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Turning with the Tide:

An exploration of challenges facing recently qualified nurses based in the community.

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Abstract

The aim of this evaluative study was to explore the challenges facing recently qualified nurses working within community and intermediate health care settings and to propose more effective support structures. The main focus of the study was on how individuals developed emotional resilience in the context of management of increasing responsibilities and the adjustment to professionally qualified status, alongside the emergence of new professional identities in this transitional preceptorship phase. A qualitative methodology was used and data gathered using individual interviews which were recorded transcribed and analysed through categorisation of key themes. Four main themes emerged: transition work; new learning; support and supervision; and identity and integration. It was concluded that transition can be challenging and stressful but even whilst working independently participants are helped by a supportive environment in which their developmental needs are identified and met and active engagement in their broader community of practice. Recommendations are made concerning the need for a more structured, planned and consistent approach to the induction and preceptorship period.

Introduction and background to the study

The challenges in facing transition from student to qualified nurse has been a preoccupation of the profession for many years (e.g. Kramer 1974, Glen 2009), in spite of radical changes in pre-registration nursing education (Department of Health 1999). In a detailed systematic review of the literature concerning the experiences and perceptions of this transition Higgins, Spencer and Kane (2010) concluded that the process itself is ill defined and lacks clarity 'which creates the potential for role conflict therefore blurring the boundaries between professional nursing and skilled health care work (p508)'. Roberts and Johnson (2009) add to the debate by questioning whether the key focus should be level of confidence rather than competence alone of newly qualified nurses and suggest that a fuller understanding of this and strategies for its development is crucial. There is agreement in the literature that a supportive environment and a positive preceptorship period make the transition process easier (Higgins, Spencer and Kane 2010) and this in turn leads to an increase in confidence, although in their review the availability and standard of preceptorship was found to be limited and variable. They go on to suggest that the transition process is complex, occurring over time and in a variety of settings and that further research is necessary, particularly given that more newly qualified nurses are currently employed in primary settings about which there appears to be limited information . Further review of the health literature by Kralik (2006) suggests that reconstruction of a valued sense of identity is essential to successful transition

The focus of *Turning with the Tide* was on developing work to date by uncovering the perceptions of qualified nurses in the transition period, within two years of post registration, who were working in community settings (either within the community itself or intermediate wards that had limited medical cover). The aim was to determine how participants adjusted to and managed increasing responsibilities, including their perceptions of professional accountability and of the ways in which they had responded to both challenging care situations and structural organisational change.

The study also builds on previous work undertaken with undergraduate student nurses related to the development of emotional resilience in practice based learning (Brigham and Smith 2008). This initial project led to the identification of a number of themes including: the ways in which

participants responded to emotional and ethical dilemmas and situations in the workplace; the challenges of perceived inadequacies in knowledge and skills; the influence of personality factors such as humour, motivation and determination and a range of coping strategies related to and determined by internal and external factors. Findings related to ways in which emotional resilience could be promoted through new resources for mentor and tutor development and proposed structures which could facilitate peer interaction and support and validate personal reflection. The investigation, however, also raised questions which highlighted the need to draw upon theoretical frameworks which shifted the emphasis on emotional resilience as an individual characteristic to a more inclusive definition also incorporating wider social, cultural and organisational factors. It was concluded that it would be useful for further consideration of these factors and application of the broader concept of emotional resilience to the situated practice context of newly qualified practitioners. *Turning with the Tide* explores what helps individuals cope with the challenges of the transition process and development of emotional resilience and addresses ways in which a professional identity is acquired and developed.

Objectives

1. To define strategies which individuals use to cope with and adjust to higher levels of responsibility in the context of a new and changing professional environment and their own emerging professional identities within the preceptorship period.
2. To understand how emotional resilience can be promoted or undermined in the situated practice context of newly qualified nurses working in community and intermediate healthcare settings.
3. From this investigation, to make suggestions for development of material relevant for CPD courses and programmes in relation to health and social care.
4. To work closely with a Trust based in the North East and use findings from this investigation to provide information for policy and procedures related to service improvement and models of clinical supervision or preceptorship.

Method and data collection

Approval for the study was granted by the internal Research and Development Team via Learning and Development and Clinical Effectiveness committees. Due to the nature of the study a qualitative approach was used to determine the sample, data generation and analytical and interpretive decisions. Individual interviews were undertaken with 10 qualified practitioners (7 working as community staff nurses and 3 as staff nurses in intermediate care). All were within the first 18 months of qualification (ranging from 8 to 18 months). Interviews were recorded, transcribed and then analysed through categorisation of key themes and more in depth narrative analysis. The dimensions of emergent categories were identified and these influenced the focus of subsequent interviews.

Results

The main findings are categorised into 4 main themes:-

1 Transition work
2 New learning
3 Support and supervision

4   Identity and integration

1. Transition work

Responses reflected the mixture of feelings participants had on first entering the profession, both of anticipation and excitement but also of their fears and concerns**.**

> *For me the biggest challenge was the transmission from being an auxiliary to having the responsibility as a qualified nurse and basically knowing that I could do it. I think university prepares you a little bit but it's not until you're out in the real world, doing it and knowing that you have got the ability to do it.* (Int.2)

> *I think the biggest challenge for me has been coming into the community. Although I've loved it and I would never change it, it's a big step going from being a student, going straight into the hospitals, coming out into the community and being quite independent, being alone and not having the back up of a nurse who is round the corner on the ward if you need them. But I quite enjoy that.* (Int.5)

Some were helped by drawing on their previous experience as health care workers and also if they had undertaken a relevant internship as students, although even the positive effect of these experiences had their limitations:-

> *I was an auxiliary for well twenty three years I've worked for the Health Service and I really feel that helped me a lot. I think if I'd been a newly qualified going into that situation (not being derogatory about people) it would have been quite daunting.* (Int.2)

> *I just think that when you're a student you don't do the things that you'll be doing when you're actually a staff nurse. Like I know we can't go out and give insulin on our own when we're a student, and give injections and take bloods, but then when you become qualified you do that all on your own.   [..] I was on my internship but it still doesn't prepare you for being on your own, I know you get your own little case load but it's just like simple things, simple dressings, eye drops and things like that.* (Int.8)

As well as learning new skills**,** learning new ways of working within a new organisation was a particular challenge for those who had undertaken their initial nurse education in a different Trust or area of the country:-

> *It was scary. The change of Trust because I did all my training in X so it was a bit of a leap and I kind of underestimated how much the change would be from one Trust to another, so that was probably the biggest thing. [..] I hadn't **realised** that this is a community ward and it was going through changes at the time when I took the job so we don't have medical staff through the night we don't have medical cover on a weekend.* (Int.1)

> *.... the paperwork and the computer systems and everything were all different [..] but then I think when you're moving from one area to another it's still quite difficult because everything's different, everyone works in different ways.* (Int.8)

Some made the effort to familiarise themselves before taking up post:-

> *Before I started here I rang and said "do you mind if I come down and say hello" you know, show my face and everything, just little things like that.* (Int.9)

I came to visit before my interview so I got to know a little bit about the layout and when they have the ward rounds and whose doctors are whose and that sort of thing. (Int.6)

Learning who's who and who does what was an important initial task:-

If you were at a patient's house and if something wasn't quite right, it was like who do I refer to? I wasn't sure about the referrals. (Int.4)

Yes, who does what? Who do I ring if such and such is wrong, who do I ring if this happens things like that. [..] ..everyone here was really good and for the first few weeks I actually followed XZ so I picked up a lot from him in terms of, these people can help you with this - there are 2 triage nurses at the surgery who you can just ring for anything. It's just little things like that that you pick up [..] everyone has their own diary with a list of different forms and things and people would say now this number's useful for such and such person and this number's useful for this person, so I just picked up little bits from everybody in the team really.. (Int.9)

Travelling could also be a challenge:-

Yes I think it was a bit of a standing joke at first, it was a bit scary because I didn't have a clue, but people would say it's such and such a place or you turn off this road and then obviously I had A to Z and everything like that so I did pick it up quicker than I expected.(Int.9)

Also working independently:-

I just think at times, and I don't mean this to sound derogatory, at times I think people forget how long you've actually been qualified, because obviously at the weekend, we work weekends as well, and weekends are totally different you're out on a limb basically, not in a horrible way. (Int.2)

You know sometimes getting thrown in at the deep end's a good thing and all of that day you just get on with it as long as you're prepared to say, oh I've never done that before. The frightening thing is if you get thrown in at the deep end and you're too terrified to say anything so you try and plod on. (Int.3)

It's like having all that responsibility because when you're a student when you don't know things you can go - oh I'll just go and get the nurse, you know what I mean -it's not really put upon you to know everything, whereas when you're the staff nurse a lot's expected of you. And sometimes you think God I know nothing, but actually when you reflect after a shift you think well actually I do know a lot. You just don't realize that you know it until it comes down to the day. (Int.6)

Perceptions of high expectations of others can also cause concern:-

Well, I had a bit of a rocky to start with, because where I was based after I first qualified I was sort of thrown in at the deep end. [..] I think because of the knowledge that I had of the community before I got seconded I think I would have sank if I hadn't have had that, but I was thrown in at the deep end. (Int.3)

> *I felt as if I had been just hoyed into the deep end and that because I was qualified I should have known everything.* (Int.4)

> *I guess people thinking that you know more than you actually do. As soon as you lose your white uniform they presume you know everything and you don't really and they forget that you're newly qualified still.* (Int.1)

However, most participants were helped to overcome some of these initial fears by an induction period which lasted 2 to three weeks. During this time they 'shadowed' another member of staff and they valued this experience highly.

> *When I first started I worked with one of the staff nurses every shift for 3 weeks until I learnt what I had to do and that really helped.* (Int.7)

> *Yes and I was doing the same shifts as her the first few weeks which I thought was good. You were not included in the number so you didn't feel as if you have to always get up and, say there's loads of buzzers going off when you're doing something important. You were not included in the number so I thought that was really good.* (Int.6)

> *. . As soon as I qualified I wasn't left on my own. I know I've been there as an internship student but I had accountability now and I think they didn't want to just leave us, and think right you've qualified off you go. So I think it was about two weeks I went round with her just until I felt a bit more comfortable even like seeing patients who I'd seen every day previously as a student, seeing them with your new uniform on, it's just different.* (Int.10)

> *It's a totally different role from student to staff nurse - I was out with X the Sister for a few weeks until I found my feet. . After a few weeks I said was it ok if I went out on my own.* (Int.8)

Summary of transition working

The initial transition from student to staff nurse was described as challenging by all participants. They were helped if they had had previous experience and had undertaken a relevant internship placement as students but the importance of a planned and structured initial induction period for all participants emerged as they tried to build up their confidence and live up to what they saw as their own and others professional expectations of them, particularly in terms of working independently. Their entry into a new community meant they had to learn quickly about organisational routines and roles which appeared to be gained mostly by word of mouth. Some also had to cope with learning how to get about a wide geographical area. A supportive team and a good role model early on, as part of a supportive induction process, if only for a period as short as 3 weeks, would appear to be vital.

2. *New learning*

Participants had gained many new practice skills although sometimes lack of confidence led them to being particularly careful at first:-

When you're on our own its quite scary, but then I think it's good for you because with you being newly qualified you check and you double check and you check again so you get it right. (Int.8)

There were many examples of the nature of the new learning they had acquired, based on their experience and opportunities to undertake practice – related courses:-

I used to think when I was a student how does she know what to put on that wound? Like when I first started and I opened the stock cupboard and there's thousands of dressings. I used to think oh how does she do that? But now it's just second nature really. It's a bit like driving when you first get in a car you think oh God how am I going to learn manual gears? But then you don't even think about it now. It's the same as that for injections and even like assessment skills. Like the nursing assessment at one time I used to think oh I really don't want to do that I don't know what questions to ask, but now you do it that much that it's just second nature really, you just get on with it. (Int.10)

Yes, obviously I feel I've become quite skilled in many different things since I've started this job, I've had a lot of training in different areas. I've done a leg ulcer training course because when you first come I think leg ulcers can be quite daunting. I wasn't quite sure about the aetiology, physiology and what dressings to use, but I did the course and it benefited me a lot in terms of I can now assess a patient quite easily. Sometimes it can be quite complex and I need a senior staff's advice but it's quite enjoyable when you actually go in and see a leg ulcer and you see them through and you obviously do the full assessment and things. (Int.5)

Participants acknowledged the differences between academic knowledge and practice knowledge:-

I think that's how you learn the most. It's alright university telling you to read this book, that book and that book but it's not going to help you when you're in someone's house really. The theory's alright for the wound, whatever's happening with the wound you need the theory for, but going into someone's house who's drugged up to the eyeballs and had a skinful of drink, who's starting you know – it's a totally different sort of knowledge - you can't teach that. (Int.10)

They were aware that even routine aspects took on new dimensions:-

Obviously my knowledge base has changed since I've qualified. I think well I've changed in the fact that obviously as an auxiliary nurse [..] you do the tasks and you say 'Bye' and you come out and you give it to the qualified nurse and then you think 'Right that's out of my hands'. Whereas it's changed now because you don't go in and just do a blood pressure, or take a blood because then you start spotting other things. (Int.3)

This might also involve a recognition of risks inherent in what seemed to be a routine task:-

When I first came there were certain injections, I've given thousands of injections as a student but there was one in particular, a gold injection, which I've never given before in my life and obviously I wasn't happy. And to be honest, luckily I'm the person that I am I did - I said it. Because I wouldn't have taken the lady's blood pressure before I gave the gold injection, I would have just…..so it's things like that just because it was an injection it doesn't mean to say I was capable of doing it, so it was that sort of thing [..] Looking back it was quite frightening to think that they just expected or presumed that you would know how to

do it without actually as a newly qualified nurse saying 'well look this is what you've got to do' and talk you through it. (Int.3)

There was a great deal of apprehension amongst all participants associated with giving medications:-

I'm constantly checking are you doing things right? Is this the way I've been shown?[…] I do the medications and then I go through, as I come back off the ward I think well I've done that, I've done that and I check the names off on the doors as I'm coming back because of the constant fear of missing something. (Int.1)

And inevitably an increased awareness of professional responsibility and accountability:-

If you went in there and did something and you weren't sure and something was to go wrong, that would be it, registration on the line and it's just not worth it. I'd rather say look I don't know what I'm doing, or I'm confused or could you help me with this rather than risk that. It's just not worth it. (Int.5)

The need for assertiveness was vital:-

I said that I hadn't been trained in using the syringe driver and I didn't know the syringe driver that was being used it wasn't one I was familiar with I'd only seen it set up as a student, and I should have said no I won't, I won't do it but there was only 2 qualified on the ward, it was hard - yes you need to be assertive and say I don't know how to do that and I won't. (Int.1)

Also clarity on what newly qualified nurses are expected to do and when:-

I mean on a couple of occasions I was expected to know how to do the syringe driver on my own and I found that daunting. I did it because I had done it previously with somebody watching me, and then I was told I wasn't to do it on my own and that I shouldn't have been expected to do it on my own at such an early stage of being qualified. (Int.4)

There were examples of how participants were learning to cope with the unexpected :-

I went to visit a lady who is one of our palliative ladies who has got a fungating tumour and I rang at the door bell and could not get an answer so I went round the back garden and here she was lying on the floor with the Zimmer on top of her. She managed to get to the front door and she had gashed her leg so I steri stripped it and things and saved her going to hospital, because that's her choice she wants to be at home. So that took maybe an hour and a half two hours getting her sorted getting her comfortable speaking to the GP who then wanted obviously a full blood count taken and check what blood she had lost and things and then cleaning up after her and reassuring the lady.[..] I rang her son and I waited till he came home because he works just round the - not very far. (Int.2)

Colleagues were identified as an important resource for information and guidance:-

I'm still learning, it's like my first year and I'm still finding my feet and I know there's loads more to learn and I just like to think that I'm just grabbing everything and just doing it the best I can. And then if I don't know what I'm doing or if I'm unsure, then luckily I'm with a lovely bunch of girls and they are all very knowledgeable in their own different areas,

whether it's continence or wound care or whatever, so I get bits from them, and I know which one to ask. (Int.3)

I go to either anyone in my team, to the district nurse, or I'll go to the staff nurse who's the same as me. Sometimes I even go to the auxiliaries because they've got a wealth of knowledge as well. Or if I wasn't to get that sorted I would go to somebody higher, but there's always somebody there you can ask. The door's always open for anyone in here, you just have to go in and they'll help you if they can. (Int.4)

Although most participants acknowledged communication skills as an asset they brought with them to the staff nurse's role, they acknowledged that this skill had increased because of the nature of the work they were undertaking:-

I think I've learnt how to speak to people better, like families and relatives when they come in and they are anxious about what's going on and what the ward's about, because it's totally different to the X and the acute side of things. They don't realise what we do here so I've given them an idea of the reason why they've come here and who can help them, the therapists and what our plan is for them.[..] so obviously you're building your confidence up because you're just learning new skills. (Int.6)

This might involve listening to, understanding and diffusing anger from patients and their relatives :-

Sometimes, if they've been given bad news and you're the next one in. I went into a patient a few months ago and I always say hello I'm X, I'm the staff nurse, how are you? "How the hell do you think I feel", and I thought 'Oh!'. So then alarms bells were ringing and I thought there's obviously something. So I said 'Oh well come on we'll sit down'- and I think silence is good as well [..] I just sat down in the chair and the patient was opposite me [..] and the silence went and they said, " I'm very, very sorry but I've been told I've only got 18 months to live". And I said "Well I do apologise if I came across as bubbly" and that patient I still visit now, but it was just that initial visit. (Int.2)

I just let them rant on for a while and then I just listen, no one's been physically violent it's just verbal usually when they've had enough of this or had enough of that or that they feel that the GP isn't doing this and you're all useless, it's that type of thing.[..] I just sit and listen, most of the time it's totally irrational what they are saying anyway. It might be something like the wife might come in and say something and then they just kick off and you think oh….and it's usually families, the person them self is fine when you're one to one but then you don't know who's going to come in that house, and family have come in and started arguing with the person and then dragged you into it saying "Well am I right and is it…" and you just think oh… I think the good parts outweigh the bad anyway. There's loads of good parts but we don't have loads of violent people. I mean even people who looking at their history would think oh I'm a bit uncertain about them, they're lovely, really nice, very appreciative. Please, thank you, do anything that you tell them to do, it just depends on circumstances and families and if they've had a bad day at work or whatever. (Int.10)

Some participants were uneasy about their ability to provide palliative care although they were anxious to develop their role and skills in this particular aspect of care:-

It's the only thing in the job that I'm scared of doing on my own it's because you only get one chance to get it right. It's a lot of pressure. Once I start doing it I think I will be all right but at

the minute I just think leave it to what I'm doing now and I kind of shy away from it. I will have do it at some point. (Int.10)

Another more experienced participant found that she could apply her knowledge and skills in her previous work to a distressing situation:-

I went into a patient last weekend, palliative patient, he was just so distressed and the family were distressed and I said would you accept an overnight from the Marie Curie nurse? Well, I thought could I get one? and I'm trying….thinking - going back when I worked there and I thought such and such works these nights. So if I hadn't have had that maybe I would have thought, "Oh what do I do in this situation, he's distressed?" I mean I know you can give them medication but sometimes that isn't the answer. (Int.2)

Summary of new learning

The data provided information concerning a large amount of new learning related to clinical and interpersonal skills which had taken place within a short time span since qualification The high value participants placed on their practice learning is seen not only in terms of the assimilation of new skills but in the way they were able to apply them to real life practice. Common concerns were centred around the giving of medications, particularly via syringe drivers, helping patients and families to cope with bad news and caring for dying patients. Sometimes, in spite of there being excellent support by their colleagues if requested, participants were unclear about what they should do when and were concerned that they were expected to do more than they felt capable and/ or confident of undertaking . Preceptorship can provide an ideal partnership through which these difficulties can be overcome, this new learning can be reconsidered, gaps in knowledge and skills recognized and achievement plans developed.

3. Support and supervision

Although a small sample, experience of preceptorship varied from models of good practice to those which were poorly structured or, in one case, non-existent. Those participants describing good practice valued their relationship highly in terms of support and clear guidance:-

You've always got somebody there; if you are unsure of something you've got that support from that one person. (Int.8)

She really taught me quite a lot when I first started, she was easy to talk to…she was approachable, she did take a lot of time out to explain things to me. (Int.7)

They've got to show you what's expected of you and what you need to be achieving and how you can achieve it - getting to know the ward, getting to know the patients and what their policies are and just doing things correctly really, so you feel secure in what you're doing. My preceptor's really nice; she's a really nice nurse. She's very thorough at what she does and she speaks to all the patients really nicely. (Int.6)

Clearly structured and planned guidance and commitment was helpful:-

We have a template that we followed. We both signed an agreement with what we were discussing and things so I feel like I've had quite a lot of support and obviously I think you find

that you do have your up days and your down days and when I did have down days and feeling a bit just generally down, and then she'd be there. (Int.5)

There were problems if there was late allocation of preceptor:-

I found it difficult at the very beginning when I was newly qualified; I found it a real struggle. [..] Possibly because I wasn't given a preceptor straight away, it was some months before I did get a preceptor. Once I got my preceptor that was fine, I was really well supported, but I just found it a struggle because at times I felt as if I was on my own and I didn't know anything. (Int.4)

Some problems related to feelings that other priorities took precedence:

I had a preceptor. I haven't found it to be really good. I found some of the other staff to be more supportive than my preceptor has been. [..] When I first started we were meant to have regular meetings and they just haven't occurred, I feel like it's pulling teeth sometimes with my preceptor. (Int.1)

I was appointed a preceptor when I first started and it was the senior nurse and it was the ward manager. She said I'm your preceptor we'll sort a meeting out and I can't even remember the amount of times I asked her for a meeting and she was just "no I can't do it, I can't do it, too busy, too busy" and then it was I think it was 6 months had passed or 8 months had passed. (Int.5)

One participant had had difficulties in her first job post qualifying, resulting in a severe loss of self confidence which she related to lack of support. She was able to compare this to a more positive experience in her current post:-

When I first qualified I was confident but because I didn't have a very good start with the practice I was in, my confidence went back over and I started to get to the stage where I was thinking I can't do it. And at one stage I did think I'm just going to go back to being an auxiliary [..] My confidence went right down but I feel that's because I wasn't supported as well as I should have been. And since then I've been moved in with another practice where they've been really supportive and loads of people have said you are a totally different person to what you were when you first started. (Int.4)

There appeared to be no common process for the allocation, timescale or documentation used for structuring the preceptorship. Some chose their own preceptor who worked within the same practice whilst others were allocated one from either within or outside their practice:-

I did choose my own preceptor who was in the area I was working in but in all fairness there was never a minute in the day, you know I just let that go and I just got straight into it. In one respect it probably learnt us a lot, in another respect looking back had I been newly qualified and went into my training straight from school and got put in that position then I would have been terrified because it wasn't structured one bit. [..] I thought preceptorship would be a bit like having a booklet working through things, getting things ticked off and I had none of that, none of that at all. But I'm fine and I came out of it the other end and I've moved on somewhere else now where I'm dead happy and which I love. (Int.3)

A week after I started my job. I was asked to come and see my cluster co-coordinator who said that she's appointed me a preceptor from a different practice, who I should meet with every 2 weeks or every month , obviously her case load had an impact on things - which I did

and I have done for a full year up until January. [..] We meet and discuss how I feel I'm getting on, how I feel I've improved since the last meeting, any targets that I've got, or any goals that I want to achieve and then at each meeting we go through and make sure that I've achieved those targets, those goals, and if I haven't then we talk about why and what I can do to meet the goals for the next meeting. (Int.5)

Although the immediacy of working in the same area as your preceptor was seen as useful by some, the above participant felt that having a preceptor who was not directly involved with her practice had other advantages :-

But I think it was a lot of oh I've got a meeting next week with her so I felt like I could just let everything out because it's not someone I've worked closely with, it's not going to impact, because I think if you work closely with someone and you've told them you've got troubles, they're going to obviously feel like it's their problem as well and I don't want to have that, I'd rather someone that I wasn't involved with day to day. (Int.5)

On the other hand, guidance could occur at an informal level if the preceptor was close at hand:-

On an informal level, we see each other every day and we're always chatting backwards and forwards about little things, "oh this could be good for your portfolio" so he's very good like that. (Int.9)

Those who did not have a framework or structure to follow for their preceptorship felt disadvantaged:-

I would like to have had some sort of plan to work through with somebody within the team or in one of the surrounding teams that you could just work through and think alright, and all the different skills that you would need. So that things like different injections and stuff like you couldn't think well actually I need to go and see one of them. So I think it could have been a lot better than just being thrown in. (Int.3)

This occurred even if the individual was praised by colleagues:-

Everyone was saying you are doing really well, but I just think that if there was something a little bit more structured. (Int.2)

One of them said, "Eee God X you'd think you've been here all your life. You've just slotted in". And it was just thank goodness you're here - that sort of stuff. But we didn't get a detailed sort of thing- it was just literally just get on with it- type of thing. (Int.3)

One participant made up her own template and recorded her achievement -

We didn't have a book, I don't know if there's a book now I made my own book of what I felt I needed to transfer from being a pre reg to a post reg. (Int.2)

Protected time for discussion and to complete the portfolio was important

…. because more often than not you arrange to meet and it gets put off, so I think there should be protected time to actually sit down and have that time together. (Int.4)

'Good' preceptors were able to offer useful criticism and guidance :-

She asks me how I feel about how I'm improving or what I feel I could improve on. She delves into my positives and negatives rather than just saying right what have you done that's good, so it was really good and she followed the structure quite well, she knew what to ask me. (Int.5)

There were some indications however that sharing preceptorship experiences could yield valuable insights into effective practice. One participant compared her own experience with that of another member of staff who was also newly qualified :-

She meets up with her every month and they seem to be talking about loads of stuff and have reams of paper which she comes out of the meeting with her, and I think well what have you been talking about? Because when I go to see my preceptor we just kind of, not that it's a bad thing but we don't really have that much to talk about. (Int.10)

It was interesting that the same participant spoke openly about her fears when caring empathetically for a relative in distress following bereavement but said that she had not discussed the incident with her preceptor. The following interaction took place :-

Participant : *So when he died and I went round to do that bereavement visit that was quite hard because I think it just all came out because I don't know if she felt she could say what she wanted to say while he was still alive. They didn't really like communicate, I think just because he was so…. didn't want to face facts type of thing, and when he died that was hard. [..} And just that people can trust you that much and be crying their eyes out and telling you really personal things and you think oh God,. I dunno, I mean you can cope with it but I just think I'm so young and people say something and think God she's young.*

Interviewer: *Would that have been helpful to talk to your preceptor after that situation do you think? Did you talk to anyone about it?*

Participant: *No. Well I went back to the office and I said oh I've been to see her, she's really upset and what not, that was it really, I didn't say anything more.*

Interviewer: *Did that finish there or did you go back to her again?*

Participant: *I think I just left the phone number - oh no I didn't sorry after that he had loads of equipment and things in the house and drugs and tablets and things and she didn't feel like she could face taking them back, so I said well I'll come round and get rid of those. There was catheter stuff and incontinence pads whatever so I went round and got rid of them for her, and by then she was a lot better, she was still quite weepy though.*

Interviewer: *Do you think that it helped her that time when she did let go of lots of the emotions when you went there?*

Participant: *I think it did for her, it was quite hard for me.* (Int.10)

Although the focus during the interviews was on the initial support they had received, participants were aware that they were moving on to clinical supervision and of the need to complete KSF portfolios. Some had already been allocated clinical supervisors and had experienced 'live' supervision which they saw as useful:-

Especially if you think you're doing something right and somebody comes and helps you with it and you realise you're not quite doing it the right way, it can be useful in some ways. (Int.7)

It was helpful to be given tangible examples of what kind of evidence was required to meet KSF requirements and this could begin during the preceptorship stage*:-*

When I was still with my preceptor and she said we'll keep hold of this because it will be handy and then my manager (supervisor) helped me. She sort of gave me the information and said get this sort of thing, and then we went back to it and put it all together and I also borrowed another staff nurse's to look at to get the basic idea of what went where for the evidence. (Int.7)

Some participants would welcome more guidance about this which some thought could be given on a group basis. One had been discussing this with a newly qualified friend working elsewhere: -

I know that the preceptorship over there is excellent and they meet up on a monthly basis [..] And they are also guided on their KSF which is another thing I've been asking and asking for some support. I don't know what I'm meant to be doing with it and I've had no support with that. [..] it's basically setting up your filing, knowing how to….just basic things like that. Once you've done it once you've got it there as a template for your following years, but you want to get it right in your first year. (Int.1)

Summary of guidance and support

There was much evidence from the data of some excellent support and guidance by preceptors and also by the team in general. However there appeared to be lack of consistency in the preceptorship process with variations associated with allocation, structure and timing. Limited guidance from preceptors led to loss of confidence and lack of clarity concerning how to ensure the newly qualified staff felt they were meeting expectations. It would also appear that sharing good practice and providing clear examples of this including ways of capitalizing on learning opportunities would benefit both preceptors as well as preceptees. It is likely that a positive preceptorship will have an impact on subsequent supervision.

4. Identification and Integration

Participants in the study were also conscious of the fact that they had to take on a new professional identity and integrate into the workplace team. Their professional identity not only depended therefore on how they saw themselves but also on how they were perceived by and were helped by others. There was evidence of strong patient focus to their work and part of their sense of self was about working in the community rather than just being a qualified nurse. All were very positive about the work they were engaged in and saw it as an opportunity to continue focusing on their ability to care for others which they saw as an essential part of the professional role and identity:-

I can sort of empathise and sympathise with my patients and I just love providing the care for them. I love the 24 hour care that we can give the patients end of life and forming that bond, that nurse-patient bond, I really enjoy it. (Int.5)

.. And everyone said oh give another ward a chance it might change your mind but I just knew I wouldn't like the hospital [..] I felt trapped on the ward and it was just….I don't know,

you want to give the best care you can and I'm not like judging wards and things but I don't think you can because there's that much put on you while you're on the ward that I don't think..[..] And it means that you can't give basic care like washing people properly and shaving them and dressing. You couldn't do it, it was too busy and it was just too stressful I think. It's a different sort of stress to what it is in the community. It just wasn't me I don't think. (Int. 10)

The close relationship that they were able to build up, often over a period of time with patients with long-term conditions was important :-

Knowledge of what's going on with them because I think that helps, if they are feeling very vulnerable just maybe one little sentence that brings them back oh well I am an individual - I am a person.(Int.2)

And could reinforce feelings of professional legitimacy:-

It just makes you feel good and you think well yes I have done what I came out originally to achieve. (Int.2)

It also brought particular challenges in terms of decision-making:-

He said that he had been having suicidal thoughts and that he was thinking about killing himself. I tried to ask him why he was feeling like that, because I see him nearly every day and he never said that, this is the first time he ever said that. And I thought well something has triggered it he's usually dead bright and he has no history of depression or anything. So I just sat and talked to him for ten fifteen minutes just saying what is it, he just said that he was fed up with his legs being the way they were because he's stuck in the house more or less. I just said we've got you the referral to the hospital, the wheels are in motion, and I think he kind of thought - sometimes he says things and you don't know whether to believe him or not. I know that sounds awful but all his family don't see him because of that he used to say things and cause a lot of trouble saying things that were not true and sometimes you think is he saying it just because he's lonely and he wants me to sit there and talk to him or is he actually suicidal? (Int.10)

Although participants were anxious about working independently at first, they were helped by recognition of themselves as part of a wider team:-

It's definitely a team effort, it's not like…..I thought it would be a bit isolated when you're in the community, you're on your own, but the one thing that everybody kept saying to me when I started was we're only at the end of a phone, and just ring and I mean everyone…. I'm obviously spending time with the team and realise that actually everyone does ring each other, even if it's just for a little bit of back up, say oh I've done whatever with Mrs such and such, what do you think, so everyone does really help each other it's not an isolated thing at all, it's very much a team effort I think. (Int.9)

Because of the nature and distribution of the work over the weekend period, integration had to occur within more than one team:-

On weekends we all work geographically and there's a lot of different district nursing teams clubbed together, so at first it was meeting different people because it's a completely different team and we have set weekends that we work, but it's the same as anything, I've

got to know that specific team and everyone was really sympathetic to the fact that I was new. I didn't do a weekend for quite a while for a few months, so I had already met some of my weekend team before I worked the weekend and they were all supportive. (Int.9)

Being accepted by the team meant that you could acknowledge any limitations you might have:-

You are supported you can ask anybody they'll never say "eh I'm sick of you" or things like that [..] I felt welcome from the start [..] I think everybody - they've got their own skills, sometimes we ring people and ask if they can come and do a blood if we can't - so it's a nice team of different skills. (Int.8)

I think a lot of credit is due to my team because we always discuss how I feel, about how I feel where I am and they know not to give me something where I feel like I may get in there where I'm on my own and out of my depth, we always go together. If there's something I'm unsure about we go, myself and a senior nurse, and discuss things when we get there so I've never found that I've got there and thought oh God I don't know what I'm doing here. (Int.5)

However participants were also gaining confidence in their ability to contribute to the team:-

In my first 6 months I had a load of rectal flushes and the different button pegs that they are coming out with, and the girls, because they've been on the community for such a long time hadn't really come across that, so yes it's quite nice because they ask me just like they would ask any other qualified nurse, even though I'm only a year in… (Int.3)

Ironically some of the girls that I work with who have been on the community for years and years and years, just hate and cannot take bloods very well so they'll always come back in and go XX, [..] and they are trying not to because they know I'm newly qualified and they don't want to just think, eee bless you know we're giving her another blood. (Int.3)

They also looked for and recognised evidence that they were accepted :-

I think we all tend to ask each other advice on everything really. It's sort of a real feeling that your opinion's valued which is nice when you're new. (Int.9)

One participant who had had long experience as health care support worker in mental health before undertaking registration showed how this could contribute to her feelings of professional self worth:-

There are so many people out there with mental health problems, and issues. A prime example a lady I visited who's got bi polar (to undertake a wound dressing) *and she wouldn't let anybody in the house. Anyway I struck up a very good relationship with her so now when she rings the surgery she says can you just tell X to come down, but she won't tell them what for [..]. I went in one morning and she was really distressed [..] I just said I think we need to ring your little friend, this is what she called the CPN, and I said are you happy for me to do that and she said yes, so that prevented her being admitted under section bless her which she has been in the past.* (Int.2)

Beginning to take on a management role, meant learning about when and how to delegate:-

Sometimes when you're working with support workers it's delegating your work if you're your busy doing something … you've got to say to them right can you go and check this, can

you go and check that. I've no problem with it, but when you first start you're like I feel like I'm picking on someone, like can you go and do this job can you go and do that job and I've got to ask her to do something you know what I mean but you're thinking well I'm not asking for my benefit I'm asking for the patient's benefit.[..] I mean I go to them for advice as well because they've been working here ten years and they know the ward a lot better than I do. (Int.6)

*It is really hard (*delegation*) . Sometimes you think oh am I being a bit cheeky in saying to someone would you mind doing this and it's not something that I particularly enjoy [..] There's an auxiliary here who works here, but I like to think really that she delegates to us as well, I don't know if that sort of power - Yes I don't like that I think…because I'd like to think that she would delegate stuff to me and say oh would you mind going to see this patient as much as I'd say to her oh can you go and see this one.* (Int.9)

Being actively supported was particularly important when things went wrong and it could turn a negative experience into a positive one :-

I was involved in an incident I didn't expect that, and it was a quite a serious one and that was from lack of knowledge and I hadn't had training on a piece of machinery. So that was a big one and it made me….that knocked my confidence massively. [..] *We (*the ward manager and the clinical leader*) had a meeting straight away following the incident. I was allowed the time to go and write my statement down what happened and me and the other nurse that was involved supported each other. We talked about how we felt, what went wrong, why it went wrong. There was then an interview from an outside body into the incident as well and x, the clinical leader, was very good- she rang up daily, visited the ward just to check we were both ok. So it was very supportive.* (Int.2)

Participants were asked if they felt there was anything the wider organisation could have done to help them integrate. The following participant reflected :-

I don't think so really because I think a lot of it was my anxiety before starting in the post and once I was here I was introduced to everybody, introduced to different ways of working and things like that and it was all really gradual but really supportive so I think anything that I did have, you know any anxieties I did have before I started the job were down to me not the organisation. (Int.9)

Not surprisingly those who experienced difficulties, particularly initially, thought that careful consideration should be given as to where newly qualified staff are placed and with whom:-

Well I think they need to be put with somebody who is going to support them and somebody who's not just going to expect them to get on with it and that they should actually know everything. I think they've got to be really careful who they place you with to make sure you're going to get the support, so they don't go through what I went through where I really felt I had no support and I just wanted to go back to being an auxiliary. Hand my notice in, do anything but not nursing. (Int.4)

Look at the teams you've got and think right is that appropriate to send a newly qualified into that team? Are they having problems at the minute? Look at what the skill mix they've already got, could they accommodate a newly qualified nurse or is it really a more experienced nurse they need? And I think that could have been done better. (Int.3)

The skills mix was important not only in terms of work and support but also opportunities for professional development, which they saw as a need if they were to fully integrate into the team:-

> *I did that all myself nobody did that for us. And had I not booked on them in my first year I'd probably still be sitting waiting to go on, [..] because at the end of the day they want you to go and work with cannulas more or less straight away, but you cannot go and work weekends if you haven't done a lot of this training.* (Int.3)

> *… we could definitely do with newly qualifieds training on controlled drugs and syringe drivers and palliative care.[..] And tissue viability as well .[..] You could ring and see if there are any places but normally they come round to each health centre, but I just ring up and book myself on, but it's whether there's enough staff for you to go on them…* (Int.8)

Summary of identification and integration.

It was evident that at the time of interview, all participants enjoyed the work they were undertaking and felt that they had the opportunity to provide care and develop effective relationships with patients and their families which was an important part of their self-image as a professional nurse. Data also reflected the importance participants held of becoming an integral part of the immediate team in which they worked. This led some to use their initiative in finding opportunities to develop what they saw as relevant skills to ensure they were able to participate as much as they could in undertaking more complex tasks. The importance of feeling part of the team not only in terms of receiving support but also in contributing to and being recognised for the skills they already possessed, led to the likelihood of full integration into the team. The significant positive effect of the organisation in supporting them when difficulties occurred and in consideration of their needs, particularly in their initial placement was also indicated.

Discussion

The findings reflect the challenges faced by newly qualified nurses working in environments in which they were expected to work independently and make significant decisions with an associated level of accountability. Their entry into a new community meant they had to learn quickly about organisational routines, environmental and geographical factors, new skills and new ways of communicating and networking. They felt more competent if they had had previous experience and had undertaken a relevant internship placement as a student but there was recognition that although helpful, this still fell short of experience of the reality of the role as a qualified nurse. Stress occurred when colleagues had what they saw as unrealistic expectations of them, particularly if the participants had had previous experience as health care support workers. The importance of a planned and structured initial induction period for all participants emerged as they tried to build up their confidence and live up to what they saw as their own and others professional expectations of them, particularly in terms of working independently.   Although this was variable there was evidence that a good role model early on, as part of a supportive induction process, if only for a period as short as 3 weeks, was beneficial and could influence a growth in self confidence and integration into the team.

Data provided information concerning a large amount of new learning related to clinical and interpersonal skills which had taken place within a short time span since qualification and also of the skills that concerned participants most. There was evidence of ways in which they enjoyed and rose to the challenges of working independently but also aspects about which they were expected to do more than they felt capable and/or confident of undertaking. Specific areas of common concern

related to giving medications, particularly using syringe drivers and all aspects of palliative care and communicating with bereaved relatives.

Although there was much evidence of excellent support and guidance by the team in general and also by preceptors, there appeared to be lack of consistency in the preceptorship process with variations associated with allocation, structure and timing. Limited or no guidance from preceptors at all led to loss of confidence and lack of clarity concerning how to ensure the newly qualified staff felt they were meeting expectations and competencies. Even those who were given welcome but generalised positive feedback felt that they would benefit from more detailed analysis of how they could progress further. There was also evidence of lack of clarity about the nature of the preceptor/preceptee relationship and ways in which both participants could capitalize on this to promote learning. It would seem that finding ways of providing clear examples and sharing good practice would benefit both preceptors and preceptees particularly since it is likely that a positive preceptorship will have an impact on the effectiveness of subsequent supervision.

In spite of any difficulties expressed, all participants enjoyed the work they were undertaking and relished the opportunities they had to provide care and develop effective relationships with patients and their families, an important part of their self- image as a professional nurse. One participant acknowledged the significant effect of the support gained from the organisation when a mistake occurred both in consideration of individual needs and helping to learn from the incident.

Data also reflected the importance participants held of becoming an integral part of the immediate team in which they worked. This led some to use their initiative in finding opportunities to develop what they saw as relevant skills to ensure they were able to participate as much as they could in undertaking more complex tasks. Full integration to the team was also helped if participants felt able to contribute to the skills and knowledge through their recent educational experiences or particular experience. Data revealed that in spite of being 'isolated' and working on their own, most participants appreciated the sense of belonging to and being able to access a network of colleagues who could give them advice and support. Overall, there was much evidence within the data of the positive effects of what Wenger (1998) describes as communities of practice where individuals with common characteristics of mutual engagement, joint enterprise (or endeavour) and a shared repertoire of language, styles and routines, learn by developing and sharing knowledge through meaningful participation in practice. However, participants did find delegation challenging and there were some indications in the data that there was a blurring of boundaries between professional nursing and skilled health care work, as described by Higgins, Spencer and Kane (2010).

Clear up to date policies concerned with ensuring supportive structures for helping newcomers over the transition period from student to registered practitioner, in terms of induction preceptorship and supervision, will complement and underpin the informal supportive networks which are evident and effective. Such positive and nurturing professional relationships within a clear support system will create a culture necessary for the development and maintenance of emotional resilience so that individuals are more likely to cope with and learn from any professional challenges they might face (Jackson, Firtko and Edenborough 2007).

Recommendations

- Clear and up to date policies related to induction, preceptorship and supervision, with implementation and robust evaluation.
- Guidelines implemented relating to the role, expectations and responsibilities of both preceptor and preceptee.

- Review of preceptorship preparation, appraisal and methods of sharing good practice.
- Individual skills analysis and more coherent planning concerning the development needs of newly registered nurses, particularly in relation to common concerns about medication management, including syringe drivers, communication and all aspects of palliative care.

Conclusion

The aim of this study was to explore the challenges facing newly registered nurses and to learn how they adjusted to and managed increasing responsibilities and developed a professional identity. The strength of commitment of participants to their patients, colleagues and the profession was reflected in the data. There were many examples of excellent practice and supportive networks, even when participants were working 'in isolation' within a community setting. Most concerns related to what participants saw as specific deficiencies in their skills and the ad hoc nature of way in which they could access courses to overcome these deficiencies was seen as a major obstacle. Whilst some learned from and appreciated the chance to use the preceptorship relationship as a way of evaluating how they were performing and what they still had to learn, there was a lack of clarity and coherence with how some preceptorships were allocated and implemented. Any feedback which did not provide enough detail and analysis, even if positive was seen as less helpful. A major achievement by all participants was a growth in confidence when they felt an integral member of the team. This study reflects the findings of the work by Higgins et al (2010), that the environment in which newly qualified nurses are working is essential for a smooth transition, and the provision of a supportive environment will not only help professional development but is also likely to improve patient care. It also relates to the work on emotional resilience by Brigham and Smith 2008 that suggests emotional resilience must be considered as more than purely an inherent trait or set of individual skills but as the interaction between individual, acquired coping skills, immediate environment and broader social, cultural and political context.

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