The interviews will last no more than 60 minutes, unless you wish them to last for longer. I would like your permission to digitally record the interviews, but this is up to you.

Expenses and payments?

There will be no payment or reimbursement for taking part in this study.

What are the possible disadvantages and risks of taking part?

Taking part in this study in unlikely to cause you any harm. However, should you become upset while talking to me, we will stop the interview unless you wish to continue. You will also be able to access the educational and senior nursing staff for support.

What are the possible benefits of taking part?

You may not benefit from the results of the study directly. However, it is hoped that the findings from the study will help this and other hospitals to

What if there is a problem?

Should you have any concern or wish to make a complaint, please speak to me first. If you are still unhappy, please contact.

Add Supervisor details;xxxxxxxxxxxxxxxxxxxxxxxxx

Will my taking part in the study be kept confidential?

Yes. All information collected about you during the course of the research will be kept strictly confidential. Maintaining your anonymity means ensuring that you as an individual cannot be linked to the data you provide. Pseudonyms will be used in any written reports or presentations to ensure anonymity. Should you wish to take part I will ask you to sign a consent form. This is the only time I will record your name. All consent forms will be kept securely but physically separate from anonymised data. All data will be transcribed as

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

You may withdraw from the study at any time. If you withdraw from the study after I have collected data I will ask for your consent for the data collected to be used in the study. If you do not want this to happen, any data will be destroyed unless it has already been analysed for the final report.

What will happen to the results of the research study?

You will receive a copy of the results. These will also be shared with senior staff at the hospital and the Ministry of Health and the Ministry of Education. The results from the study will be published as a PhD thesis and submitted for publication in social and healthcare journals. The results may also be shared through poster presentations and conference presentations. I would also like your permission to use the anonymised data for teaching and educational purposes.

Who is organising or sponsoring the research?

I am a postgraduate research student with a scholarship from the Saudi Ministry of Higher Education and I have been given permission by them and senior staff at the hospital to undertake this study. The research sponsor is the University of Salford, U.K. The research has been subject to scrutiny by the University of Salford, CARe research ethics committee.

Further information and contact details:

Researcher XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Email Address XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

APPENDIX 6: Participant information sheet (head and experienced nurse)

Title of study: Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

Name of Researcher: XXXXXXXXXXXXXXXX

Invitation paragraph

Interpreting the experiences of newly qualified graduate nurses during the initial 12 months of their first destination posts in a government hospital, Ha'il region SA - A Case Study

What is the purpose of the study?

The purpose of this study is twofold; to explore, describe and interpret the experiences of newly graduate nurses in Saudi Arabia during the initial 6 months in their first destination posts; and to examine the part that culture and social attitudes play in their experiences. I am undertaking this study to fulfil the requirements of a PhD qualification at the University of Salford, UK

Why have I been invited to take part?

You may be invited as you are employed as a head or experienced nurse at XXXXX Hospital. Newly qualified nurses within your team are the focus of the study.

What will happen to me if I 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.

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. I would also like to interview you on two occasions, or more should you wish to talk to me about other things. The interviews will last no more than 60 minutes, unless you wish them to last for longer. I would like your permission to digitally record the interviews, but this is up to you.

Expenses and payments?

There will no payment or reimbursement for taking part in this study.

What are the possible disadvantages and risks of taking part?

There are no possible disadvantages or risks.

What are the possible benefits of taking part?

You may not benefit from the results of the study directly. However, it is hoped that the findings from the study will help this and other hospitals to improve the experiences of new graduate nurses, leading in turn to a reduction in the current attrition rate.

What if there is a problem?

Should you have a concern or wish to make a complaint, please speak to me first. If you are still unhappy, please contact

Add Supervisor details;

And, Anish Kurien, Research Centres Manager, G.08 Joule House Acton Square, University of Salford, M5 4WT

a.kurien@salford.ac.uk 0161 295 5276

Will my taking part in the study be kept confidential?

Yes. All information 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. Pseudonyms will be used in any written reports or presentations to ensure anonymity. Should you wish to take part I will ask you to sign a consent form. This is the only time I will record your name. All consent forms will be kept securely but physically separate from anonymised data. All data will be transcribed as soon as possible and uploaded to an encrypted pen-drive before being uploaded via a secure password-protected link to the University of Salford.

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

You may withdraw from the study at any time. If you withdraw from the study after I have collected data I will ask for your consent for this data collected to be used in the study. If you do not want this to happen, any data will be destroyed unless it has already been analysed for the final report.

Who is organising or sponsoring the research?

You will receive a copy of the results. These will also be shared with the hospital and the Ministry of Health and the Ministry of Education. The results from the study will be published as a PhD thesis and submitted for publication in social and healthcare journals. The results may also be shared through poster presentations and conference presentations. I would also like your permission to use the anonymised data for teaching and educational purposes.

Further information and contact details:

I am a postgraduate research student with a scholarship from the Saudi Ministry of Higher Education and I have been given permission by them and senior staff at the hospital to undertake this study. The research sponsor is the University of Salford, U.K. The research has been subject to scrutiny by the University of Salford, CARe research ethics committee.

Contact Details

Contact Details

Researcher XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

Email Address XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX

APPENDIX 7: Interview Guide (New Graduate Nurse)

Introduce myself and explain the purpose of the study.
Explain to the participant the privacy and confidentiality of the data and that it will be used only for the purposes explained in the PIS and ask for verbal consent.

What was the reason you studied nursing?
What does the profession of nursing mean to you?
What do you most enjoy or like best about being a nurse?
Is there anything you dislike in nursing?

What has surprised you the most or been the most different to what you expected?
How well do you think your programme has prepared you for clinical practice?
Is there anything that could make your move to being a qualified nurse easier?
Is there anything you would put in place for other students/NGNs that you think would help them?

How would you describe the difference between being a staff nurse and a student?
What do you expect to happen in the future with regard to your career?
How do you think your experience as an NGN will impact on your future career?

Is there any difference between the expectations of others, such as the administrators of nurses, head nurses, and other professionals and what you can do? Please explain further.
Are you capable of achieving your personal expectations and values?

How would you describe your work environment?
How have you found and experienced the workload, how does it make you feel?
Do you ever think about or worry about work when you go home?
How do the conditions of working impact your interaction with others? (Your head nurses, preceptor, patients and their relatives, other professionals and other nurses).

Who has been most helpful/supportive since you have been here?
Is the support offered what you expected? How would you describe it?
In the working environment, whom do you regularly ask for support?
What is your perception of the support that is offered to you?
Has your view or vision of nursing changed since you qualified?

Some of the NGNs I have spoken with have told me that they have experienced circumstances where they felt mistreated or abused by others. What is your experience?
If challenging situations happened, how do you typically deal with them?

Can you tell me about working as a nurse in the Saudi culture?
How do you manage your work life balance? For instance do your shifts interfere or stop you from doing something you like or do they help you to do different things?

Can you tell me about the relationship between your work and family matters, and social life?

Can you tell me what makes you happy when you are at work?
How would you describe a good day?
How would you describe a bad day?

Do you think you would choose nursing as a career knowing what you know now?
What would you tell your younger self/other Saudi females contemplating a career in nursing?

APPENDIX 8: Interview Guide (Head Nurses)

Introduce myself and explain the purpose of the study.

1. Explain to the participant the privacy and confidentiality of the data and that it will be used only for the purposes explained in the PIS and ask for verbal consent.
2. What is your view/opinion about Saudi nationals that take up nursing?
3. How do you feel about employing them? Are there any special considerations
4. How does the Saudi culture support them (or otherwise)?
5. Do you have a direct contact with NGNs?
6. What do you think about the skills and knowledge of NGNs?
7. What are the challenges NGNs face at the hospital?
8. Have you dealt with any concerns/challenges about NGNs?
9. How do you think you can support new graduates?
10. What are the plans to support NGNs if available?

When I did my observation, I noticed some points I would like to discuss with you

11. It seems that the nursing office prefers not to let the Saudi nurses work together; do you have a view on this?
12. How do you determine how many NGNs should work on any shift? Lack of staff nurses on the shift
13. Do you have any thoughts on their relationships with medical staff or other healthcare professionals?
14. Relationship of NGNs with nursing office, head nurses, patients. What do you think the patients think of the NQ Saudi nurses?
15. Can I just move on…. I was wondering what you thought about the workload of NGNs? - Going to the pharmacy, X-ray, laboratory, dialysis centre and blood bank, finding solutions to more organisation and resourcing, e.g finding a wheelchair to transfer patients, calling patients' family from their mobile number, going to the doctor to sign a paper and going to the other departments to bring some staff - do you think all of this is valuable? Can you tell me a little bit more about why?
16. I‘ve noticed that sometimes they cannot get food, or have difficulty going out for food on breaks, or getting lifts home – do you have any thoughts on this?
17. Closing up
18. Ask if there is something else they want to add
19. What happens next, how will the report be disseminated?
20. Thank her for contribution

APPENDIX 9: Approval Letter Ministry of Health Saudi Arabia

Kingdom of Saudi Arabia
Ministry of Health
King Fahad Medical City
(162)

المملكة العربية السعودية
وزارة الصحة
مدينة الملك فهد الطبية
(١٦٢)

IRB Registration Number with KACST, KSA: H-01-R-012
IRB Registration Number with OHRP/NIH, USA: IRB00010471
Approval Number Federal Wide Assurance NIH, USA: FWA00018774

December 12, 2016
IRB Log Number: 17-316E
Department: External
Category of Approval: EXEMPT

Dear Awatif Al-Rasheeday,

I am pleased to inform you that your submission dated **November 14, 2016** for the study titled **'Interpreting the experiences of newly qualified graduate nurses during the first 6 months of their first destination posts in a government hospital, Hail region KSA - A case study'** was reviewed and was approved according to ICH GCP guidelines. Please note that this approval is from the research ethics perspective only. You will still need to get permission from the head of department or unit in KFMC or an external institution to commence data collection.

We wish you well as you proceed with the study and request you to keep the IRB informed of the progress on a regular basis, using the IRB log number shown above.

Please be advised that regulations require that you submit a progress report on your research every 6 months. You are also required to submit any manuscript resulting from this research for approval by IRB before submission to journals for publication.

As a researcher you are required to have current and valid certification on protection human research subjects that can be obtained by taking a short online course at the US NIH site or the Saudi NCBE site followed by a multiple choice test. Please submit your current and valid certificate for our records. Failure to submit this certificate shall a reason for suspension of your research project.

If you have any further questions feel free to contact me.

Sincerely yours,

Prof. Omar H. Kasule
Chairman, Institutional Review Board (IRB)
King Fahad Medical City, Riyadh, KSA
Tel: + 966 1 288 9999 Ext. 26913
E-mail: okasule@kfmc.med.sa

مدينة الملك فهد الطبية
King Fahad Medical City

APPENDIX 10: Approval Letter from University of Salford

University of Salford MANCHESTER

Research, Innovation and Academic Engagement Ethical Approval Panel

Research Centres Support Team
G0.3 Joule House
University of Salford
M5 4WT

T +44(0)161 295 2280

www.salford.ac.uk/

10 November 2016

Dear Awatif Alrasheeday,

RE: ETHICS APPLICATION HSCR 16-100 – Interpreting the experiences of newly qualified graduate nurses during the initial 6 months of their first destination posts in a government hospital, Ha'il region.

Based on the information you provided, I am pleased to inform you that application HSCR16-100 has been approved.

If there are any changes to the project and/ or its methodology, please inform the Panel as soon as possible by contacting Health-ResearchEthics@salford.ac.uk

Yours sincerely,

Sue McAndrew
Chair of the Research Ethics Panel