Practice Readiness: An English exploratory study describing newly qualified graduate nurses' perceptions of practice readiness and professional identity

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Thesis submitted to Keele University for the degree of

Education Doctorate (EdD)

June 2022

Keele University

ABSTRACT

Background: Greater understanding of NQNs' perceptions of their pre-registration and transition experiences, and influences on their perceptions can inform pre-registration curricula and preceptorship programmes to support a positive transition to qualified practice.

Aims: To explore how NQNs from one English Higher Education Institute (HEI) perceived practice readiness and professional identity, on entry to the workforce.

Study Design: A qualitative exploratory research design.

Methods: An inductive semi-structured interview approach with a purposive sample of 20 NQNs. Data was collected within the first four months of qualified practice. Data analysis was completed using a thematic approach.

Results: Some NQNs continued to find transition to qualified practice difficult, with support being a key factor. Changes to personal habitus (Bourdieu, 1992) were affected by demographic and generational differences (HEE, 2015). Protection from the multifaceted workload of the qualified role led to anxiety and a lack of confidence in managing their responsibilities on qualification. Where workplace transition support was not available to NQNs, either through preceptorship programmes or more informal colleague support, NQNs could not align their habitus and expectations with the qualified role and were looking for alternative nursing employment.

Conclusions: Greater focus is needed within the pre-registration curriculum to develop students' understanding of changing capital and habitus, with consideration of life experiences and generational needs. Structured opportunities to develop resilience and identify areas of challenge to habitus, will support students' preparation for qualified

practice. HEIs should liaise with clinical colleagues around individual student needs with development plans spanning theoretical and practice elements of the programme. These plans should inform bespoke preceptorship programmes developed through liaison between the HEI and the employer. Greater recognition of CPD and support needs of staff in the workplace, and increased managerial oversight of preceptorship provision, can enhance effective support for the NQN during their transition.

ACKNOWLEDGEMENTS

Writing these acknowledgements has allowed me to reflect on the people who have helped me through this amazing experience and been there to support and encourage me. Words of thanks do not feel enough, so these acknowledgements are sent with the deepest gratitude possible.

My first thanks go to the newly qualified nurses who gave up their time to talk to me; your enthusiasm and candid discussions were truly valued and made this project so worthwhile.

Special thanks go to my supervisors: Professor Sue Read, whose patience, guidance, encouragement, and belief started me on this doctoral journey and remained with me throughout. Your wisdom and support were always available and without you I would not have reached this point in my journey – thank you for everything Sue. Dr Alison Pooler, I cannot thank you enough for your guidance, encouragement, and time. Your selfless support and expertise were immeasurable, and I will be forever grateful to you. You are a true inspiration, and your knowledge knows no bounds – thank you Ali. To Professor Christian Mallen, your guidance, support, and belief in me picked me up and kept me moving forwards – thank you Christian. To Dr Jane Boylan, who started this journey with me; thank you for your nurturing and belief in me. Your support through the first half of my doctorate was greatly appreciated.

To my best friend, Joanne Ward; for always being there to pick me up and push me forward when it all became too much, and for taking the time to proofread this thesis for me – thank you Jo, I love you.

To my two boys, Sam and Jacob; you embarked on your own university journeys when I started this doctorate, and you are now men with partners of your own (Alison and

Hannah). I could not be prouder of you, the four of you are always there to offer me love and support and I will never take for granted how lucky I am to have you. Sam and Jacob, you will forever be my greatest achievements.

And finally, to my wonderful husband and soulmate Jonathan. Your love and support have spanned over 35 years, with I hope, many more years still to come. I would not be here without you. You have never complained at the suitcase of textbooks and writing pads that accompanied our holidays for the last few years, and all the evenings and weekends I spent locked away working on this. Your quiet patience and encouragement have been my rock and I will love you forever.

Dedication

In celebration of our first grandchild Maya Rose; to my darling princess, granny dedicates this thesis to you with all my love xxx.

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LIST OF ABBREVIATIONS

CASP	Critical Appraisal Skills Programme
CoD	Council of Deans for Health
DH	Department of Health
GNC	General Nursing Council
HEE	Health Education England
HEI	Higher Education Institute
NHS	National Health Service
NMC	Nursing and Midwifery Council
NQN/s	Newly qualified nurse/s
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
RCN	Royal College of Nursing
UK	United Kingdom
UKCC	United Kingdom Central Council for Nursing, Midwifery and Health Visiting

GLOSSARY

Academic Assessor	Nursing and Midwifery Council registered nurse from the Higher Education Institute, responsible for confirming a student's achievement of proficiencies and programme outcomes in the academic environment. Works in partnership with the Practice assessor to determine a student's progression through the pre-registration programme.
Beneficence	The ethical principle that a nurse's actions should promote good.
Enculturation	"the gradual acquisition of the characteristics and norms of a culture or group by a person" ("Enculturation", 2012).
Enrolled nurse	A qualified second level nurse who works in a team led by a registered nurse.
Generation X	Born between 1965 – 1979 (Jones, Ingram and Mustafa, 2017; McCrindle and Pleffer, 2008).
Generation Y	Born between 1980 – 1994 (Jones et al, 2017; McCrindle and Pleffer, 2008).
Higher education institute	University approved by the Nursing and Midwifery Council, working in partnership with practice placements and work placed providers, to deliver approved nursing education programmes.
Human factors	"understanding the effects of teamwork, tasks, equipment, workspace, culture and organisation on human behaviour and abilities before applying knowledge in clinical settings". (Health Education England, 2017, p42).
National Health Service	The publicly funded healthcare systems of the United Kingdom.
Newly qualified nurse	A qualified nurse within the first six months of qualified practice, following entry to the professional register.
Nursing associate	A member of the nursing team in England, regulated by the Nursing and Midwifery Council. The role is a bridge between healthcare assistants and registered nurses.
Nursing and Midwifery Council	The professional body with responsibility for regulating nurses and midwives in the United Kingdom and nursing associates in England. They set the professional standards, maintain the professional register, provide quality assurance of education, and investigate complaints.

Nursing and Midwifery Council professional register	A register of nurses and midwives who meet the Nursing and Midwifery Council standards to practice in the United Kingdom.
Practice assessor	Nursing and Midwifery Council registered nurse responsible for assessing a student's competency in clinical practice and confirming the student's achievement (or not) of the proficiencies and outcomes.
Practice supervisor	Nursing and Midwifery Council registrant or other registered health and social care professional, who supervises and teaches student nurses in clinical practice.
Preceptorship	A period of support for newly qualified nurses to support their transition to qualified practice.
Registered nurse	A qualified nurse who has successfully completed a pre-registration nursing programme, approved by the Nursing and Midwifery Council, and been accepted onto the professional register.
Registered nurse teacher	A registered nurse who has also completed a teaching programme approved by the Nursing and Midwifery Council.
Revalidation for nurses	The process of renewing a qualified nurse's registration to ensure that the nurse remains fit to practice.
Royal College of Nursing	A membership organisation and trade union for nurses in the United Kingdom.
Stakeholders	"any person, group or organisation that has an interest or concern in the situation in question, and may affect or is affected by its actions, objectives or policies. In the context of the Nursing and Midwifery Council Standards for education and training this includes students, educators, partner organisations, service users, carers, employers, other professionals, other regulators and education commissioners" (Nursing and Midwifery Council, 2018: 14).
Supernumerary status	"students in practice or work placed learning …, supported to learn without being counted as part of the staffing required for safe and effective care in that setting" (Nursing and Midwifery Council, 2018: 14).
United Kingdom	The United Kingdom of Great Britain is made up of England, Scotland, Wales and Northern Ireland.

CHAPTER ONE INTRODUCTION

1.1 The regulation of nurses

Within the United Kingdom (UK) any qualified nurse wishing to practice in any setting or context must be registered with and be accountable to the Nursing and Midwifery Council (NMC). It is the NMC's responsibility to ensure that nurses have the knowledge, skills and attitudes to provide safe care for people. They monitor qualified nurses to ensure that nurses continue their professional learning and development throughout their nursing career, and they investigate; and if necessary, discipline nurses if concerns are raised or patient safety is compromised.

As part of their responsibilities, the NMC regulate, scrutinise, and decide if the pre-registration curriculum, developed by a HEI, is suitable for approval. They ensure that the nursing education curriculum meets their Professional Standards (NMC, 2018; 2018a; 2018b), is delivered by appropriately qualified staff and provides relevant quality supervised placement learning experiences. Students and qualified registered nurses must practice under (and adhere to) the NMC code of professional conduct [The Code] (NMC, 2018c) which contains the professional standards of practice and behaviour that must be upheld (prioritising people, practising effectively, preserving safety, promoting professionalism and trust), and they are monitored by and accountable to the NMC for their practice. As part of that monitoring process the registered nurse must provide evidence of their up-to-date knowledge, skills, and professional practice.

Within contemporary healthcare, UK nurses are heavily regulated and must demonstrate competence and proficiency, as detailed by the NMC (NMC, 2018d).

Regulation of nurses is not just a requirement within the UK, and nurses globally are accountable to different regulatory bodies, for their actions and omissions. Within the Organisation for Economic Cooperation and Development countries, regulation differs by country with some regulating at a national level and some at a regional level (Robinson and Griffiths, 2007). However, regardless of approach, the purpose of the regulation is to ensure that nurses practice in a safe, professional manner within the principle of beneficence. A key area of the nurse's role within the UK is the education of others, to ensure nurse practice complies with the professional body's requirements. It is therefore important for all registered nurses to recognise and remember the significance of this when preparing students for qualified practice or supporting, the newly qualified nurse (NQN) on entry to the workplace. The education of student nurses does not lie solely with nurse educators but is the professional responsibility of all registered nurses (NMC, 2018c), and the nursing curriculum must prepare NQNs for the realities of qualified practice.

1.2 **The education of pre-registration student nurses**

The educational development of UK nurses aligns closely to the regulation of the profession. Project 2000 was a new concept in the education of student nurses that came into effect in 1989. From the introduction of Project 2000, student nurses were no longer trained under the responsibility of the hospital as employees, but instead were educated in an HEI to a minimum of diploma level (Ousey, 2011). In recognition of the generic and specialist roles within nursing, all student nurses completed a generic 18-month common foundation programme, followed by an 18-month specialist programme in their area of interest (adult, child, learning disability or mental health). They were based in an HEI and undertook placement experiences in clinical settings, with supernumerary status and

supervision from a qualified nurse. In recognition of the developing academic role of the nurse, the enrolled nurse programme ceased, and all students were required to study to the minimum diploma level. For enrolled nurses who wished to continue their development, a specially designed conversion programme was introduced. Although it was expected that few enrolled nurses would choose to upskill to registered status, the number far exceeded expectation (Humphreys, 1997).

As part of the new approach to the education of student nurses, the measurement of competencies was removed. This was greatly criticised as it was argued that NQNs were no longer sufficiently prepared for working in the clinical area (Neary, 1997; Redfern, Norman, Calman, Watson and Murrell, 2002). However, some felt that the new approach to nurse education had a positive impact on the profession and argued that there was reluctance from clinical managers to accept that the role of the nurse was changing, and nurses needed to be viewed differently (Luker, Carlisle, Riley, Stilwell, Davies and Wilson, 1997).

In response to the criticism about Project 2000's preparation of students for their qualified role in the clinical area, a further review of nurse education occurred. As a result, the UKCC Commission for Education evaluation of Project 2000 (UKCC, 1999) recommended that student nurses received a shorter generic programme and two full years concentrating on their chosen area of nursing. It was recommended that nurse education be split equally between theory and clinical practice, in line with the European Union requirements for student nurses to receive a minimum of 4600 hours of theory and clinical practice, with at least 2300 hours for clinical practice (World Health Organisation, 2009). These recommendations were developed into Standards for Pre-registration Nursing Proficiency and in 2004 were introduced by the new professional body, the NMC (NMC, 2004). To ensure that nurses were suitably supported and educated in clinical practice, Standards to Support Learning and Assessment in Practice were introduced in 2008 (NMC, 2008).

Since then, developments continued with a move to an all-graduate profession and updated Standards for the Pre-registration of Nursing Education (NMC, 2010) as part of the European approach for greater international alignment of nurse education. Within these standards was a greater focus on the role of care and compassion alongside management and leadership skills. Whilst continuing with the 50:50 split of education between the academic and practice environment, these standards saw a more integrated approach to generic nursing. There was a greater recognition of the similarities and generic qualities required of all nurses, regardless of their field or specialism following qualification. Moving forward to 2018, new updated professional standards, known as Future Nurse Standards, were introduced once again to overhaul how nurses are educated and supervised (NMC, 2018; 2018a; 2018b; 2018d). Greater focus is placed on leadership, management and resilience and an acknowledgement that 21st Century nursing requires nurses to have skills far wider reaching than the care delivery that the role required when nurse education was first introduced (NMC, 2018). The changes to the professional Standards for student supervision and assessment (NMC, 2018b), have seen the NMC move away from the mentorship mandatory arrangements where each student was required to spend a minimum of 40% of their time in clinical practice with a trained mentor. This has been replaced with the introduction of the Practice Supervisor, Practice Assessor and Academic Assessor, with NMC guidance available for all roles. This triad approach to student support, supervision and assessment means that all registered nurses in clinical practice are now expected to undertake the role of Practice Supervisor to support and educate student nurses, from any of the four fields of nursing, and provide feedback on their performance and progress. Separate Practice Assessors from the student's field of nursing then make decisions about the student's achievement of proficiencies for each level of their programme, and in liaison with Academic Assessors from the HEI to make decisions about the student's ability to progress to the next level of their programme and ultimately to qualified status. This provides more of a team approach to the education and assessment of students and greater liaison opportunities between qualified staff in the

practice area, and between practice areas and the HEI. The discussions required between the HEI and practice colleagues, to make and evidence meaningful decisions about the student's progress and achievement will also provide opportunities for greater bespoke support to be available for each student, developed through joint initiatives from practice and the HEI.

Although standards are set by the professional body for the education of pre-registration nurses, how those standards are interpreted and taught remain the responsibility of the HEI. As each HEI interprets the standards and constructs their curriculum differently, caution must remain in the varying learning experiences of student nurses; the impact those experiences have on the development of their professional identity (Johnson, Cowin, Wilson and Young, 2012), and their readiness for qualified practice.

1.3 **The current nursing context**

The UK benefits from an NHS whose original aim was to provide free healthcare from cradle to grave, for all those in need, regardless of ability to pay (Greengross, Grant and Collini, 1999). Although the healthcare needs of the UK population and the demands on NHS services have changed considerably since its introduction, the role of the nurse has remained an essential component. Education ensures that nurses stay abreast of new developments, enabling them to expand their knowledge and deliver evidence-based care. Through the successful completion of a three-year degree programme, which meets the professional standards of the NMC (NMC, 2018; 2018a; 2018b), encompassing 2300 hours of theory and 2300 hours of clinical practice, UK student nurses gain academic recognition of their learning (currently at minimum graduate level), and admission to the NMC professional register. Within the UK, a pre-registration student nurse completes a programme of education that encompasses a range of generic skills and knowledge but

with a focus on one specialised field of practice: Adult Nursing, Child Nursing, Learning Disability Nursing, or Mental Health Nursing. On successful completion of their pre-registration programme, the NQN can then enter the professional register in their chosen field of nursing. Following qualification and registration with the NMC, NQNs embark on their qualified career during a period that was termed “the flaky bridge” by the RePAIR project (Health Education England (HEE), 2018). This can be a particularly challenging time for the qualified nurse and Collard, Scammell and Tee (2020) advised that more nurses leave the profession during the newly qualified period than at any other time in their career. Whilst data on the exact numbers of NQNs leaving the profession during the first year of qualification is not clear from the NMC registration data reports (NMC, 2021), the suggested figure is between 20% (Aldosari, Pryjmachuk and Cooke, 2021) and 30% (Monaghan, 2015). Internationally there have been different approaches to tackling this issue, and within the UK a system of preceptorship aims to support NQNs on entry to the qualified workplace (Department of Health (DH), 2010; NMC, 2020), as they adapt to their new role and develop their confidence as autonomous practitioners. Whilst there is no set timeframe for preceptorship programmes, HEE (2017a; 2018) recommend that the programme should last for 12 months.

1.3.1 Motivation for the study

My career as a nurse commenced during the mid-1980s when the NHS landscape was very different, as was the nurse training that students undertook. At that time, the focus of nurse training was to prepare nurses at certificate level, for the qualified role using an apprentice style approach. However, for certificate level nurses there was an expectation that they would be self-motivated to increase their educational acumen through continued professional development. Through the development of diploma then degree and masters programmes, opportunities for nurses to become more questioning and challenging of

traditional practices emerged and the focus of a more academic approach to nurse education developed (Ousey, 2011).

I came to this doctoral study from a long career in nurse education. My interest in education started as a nurse and a midwife in clinical practice, supporting and teaching students. The satisfaction I gained from those early teaching experiences piqued an interest in me that led to a deeper study of educational theory and a move into nurse education in 2005. An interest in curriculum development and assessment led to my engagement in the creation of several curricula at pre-registration level; with increasing responsibilities for assessment and curricula development as my education career progressed. However, a greater understanding of the effectiveness of the curriculum from the NQN perspective was always an ambition. Anecdotal evidence of distressed personal students returning to meet with me or my colleagues for support and reassurance during the first few months of qualified practice, led to the exploration of the period immediately following qualification. NQNs reported a lack of practice readiness and disappointment on entry to the qualified workplace which was perplexing. Curricula are developed with contributions from a range of stakeholders including service users, students, and experienced nurses. I was interested to explore how the voice of the NQN, during the first few months of qualified practice, could bring added value to the curriculum development process. Registered Nurse Teachers within an HEI have a responsibility to support and educate the nursing workforce of the future. Their role is to ensure that the curriculum developed and implemented achieves the requirements of the NMC and the HEI (NMC, 2008). Yet, just as importantly, curricula must develop and support student nurses in readiness for the realities and challenges of contemporary qualified practice (Mirza, Manankil-Rankin, Prentice, Hagerman and Draenos, 2019).

A review of the literature revealed that there is a plethora of research around the transition period (Dames, 2019; Goodare, 2015; Hawkins, Jeong and Smith, 2018; Kaihlanen,

Salminen, Flinkman and Haavisto, 2019; Tucker et al, 2019). Within the UK, researchers have explored the experiences of NQNs during their transition period and have recommended that there needs to be greater understanding of the needs of NQNs during this period, and their generational differences, so that preceptorship programmes and support can be effective in meeting their needs (Aldosari et al, 2021; Beech, Bottery, Charlesworth, Evans, Gershlick, Hemmings et al, 2019; HEE, 2015; HEE, 2018; Watson, Wray, Barnett, Gibson and Aspland, 2020).

1.3.2 The changing role of the nurse

In recent years, the image of nursing saw a dramatic change with more public questioning of nurses' values, attitudes and practices (Francis, 2013). As part of this, the NMC was criticised for its lack of effectiveness in protecting the public and monitoring the activities of professionals on its register (Council for Healthcare Regulatory Excellence, 2012), leading to a change in the monitoring and revalidation of nurses on the professional register (NMC, 2016). Nurses have seen their professional role undergo immense change with the introduction of more medical and leadership responsibilities (DH, 1991), leading to greater autonomy and decision making. The nursing identity moved from one of care giving to a greater focus on the technical and managerial elements of care (Hall, 2004). The reduction in junior doctors working hours (DH, 1991) added to the changing focus for the nurse's role with more traditional medical skills and extended roles becoming the domain of the nurse. The introduction of an all-graduate profession bringing nursing in line with similar professions, for example, teaching and physiotherapy, provided greater academic acumen for nurses, but the boundaries of the professional nursing role became arguably more blurred (De Meis, De Almeida, Souza and Da Silva Filho, 2007; Harmer 2010).

The changing demands of the NHS and changing role of the nurse means that the NMC review their requirements and professional standards regularly to ensure that nurses are fit for contemporary practice (NMC, 2020a). Under the NMC Standards for Pre-registration Nursing Education (NMC, 2010), the first students to qualify nationally entered the professional nursing register in 2014. More prescriptive in their approach than previous ones, the 2010 standards attempted to address the contemporary challenges facing nursing by focusing on both the caring skills traditionally associated with the profession, and the leadership and management skills required by a modern-day NHS (Darzi, 2008). For student nurses studying under those standards, the challenge to their professional identity became ever more complex. Following a number of reviews into healthcare and nurse education, there was a call for nursing to refocus on more fundamental skills of bedside nursing and care and compassion (Willis, 2012), alongside the preparation for a graduate nursing career.

As qualified members of the profession, nurses needed to negotiate the juxtaposition of meeting the public's demands for bedside nurses delivering essential care, with the organisational needs of management, leadership and research. It is the responsibility of HEIs in partnership with healthcare providers, to ensure that students are effectively taught to meet the demands they will encounter so that they develop what Johnson et al (2012: 562) called a "…. positive and flexible professional identity". There also needs to be recognition that this is not the end of the learning journey for the qualified nurse. Support and nurturing on entry to the workplace, alongside an effective preceptorship programme can be a key step in developing lifelong learners (Whitehead et al, 2016). HEIs should work closely with employers to develop preceptorship programmes that recognise the learning that has occurred at the point of registration and can meet the needs of the NQN.

1.4 **Contemporary challenges for newly qualified nurses**

The NHS is facing unprecedented pressures and challenges. Constant advances in medical treatments and technologies bring additional financial demands to an over-burdened NHS and often, greater pressures for the social care system. In addition, the UK older population continues to grow with over 18 percent of the population now over the age of 65 years (Office for National Statistics, 2018). The co-morbidities that are often seen in patients today mean that nurses need to have high levels of decision-making skills and an ability to lead and manage, alongside the attributes of care and compassion (NMC, 2018d). As an increasing proportion of the qualified nursing workforce moves towards retirement age (RCN, 2017), the recruitment and retention of new nurses remains problematic. Whilst nursing shortages are a global issue, the impact of these shortages for UK nurses has been increased workloads and pressures, with less opportunities for professional development and career progression (Buchan, Charlesworth, Gerschlick and Seccombe, 2019).

Within UK nursing, retention levels have become a key area for concern (House of Commons Health Committee, 2018). There have been several initiatives to attract new nurses to the profession and increase retention of nurses on the professional register, including the introduction of the nursing degree apprenticeship (NHS England, 2019). The report by the Health Foundation (Buchan et al, 2019) into current staffing trends within the NHS indicates that the current crisis in nursing levels has the potential to jeopardise the NHS Long Term Plan (NHS England, 2019) for expanding service delivery and change. During the period from April to September 2021, an additional 11,331 nurses entered the NMC register, of which, 3,962 were NQNs (NMC, 2021a). Whilst attracting new nurses to the profession continues to be an area of focus, retaining those nurses once qualified needs to have a greater priority. In June 2021 there were approximately 38952 nursing vacancies in the nursing workforce in England (NHS Digital, 2021).

Within the NMC (2018d) Future Nurse Standards, it is clearly articulated that qualified nurses are now expected to be able to work autonomously, and work as an equal partner within the interdisciplinary team. With this increased autonomy and decision making comes increased leadership and responsibility (NMC, 2018) which may prove an additional challenge for the NQN. Whilst there has been a nationally targeted initiative to address and improve nurse retention across the NHS (Buchan et al, 2019), the STaR project, funded by the Burdett Trust for Nursing (Watson et al, 2020), explored how to effectively support NQNs to transition into their qualified role and reduce attrition from the profession during the first year of registration. The project concluded that the transition period continues to be a challenging time for NQNs, affected by numerous factors. It identified that whilst there is no strong evidence to link preceptorship and retention of NQNs, HEIs and employers should work more closely together during the pre-registration and immediate post-registration periods, to develop transition arrangements that are individual to the NQN.

The Covid-19 pandemic that developed in 2020 saw a change in public perception of nurses. The high media profile highlighting their autonomy, decision making and high levels of skill and knowledge in caring for people across a wide range of settings, emphasised the crucial role that nurses have in the care of the nation. There was a significant increase in the appreciation and awareness of nurses alongside other NHS staff, resulting in a period of weekly public applause to show gratitude. However, prior to the Covid-19 pandemic the incidences of poor practice reported in the UK media, for example, the failings at Mid Staffordshire NHS Foundation Trust (Francis, 2013), led to a lack of public support and increased anxiety for many nurses. The challenges and conflicts often faced in contemporary practice can lead to frustration, stress, and job dissatisfaction (Duchscher, 2001). These challenges are often exacerbated for the NQN who has yet to

develop the clinical experience, confidence and resilience to deal with the multiple challenges they face

1.5 **Professional Identity**

Professional identity can be considered as identity that links to a specific profession, with traits that are expected from individuals working under professional regulations (Wackerhausen, 2009). When this concept is applied to nursing it relates to the expectations of the profession and the regulatory body. All nurses are expected to work within the parameters of their code of conduct (NMC, 2018c) and are expected to work to the level of proficiency detailed by the NMC (2018d). Professional identity is not a fixed concept, it changes and evolves as the individual makes sense of their experiences and reviews their values, attitudes and issues significant to them. Within professional identity there can often be conflict between perceptions developed through education and learning, and the expectations of the workplace culture or organisation. Whilst maintaining standards expected by the professional body, acknowledgement must be given to the importance of socialisation for the individual (Traynor and Buus, 2016). Individuals need to develop professional relationships with their colleagues and understand the normal practices within the workplace. Through this they can develop a sense of belonging to a Community of Practice (Lave and Wenger, 1991) and develop professional confidence through engagement with that practice community. Influence on an individual's personal and professional identity can come from many sources including upbringing, life experiences, relationships, and workplace.

Bourdieu (1992) introduced the concept of 'habitus' and argued that through upbringing, education and life experience, identity develops. He suggested that views, habits and assumptions (habitus) are individual and deep seated but can change. When the

individual engages within different social contexts, Bourdieu (1992) argued that their level of engagement and their acceptance by that social context is dependent on their habitus. This can be significant for the NQN as they engage in new social contexts and as their position within their familiar social contexts change. Adapting to new social contexts can be an important factor in the development of the NQN's professional identity and the work of Bourdieu will be used within this thesis to explain the findings from the study and implications for future practice.

Within nursing, professional identity can at times be a conflicting and challenging prospect. The role, image and expectations of the nurse have changed dramatically over the last 200 years. However, fundamental to a nurse's identity remains an expectation of care and compassion, regardless of their field of specialism or area of practice. Whilst nurses are encouraged to care for people as individuals and taught to provide person-centred care, the demands and requirements of a busy and pressured NHS mean that work is often task orientated. This can cause stress and anxiety for the NQN as they try to negotiate a clear role between the principles they have been taught, which may be compromised, and the organisational needs and requirements to operate within a pressured system. The professional identity possessed by the NQN will be multifaceted but the experiences from the pre-registration curriculum will be key factors in the development of that identity. The skills and knowledge developed during the pre-registration period provide the NQN with the expertise that sets them apart from the public (Johnson, et al, 2012).

Johnson et al (2012) advised that education can be key to the student nurse developing a professional identity and Ware (2008) suggested that the formation of that professional identity can be as important as the knowledge and skills gained over the programme. The influence of nurses in clinical practice and nursing academics cannot be underestimated and their role modelling can help or hinder the development of the student nurse for the

realities of contemporary nursing practice. As Cowin and Hengstberger-Sims (2006) advised, the development of professional identity can be significant to the retention of nurses, it is important therefore that student nurses are encouraged to develop a professional identity that prepares them for the realities of 21st Century nursing as NQNs.

1.6 **The research aims and objectives**

The overarching aims of this doctoral research were to explore how a first cohort of NQNs, from one English HEI, perceived their practice readiness and professional identity, on entry to the workforce following the completion of their pre-registration study under the 2010 NMC standards. To facilitate students to develop the knowledge and skills needed to meet the challenges of contemporary nursing, with realistic expectations of qualified practice, the objectives for the study were:

1. To identify; from the NQN perspectives, what themes around practice readiness and developing professional identity emerged from the study?

2. To identify what were the key influencing factors for practice readiness?

3. To consider how the emerging themes could inform future undergraduate pre-registration nursing curriculum and student nurses' readiness for qualified practice?

1.7 **Chapter Summary**

The regulation of the nursing profession and the education of nurses is intertwined (NMC, 2020a). As the regulation of nurses has become more stringent so too has their pre-registration education and the expectations of them (NMC, 2018; NMC, 2018d). Whilst nursing has developed into a graduate profession with significant accountability and responsibility, the role of the nurse has simultaneously changed significantly. The caring element of nursing, fundamental to the nurse's role, must now be balanced against the demands of advanced skills, leadership, management, and research (NMC, 2018; NMC, 2018d). NQNs must value the importance of providing fundamental high-quality care as part of their role, whilst accepting that the role has changed substantially over the last 30 years. A recognition of the changing professional identity of the nurse must be explored within the pre-registration curriculum, to ensure that NQNs possess the attributes and skills to enter the workforce with realistic expectations of their role and their identity.

This chapter has brought me to the work of my thesis, which will explore the views of a group of NQNs in one West Midlands (UK) HEI. Through this study I will investigate their perceptions of readiness on entry to qualified practice. By listening to their voice and exploring their perceptions and influencing factors, I will identify themes which emerge from the research and how they can inform the development of future pre-registration curriculum.

Moving forward my thesis has a traditional structure with a further seven chapters.

1.7.1 Chapter Two

A comprehensive critical overview of the literature relating to the period of entry by the NQN to the qualified workplace. The chapter details the systematic approach that was used to identify and critique the literature, and the themes that emerged from the review.

1.7.2 Chapter Three

Discussion of the philosophical and theoretical underpinnings for this doctoral study. It discusses the ontological and epistemological positioning for the research, to introduce the approaches used within the study.

1.7.3 Chapter Four

The methodological approach to the study, the design of the study, the methods I used and my data analysis process. Following the rationale for the methodology, the chapter discusses the study design and approach used for the study. The data analysis approach is presented with an explanation of how this was implemented. Ethical issues for the study are presented with details of the approved ethical approach that I used throughout my research journey.

1.7.4 Chapter Five

The results from the study. Findings were identified following the thematic analysis process, and I organised the results to represent the four main themes and associated sub-themes that were identified.

1.7.5 Chapter Six

A detailed analysis, interpretation, discussion and synthesis of the results and consideration of the findings in the wider philosophical and theoretical context with reference to the identified literature. My interpretations in this chapter aim to address the research objectives for this study and consider both its strengths and limitations. Consideration is given to the impact of the findings on future curriculum practice.

1.7.6. Chapter Seven

Discussion of my critical reflection of the doctoral journey and my experience as an insider within the research process.

1.7.7 Chapter Eight

The final chapter provides a summary of my doctoral study and the unique contribution this work adds to the discourse around practice readiness and professional identity of NQNs. Recommendations for future practice and further research are made, to complete the thesis, with a final comment on my doctoral journey.

CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

This chapter provides a critical review of the literature relating to the perspectives of NQNs at the point of registration. The review was made up of two parts; Government and Professional Body reports that act as drivers to influence development of nursing education, followed by research evidence identified from academic journals and theses. A review of the literature allowed for critical appraisal of the current evidence, and analysis of methodologies used in others' research, allowing for gaps in the evidence base to be identified (Easterby-Smith, Thorpe and Jackson, 2015). Through analysis and critical discussion of relevant literature, the current study was contextualised to provide justification for the focus of the research (Wellington, Bathmaker, Hunt, McCulloch and Sikes, 2005).

Through a systematic consideration of the literature, areas of commonality and areas for further consideration were identified. There is a clear plethora of literature during the transition from student to qualified nurse (Dames, 2019; Goodare, 2015; Hawkins et al, 2018; Kaihlanen et al, 2019; Tucker et al, 2019). Within the UK there has been acknowledgement of the need to support NQNs and preceptorship programmes are recommended for all NQNs entering the workplace (DH, 2010; NMC, 2020). This literature review examined the research undertaken from an international perspective, of NQNs' perceptions at the point of registration. In addition, a search of UK literature related to preceptorship was undertaken using the same approach and databases, as this literature often captured perceptions of NQNs as part of wider studies linked to preceptorship.
All the literature reviewed was from the voice of the NQNs and from their perspectives of practice readiness and professional identity at the start of their qualified journey.

Fundamental to the literature review process was a clear and transparent review strategy, as detailed in the next section.

2.2 **Search strategy**

An initial review of the literature was completed at the start of the project with an updated review of the literature in May 2021; using a systematic approach to search UK Government and professional body reports, and for relevant research from academic journals and theses. As the review took an international approach and different countries commenced degree level nursing programmes at different times, no time limit was placed on the literature search of academic journals for the international perspective, to ensure that all relevant articles could be identified. For the UK literature search, only literature from 2000 onwards was considered to ensure a manageable amount of literature was reviewed in relation to the development and implementation of preceptorship programmes. To ensure that an appropriate literature search was undertaken for the research topic, the Population, Intervention, Comparison, Outcome (PICO) strategy was used as Sayers (2008) suggested that this would allow for a structured and effective searching process. This type of approach also helped to ensure that the literature search remained focused; identified work previously undertaken and gaps within the literature (Villanueva, Burrows, Fennessy, Rejendran and Anderson, 2001). As comparison was not an aim of this project, this element of the PICO framework was not included.

2.2.1 Government and Professional Body reports

It was acknowledged that Government and Professional Body reports provided drivers for the ongoing development of nursing education. Key reports relating to nurse education

within the UK were reviewed over the period of 2010 – 2020, through the lens of preparation for practice readiness. This period was chosen as during this time there were three different sets of NMC professional standards for nurse education in use or introduced (NMC, 2004; 2010; 2018). Thirteen reports were reviewed (Appendix 1) with five themes emerging from their critical analysis.

Theme one related to the role of support workers and the new nursing associate role. Reports (Council of Deans for Health (CoD), 2016; Francis, 2013; HEE, 2017; 2018; NHS Improvement, 2019; Willis, 2012; 2015) acknowledged that these roles can allow qualified nurses to delegate the more hands-on nursing care, to enable them to use their skills more effectively (NHS Improvement, 2019). However, Francis (2013) cautioned that support workers should be easily distinguished from qualified nurses. As part of this change in roles, qualified nurses need to have safe and effective delegation and leadership skills (Francis, 2013, Willis, 2015); which must be developed during the pre-registration nurse education programme (CoD, 2016; Francis, 2013; Willis, 2012). West, Bailey and Williams (2020) suggested that the development of leadership skills during the pre-registration period is important preparation for qualified practice, and HEIs should work with students to meet their individual needs.

Theme two considered the preparation of student nurses for their evolving future nurse role. Pre-registration nurse education curricula needs to prepare students for the more advanced skills now associated with their role (CoD, 2016), and the change management skills to continue to evolve and adapt (CoD, 2016). With attrition for nursing students in England at 24% (West et al, 2020), there needs to be acknowledgement that the realities of nursing no longer reflect the more traditional role (Willis, 2012; 2015), and student nurses and the public need to have a greater awareness of this (Willis, 2012). NQNs need to be competent and safe when they enter the workforce (DH, 2010) and able to work as autonomous independent practitioners (CoD, 2016) with knowledge and skills that span

all four fields of nursing (CoD, 2016). By preparing student nurses for their qualified role, they will be more able to develop their professional identity once qualified (CoD, 2016), but there needs to remain a focus on compassionate care (Beech et al, 2019; Francis, 2013). Students near the end of their pre-registration programme need to be better prepared for their transition to qualified practice and findings from the RePAIR project (HEE, 2018) argued that this preparation should start in Year 2 of the pre-registration programme. As students enter the final stage of their pre-registration education and move onto qualified practice, this can be a particularly challenging time, referred to as “the flaky bridge step” (HEE, 2018: 18), and HEIs need to work closely with healthcare providers to prepare students and expose them to the realities of contemporary practice (HEE, 2018). West et al (2020) argued that the pre-registration curriculum has a responsibility to provide students with the tools to be practice ready and an ability to support their own well-being. However, HEIs and employers need to be realistic about what is expected of the NQN on entry to the workforce (CoD, 2016; West et al, 2020) as it is recognised that NQNs are more confident if they perceive that they are ready for the realities of qualified practice (HEE, 2018).

Ensuring life-long learning and development for qualified nurses, was the third theme that emerged from the reports. (CoD, 2016; Francis, 2013; HEE, 2015; 2017; NHS Improvement, 2019; The National Improvement and Leadership Development Board, 2016; Willis, 2012). Greater use of the apprenticeship route into nursing can encourage life-long learning by providing career routes for experienced healthcare support workers and better opportunities for mature students and students from more diverse backgrounds (Beech et al, 2019; HEE, 2017; NHS Improvement, 2019). The pre-registration curriculum should be the starting point for nurse education (CoD, 2016; Francis, 2013; Willis, 2012). and nurses need to continue their learning (The National Improvement and Leadership Development Board, 2016). If nurses are to provide quality learning experiences and support for students in clinical practice, continuing professional development (CPD)

opportunities need to be available to support learning to continue and enable experienced nurses to support NQNs (Beech et al, 2019; DH, 2010; West et al 2020).

Theme four identified the value and significance of clinical practice learning for student nurses and the importance of ensuring that placement providers are well-prepared to receive students, with support from the HEIs (West et al, 2020). The CoD (2016) argued that experiences in clinical practice are key to the development of professional identity and the attitudes and expectations that NQNs have on entry to the qualified workplace. The culture of the practice area can greatly impact on the NQNs' confidence and sense of belonging within their workplace (Francis, 2013; HEE, 2015; 2017; 2018, NHS Improvement, 2019; The National Improvement and Leadership Development Board; Willis, 2012; 2015), but concern was raised about the need to improve workplace culture if NQNs are to stay in the profession and continue their nursing career (CoD, 2016; Francis, 2013; HEE, 2017; 2018; NHS Improvement, 2019; The National Improvement and Leadership Development Board, 2016; Willis, 2012). The RePAIR Report (HEE, 2018) advised that healthcare providers should collect data on how the workplace culture affects decisions around choosing first workplaces for NQNs. Beech et al (2019) recommended that HEIs and placement providers need to work together guided by Health Education England, to establish conditions for the quality, success and balance of placement opportunities for student nurses. They suggested that this will reduce attrition of student nurses and increase the number of NQNs entering the NHS workforce. However, if placements are to be positive learning experiences for students, promoting the values of the profession, educators in those clinical areas should be well-trained and supportive, inspirational role models (West et al, 2020).

The final theme extrapolated was around providing support for the NQN and developing practice readiness. Practice readiness should begin before the student embarks on a pre-registration nursing programme (HEE, 2018). As, by ensuring that prospective students

are made aware of the realities of contemporary nursing and by implementing robust recruitment processes, preparation for qualified practice can begin. Beech et al (2019) suggested that retention of NQNs to the workforce can be improved if students with the right attributes are admitted to the programme and prepared effectively for their qualified role through their pre-registration period. However, entry to the qualified workplace can be very stressful for the NQN and appropriate support and guidance can make the transition a more positive experience (Beech et al, 2019; DH, 2010; HEE, 2018; NMC, 2020; West et al, 2020). Whilst there was recognition across some of the reports reviewed that support needs to be available from the manager and the workplace team (Beech et al, 2019; Francis, 2013; HEE, 2015; 2018; West et al, 2020); a structured preceptorship programme was suggested as a formal support mechanism to assist NQNs with their transition to qualified practice. Both the DH (2010) Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals, and the NMC (2020) Principles of Preceptorship, identified the values and benefits to NQNs, service users and the organisation, of an effective preceptorship programme. However, there was a lack of agreement between reports about how long preceptorship programmes should last; with the DH (2010) and West et al (2020) advising a minimum period of 6 months, but the RePAIR Report (HEE, 2018) and Willis (2015) recommending at least 12 months. Preceptorship programmes should be tailored to the individual needs of each NQN (DH, 2010; HEE, 2018; NMC, 2020) with recognition of differences between generations (Beech et al, 2019; HEE, 2018). Yet, the RePAIR Report (2018) identified that preceptorship programmes are often designed by healthcare providers without input from the local HEI, and address the organisational needs of the Trust rather than the individual needs of the NQN. Across the reports reviewed, preceptorship programmes were seen as the way to support NQNs on entry to the qualified workforce and develop their skills and confidence (Beech et al, 2019; CoD, 2016; DH, 2010; HEE, 2018; NMC, 2020; Willis, 2015). Arguments were made that there needs to be greater recognition that the NQN is only starting on their qualified journey and expectations of them need to be more realistic (CoD,

2016; HEE, 2018; West et al, 2020; Willis, 2015). HEE (2018) suggested that there should be a visible aide memoir (such as a different coloured lanyard) to remind other professionals of the lack of experience and expectations of NQNs. Beech et al (2019) suggested however, that support should continue beyond preceptorship if NQNs are to be retained in the workforce and have positive mental health and well-being.

In addition to the five emerging themes there were also recommendations that further research be undertaken into the effectiveness of pre-registration curricula, the readiness of NQNs for qualified practice and factors that affect NQNs' confidence on entry to the qualified workplace (HEE, 2018; Willis, 2012). These recommendations supported the relevance of the current study and its value to informing nursing practice.

2.2.2 Academic Journals and Theses

Once the key words for the search had been established using PIO (Sayers, 2008), alternative and additional words from the individual database thesaurus and MeSH (Medical Subject Heading) facilities were included to ensure that a robust search of the subject was undertaken (Table 2.1 & Table 2.2).

Table 2.1 – PICO framework, search terms (no comparison) and combinations of terms applied to the international literature search.

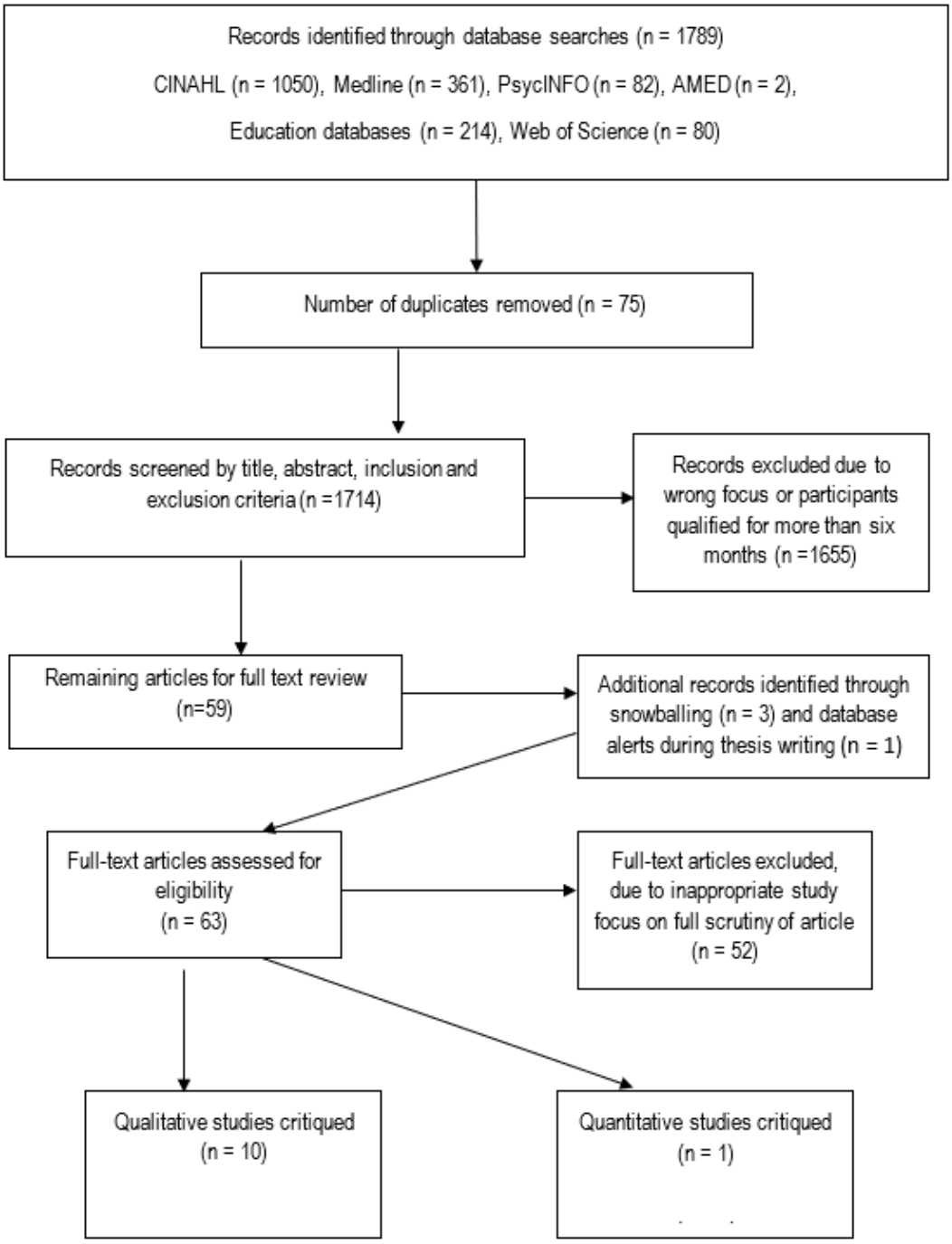
	POPULATION	**INTERVENTION**	**OUTCOME**
KEY WORDS	1. Newly qualified nurse	8. Professional identity 9. Practice readiness	19. Perception
ALTERNATIVES	2. Newly graduated nurse 3. Novice nurse 4. New nurse 5. Registered nurse 6. Neophyte qualified nurse	10. Self-concept 11. Identity formation 12. Professional development 13. Professionalism 14. Role perception 15. Professional role 16. Professional socialisation 17. Practice preparedness	20. Attitudes 21. Opinions 22. Experience 23. View 24. Reflection 25. Belief 26. Perspective 27. Impression
ADDITIONAL	7. Thesaurus, MeSH phrase and/or related words, truncation of key root words	18. Thesaurus, MeSH phrase and/or related words, truncation of key root words	28. Thesaurus, MeSH phrase and/or related words, truncation of key root words
Search Strategy Searches were completed using the following search term combinations: 1 or 2 or 3 or 4 or 5 or 6 or 7 **AND** 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 **AND** 19 or 20 or 21 or 22 or 23 or 24 or 25 or 26 or 27 or 28			

Table 2.2 – PICO framework, search terms (no comparison) and combinations of terms applied to the UK literature search.

	POPULATION	**INTERVENTION**	**OUTCOME**
KEY WORDS	1. Newly qualified nurse	8. Professional identity 9. Practice readiness	22. Perception
ALTERNATIVES	2. Newly graduated nurse 3. Novice nurse 4. New nurse 5. Registered nurse 6. Neophyte qualified nurse	10. Self-concept 11. Identity formation 12. Professional development 13. Professionalism 14. Role perception 15. Professional role 16. Professional socialisation 17. Practice preparedness 18. Preceptorship 19. Transition 20. United Kingdom	23. Attitudes 24. Opinions 25. Experience 26. View 27. Reflection 28. Belief 29. Perspective 30. Impression
ADDITIONAL	7. Thesaurus, MeSH phrase and/or related words, truncation of key root words	21. Thesaurus, MeSH phrase and/or related words, truncation of key root words	31. Thesaurus, MeSH phrase and/or related words, truncation of key root words
Search Strategy Searches were completed using the following search term combinations: 1 or 2 or 3 or 4 or 5 or 6 or 7 **AND** 8 or 9 or 10 or 11 or 12 or 13 or 14 or 15 or 16 or 17 or 18 or 19 or 20 or 21 **AND** 22 or 23 or 24 or 25 or 26 or 27 or 28 or 29 or 30 or 31			

Relevant health and education related databases were accessed via the EBSCO, interface, ProQuest, Web of Science and the Joanna Briggs Institute Evidence Based Practice database. The Boolean and Truncation facilities were used to ensure retrieval of the most relevant data, regardless of alternate spelling of words from different countries. Easterby-Smith et al (2015) recommended that Boolean operators can be valuable in focusing literature down to specific results and relevance. This also allows for a systematic approach to be demonstrated in the search. Potentially relevant literature was identified from the following: Cumulative Index of Nursing and Allied Health Literature (CINAHL), Medical Literature Analysis and Retrieval System Online (MEDLINE), PsycINFO, The Allied and Complementary Medicine Database, Educational databases [Academic Search Complete, Teacher Reference Center, British Education Index, Education Resource Information Center], Web of Science and grey literature. CINAHL was a particularly relevant database to access as it includes literature from nearly all nursing and allied health journals that are written in English. Likewise, MEDLINE was important as it contained literature from a vast amount of international medical nursing and health related journals (Polit and Beck, 2012). Literature searching using subject specific electronic databases can be an effective method for identifying pertinent literature. However, Papaioannou, Sutton, Carroll, Booth and Wong (2009), argued that such searches do not always identify all the relevant literature, particularly when the literature is spread across a range of databases, as in this case. They recommended supplementary search techniques, such as snowballing, including hand searching from reference lists and citation searches, which can identify additional relevant literature. Once all database searches were completed and reviewed, the snowballing technique was applied to capture any additional material. This is illustrated for the international search in the PRISMA chart in Figure 2.1.

Figure 2.1: PRISMA flowchart of relevant literature scoping, retrieval, and refinement of the international literature



The final 11 international articles are detailed in the data extraction table (Appendix 2).

Once an initial international search of the databases was complete, inclusion and exclusion criteria were applied. The inclusion and exclusion criteria enabled a more specific and relevant focus for the articles identified, ensuring the research undertaken was with NQNs within the first six months of post-registration looking at perceptions of their practice readiness and identity (Table 2.3). Although the focus for the current project was the start of the NQNs' journey, for pragmatic reasons the first six months of that journey was considered within the literature, to ensure sufficient research data was reviewed.

Table 2.3 – Inclusion and exclusion criteria for the literature search.

Inclusion Criteria	**Exclusion Criteria**
Newly qualified nurses within first 6 months of qualification	Newly qualified nurses more than 6 months post qualification
Perceptions or expectations of newly qualified nurses	Other qualified nurses
Professional identity	Student nurses
Role expectation	Perceptions or expectations of anyone other than the newly qualified nurse
Studies available in English or English translation	Studies not available in English
Research studies and thesis	Discussion papers
Perceptions of readiness/preparedness on entry to the qualified workplace	

The initial international literature search revealed many articles (n=1789). However, once duplicates were removed and the inclusion and exclusion criteria were applied, there was a significant decrease in the number of relevant articles (n=59), (Figure 2.1). The supplementary snowballing search identified an additional three articles; these were then included in the literature review, and this was beneficial in identifying literature from more obscure locations (Greenhalgh and Peacock, 2005). Once the abstracts of remaining articles were reviewed it was identified that a considerable number of those articles either focused on the perceptions of other more senior nurses in clinical practice or defined newly

qualified nurses as being those with six to twelve months post-registration experience. This then reduced the number of relevant articles still further.

A review of the full text articles then allowed for the final number of relevant articles to be identified. A total of 11 articles were ultimately reviewed (Figure 2.1). Three studies were undertaken in the United States of America and three in Canada, whilst there was one study in each of the following countries, Sweden, Australia, Taiwan, New Zealand, and Singapore. Whilst it is acknowledged that the approach to nurse education in each of these countries may be different, all participants were embarking on their journeys as qualified nurses. As the current research explored how newly qualified nurses perceive their identity at the beginning of qualified practice, each of the studies, and their findings were therefore relevant for consideration.

When the additional search terms of 'Preceptorship', 'Transition', and 'United Kingdom' were added to the UK focused search and the same process completed, a further 97 research papers, systematic reviews and theses were identified. Following the same refining process as used for the international search, a final 22 papers from the UK were included in this review (Appendix 3).

2.3 **Methodological approaches and quality considerations of the literature**

Once relevant literature had been identified, consideration was given to the robustness, reliability and trustworthiness of the research undertaken. Ensuring that the literature was authentic and reflective of the perceptions of individuals, was important when using the literature to provide a context for the current study and identifying the new knowledge that was added to the topic under consideration (Denzin and Lincoln, 2011). Critical appraisal of the literature was therefore a key part of the literature review process; Bettany-Saltikov (2012) argued that critical appraisal is valuable when considering the relevance of

literature findings to future practice. As the validity of research undertaken can be compromised at any stage in the process, Ricketts (2011) suggested critical appraisal of the literature using a recognised framework such as the Critical Appraisal Skills Programme (CASP) framework, (CASP, 2018), to ensure that a methodological approach is used across all the literature under review. The CASP tool is widely used in the review of social science literature and takes into consideration the methodological approaches used in qualitative research. As most of the articles under review for this project were qualitative in their approach, I determined that the CASP tool would be an appropriate and systematic way to critically review the qualitative literature, with a CASP quantitative framework used for quantitative studies.

Quantitative research aims to generalise findings to a wider population and tends to use large sample sizes to ensure a good range of the population group are captured within the research (Polit and Beck, 2012). To support any generalised findings, researchers need to be able to demonstrate that the research has gathered data from a wide range of participants and has statistical significance (Polit and Beck, 2012). By comparison to the numerical data and statistical analysis collected in quantitative research, qualitative data has more focus on textual information and meanings gained from that textual data analysis (Creswell, 2013). As a large amount of data is often collected during qualitative research, sample sizes are usually small by comparison. Crouch and McKenzie (2006) suggested that a small sample size can give the researcher an opportunity to gain deeper insight into the data. Qualitative research, unlike quantitative, does not set out to provide generalised findings, but instead concentrates on describing specific experiences of a small group of individuals in each context, with the aim of producing findings that can be related to alternative contexts (Creswell, 2013).

Braun and Clarke (2013) suggested that although very small numbers can be used for sampling in qualitative research, compared to those in quantitative research, a sample

size of 15-30 for individual interviews is common when themes are to be identified across the data set. To ensure that all relevant data is captured, a process known as saturation (Polit and Beck, 2012) is often used as an indicator of the sample size required. However, Bryman (2012) argued that small sample sizes can make data saturation difficult to achieve. Nevertheless, whilst this process is not an indication of the quality of data collected, it is a mechanism that may indicate when no new information is emerging from the data. Corbin and Strauss (2015) advised that sufficient data must be collected to not only ensure that no new information emerges, but also that the emerging concepts can be sufficiently explained.

Identifying the potential sample is key to ensuring relevant data is collected. To ensure that participants are knowledgeable of, or experienced in the phenomenon being explored, the researcher needs to be clear about inclusion and exclusion criteria for their sample. A common approach to data collection can be a convenience sample, where participants are recruited due to easy accessibility (Bryman, 2012). This can be a useful approach when the phenomenon being considered is common within the convenience sample. However, if the research aims to look at a specific experience or context, then a purposive sample is more appropriate (Polit and Beck, 2012). In this case potential participants are identified because they have specific experience or characteristics (Boswell and Cannon, 2017).

Within all but one of the research papers reviewed (Ross and Clifford, 2002) purposive sampling was used for recruitment. The sample size of NQNs for the qualitative studies ranged from 5 (Duchscher, 2001; Hunter and Cook, 2018) to 136 (Hardyman and Hickley, 2001); and for the quantitative research ranged from 44 (Marks-Maran et al, 2013) to 288 (Halpin et al, 2017).

Small sample sizes were acknowledged across the qualitative studies, where individual perspectives were explored, and no attempts were made to generalise the findings more widely. Within the reviews included as part of this literature search, the number of papers

critiqued by the authors ranged from 8 (all from the UK) (Monaghan, 2015) to 60 (including 16 from the UK) (Aldosari et al, 2021).

Ethical considerations are a significant part of the research process in ensuring that research undertaken is relevant, appropriate and does not harm those participating in it (Mauthner, Birch, Jessop and Miller, 2012). It is important that participants are fully aware of the purpose and process of the research, and can understand information, to make an informed decision regarding participation in the research and right of withdrawal (Brooks, te Riele and Maguire (2014). Cohen, Manion and Morrison (2011) suggested that this informed consent is a key principle in forming an implicit contractual relationship between the researcher and the participant.

Within the identified research studies ethical approval and consent was stated in all but three of the studies (Hardyman and Hickey, 2001; Johnson et al, 2015; Kapborg and Fischbein, 1998). Some studies highlighted the right of participants to withdraw from the study, but this was not made clear by all authors. Initial identification of the potential participant sample was not made clear in several studies, and it was difficult to determine if participants were known to the researchers or may have felt any coercion to participate. Where studies acknowledged a relationship between researcher and participants, efforts were made to reduce the impact of that relationship. For example, Price et al (2018) did not conduct any interviews until after graduation when they no longer had any perceived influence over the participants.

By comparison, the study by Boyle et al (1996), did not appear to give any consideration to the potential impact their relationship with respondents may have had on the research. They recruited during the initial orientation period in participants' new workplace areas. They obtained an 81% response rate to their recruitment but as the participants were just embarking on their professional journey with their new employer, they may have felt

coerced into taking part in the study. The questionnaire was completed during the orientation class, potentially placing more pressure onto potential participants. This may have been a significant factor and participants may have felt that their answers needed to reflect a position that would be favourable to the researchers, rather than an accurate interpretation of their views.

The purpose of qualitative research is to explore a given experience, to gain insight into individuals' perceptions of that experience (Polit and Beck, 2012). A criticism of qualitative research is the lack of controlled rigour to provide internal and external validity and reliability to the findings (Mays,1995). Qualitative researchers are often closer to the data than in quantitative research, and recognition of their own potential influence can be an important factor. Petticrew and Roberts (2006) purported that when reviewing research literature, it is important to consider all aspects of the study to determine any bias or issues with the research that have not been acknowledged. Bias must be addressed when undertaking research and the use of reflexivity can be a valuable way for the researcher to consider their own preconceptions and perceptions relating to the topic under consideration (Petticrew and Roberts, 2006). For example, within phenomenology a technique known as 'bracketing' is used to recognise and acknowledge these issues. Braun and Clarke (2013) argued that the issue of bias within qualitative research is less of a concern, as by its nature, research in this paradigm is more subjective. They suggested that reflexivity can be a valuable tool for recognising and acknowledging any potential researcher influences on the study, through personal reflexivity and functional reflexivity. By considering how the chosen research methods (functional reflexivity) and the role of the researcher (personal reflexivity) may influence the research, an element of quality control can be added to the study.

Within the reviewed literature, these influences were addressed to different degrees. Some authors acknowledged the potential impact of their professional role on the

development of the questions and data collection process. To combat this, an inductive approach to the interview schedule was used to enable the voice of participants to drive the focus of the data collection. However, within some studies, the potential for bias was evident and there was no clear discussion of how that was managed. When determining the questions in a questionnaire or for an interview schedule, careful consideration needs to be given to the drivers for those questions. If the researcher is experienced in the area of study, they will have preconceived views about the events being explored. Without due care and awareness of those views, the questions being asked may unconsciously lead participants down a predetermined route. In the studies by Boyle et al (1996) and Kapborg and Fischbein (1998) there was no discussion of how the questions in the research were formulated or informed. With no evidence of reflexivity within these studies, the potential for researcher bias is a factor in the data collected and interpreted. Through acknowledgement of their presence, and engagement in the sometimes-difficult process of reflexivity however, these influencing factors could have been mitigated against.

The main methodological approach used across the research studies reviewed was qualitative, but seven studies used a quantitative or mixed methods approach (Boyle et al, 1996; Halpin et al, 2017; Johnson et al, 2015; Marks-Maran et al, 2013; Mawson, 2020; Ross and Clifford, 2002; Watson et al, 2020). Whilst quantitative questionnaires often collected data from a larger sample, the qualitative approaches captured and described the participant voices and perceptions. Several different approaches were used across the qualitative studies reviewed, including narrative descriptive, phenomenological, interpretivist and grounded theory.

The narrative approach allows each individual to tell their story in their own way and structure (Polit and Beck, 2012), and Riessman (2008) suggested that a benefit of this approach is that analysis can consider why the story was told in that manner, as its structure has not been dissected by the researcher's questions. By comparison, the

descriptive approach gives a voice to participants (Braun and Clarke, 2013) and allows for those voices to be accurately described and portrayed. Phenomenology, whilst capturing the lived experiences of the participants, aims to do more than just describe the perceptions of individuals (Polit and Beck, 2012). Within this approach the researcher gives meaning to those perceptions to explain and understand the experiences. Similarly, the interpretivist inquiry approach aims to interpret the meanings that participants give to their experiences, to understand why they interpret their experiences that way (Creswell, 2013).

A common approach used in qualitative research and utilised by Dearmun (2000), Gerrish (2000) and Leong and Crossman (2015), is grounded theory (Glaser and Strauss, 1967). Significant in this approach is that no set question or hypothesis is established at the beginning of the research. Rather, the issue under consideration, and participants responses to that situation, emerge as the data is gathered and analysed. Through constant comparison analysis (Polit and Beck, 2012), as data is collected and analysed, categories are formed. These categories are then constantly compared to the data, and amended, as more data is collected. Although a popular approach, grounded theory evolved as Glaser and Strauss developed different views on its purpose. One development from Charmaz (2006) was the introduction of constructivist grounded theory, where the shared experiences and relationships of the researcher and participants is a key factor in the emerging theory; this constructivist approach was used by Leong and Crossman (2015).

Despite the different research methodological approaches used across the reviewed studies, semi-structured interviews at times supported with other research methods such as focus group, reflective journals, field notes or documentary analysis were the preferred method of data collection for twenty of the thirty three studies. Semi-structured interviews are a very effective method for gathering qualitative data. As seen in the studies in this

literature review, they allow for the exploration of the individual's views and perceptions with a loose structure, that keeps focus on the area of interest, whilst allowing participants to drive the interview forward. Using open-ended questions, participants can explore issues considered important to them, using vocabulary that allows them to express themselves (Arksey and Knight, 1999). This 'thick descriptive' data can then be explored further with individual participants when issues of significance or ambiguity arise. Although a lot of data can be captured in this method, and a significant amount of time might be needed for the gathering and analysis of that data, it can be a powerful way to hear and report the voice of the participant. When the researcher develops a good relationship with the participant, individuals who may feel that their voice is not often heard or acknowledged, can feel empowered (Arksey and Knight, 1999).

Within the studies by Duchscher (2001), Marks-Maran et al (2013) and Watson et al, 2020, entries into a reflective journal and semi-structured interviews were used to capture perceptions of the NQN during the early period following qualification. The reflective journal allowed for areas of key significance to be recorded by participants, whilst the interview allowed for exploration of areas important to the NQN. By comparing data from both sources, confirmation of areas of significance was made. By comparison, in 1998, Kapborg and Fischbein reported on their Swedish qualitative narrative study. They investigated how NQNs perceived their transition to qualified practice during a two-month period following qualification from their nursing diploma programme using a semi-structured diary. Although this method enabled participants to record their perceptions, they were asked to focus on specific areas determined by the researchers. Whilst this allowed for consistency of information gathered and easier comparison between the data, it did not encourage participants to identify other issues significant to them which could have brought new insight to the research and given participants a greater voice.

Although different methods of data collection were used across the studies, analysis by researchers identified several common themes. Though the methods of data analysis

varied, including multivariate statistical analysis (Boyle et al, 1996), content analysis (Clarke and Holmes, 2007; Feng and Tsai, 2012; Kapborg and Fischbein, 1998; Ortiz, 2016; Watson et al, 2020) and thematic analysis (Child, 2015; Darvill et al, 2014; Dearmun, 2000, Halpin et al, 2017; Johnson et al, 2015; Kelly and Ahern, 2009; Marks-Maran et al, 2013; Mawson, 2020; Ross and Clifford, 2002), conclusions from the findings had key similarities across the range, and were constructive in addressing the aim of the literature review.

I included seven literature reviews as part of the analysis (Aldosari et al, 2021; Arrowsmith et al, 2016; Edwards et al, 2015; Irwin et al, 2018; Monaghan, 2015; Odelius et al, 2017; Whitehead et al, 2013). There was a range of approaches used to review and analyse the literature identified, with similar conclusions, again contributing to the aim of this literature review.

2.4 **Emerging concepts from the literature**

Through critique of the literature using the CASP framework (2018) and thematic analysis (Braun and Clarke, 2006) three key concepts emerged relating to the perceptions and views of NQNs on qualification and entry to the workplace. The concepts which emerged from the literature reviewed were

- Reality shock compared to expectations
- Belonging and role identity
- Taking responsibility

and each concept emerged from a number of separate studies. The concept of greatest consistency was the comprehension that the realities of working as a qualified nurse did not meet their idealistic expectations of what the role would be (Aldosari et al, 2021;

Arrowsmith et al, 2016; Clark and Holmes, 2017; Dearmun, 2000; Delaney, 2003; Duchscher, 2001; 2008; Feng and Tsai, 2012; Gerrish, 2000; Halpin et al, 2017; Hunter and Cook, 2018; Johnson et al, 2015; Kelly and Ahern, 2009; Leong and Crossman, 2015; Maben, 2003; Mark-Maran et al, 2013; Mawson, 2020; Monaghan, 2015; Ortiz, 2016; Price et al, 2018; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2016). As a result, the NQNs developed a lack of job satisfaction and were more likely to consider leaving the profession. However, all identified concepts resonated with findings from international research done with newly qualified nurses following a period of enculturation and preceptorship of at least six months post qualification (Martin and Wilson, 2011; Odland, Sneltvedt and Sörlie 2014; Pellico, Brewer and Kovner, 2009; Whitehead, 2001). This suggests that the initial concerns of the NQN continue for some time during their early career, despite support and development programmes.

2.4.1 Concept one – Reality Shock compared to expectations

The concept of reality shock introduced by Kramer in 1974, identified that the idealistic expectations of the NQN on entry to the workplace did not translate to the realities of clinical practice. The shock that the reality caused led to high levels of stress and disillusionment for some NQNs. As Kramer (1974) identified, no two NQNs will perceive their new experience in the same way and for some this may be a period of conflict.

Within twenty three papers reviewed, reality shock was a key concept that emerged (Aldosari et al, 2021; Arrowsmith et al, 2016; Clark and Holmes, 2017; Dearmun, 2000; Delaney, 2003; Duchscher, 2001; 2008; Feng and Tsai, 2012; Gerrish, 2000; Halpin et al, 2017; Hunter and Cook, 2018; Johnson et al, 2015; Kelly and Ahern, 2009; Leong and Crossman, 2015; Maben, 2003; Mark-Maran et al, 2013; Mawson, 2020; Monaghan, 2015; Ortiz, 2016; Price et al, 2018; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2016)). Despite there being a timespan of nearly fifty years between Kramer's work,

and the latest research studies (Mawson, 2020; Watson et al, 2020), and studies occurring across several countries, NQNs still appear to have unrealistic expectations on entry to the workforce. Influences on the NQNs' transition to qualified practice can be multifaceted including the individual's ability to react to stressful situations (Watson et al, 2020). But, as the STaR project (Watson et al, 2020) identified, despite considerable research and investment into the support for NQNs, their experiences and perceptions have remained largely unchanged. Workload expectations and time management were key factors in causing job dissatisfaction and disillusionment for participants (Arrowsmith et al, 2016; Delaney, 2003; Duchscher, 2001; 2008; Feng and Tsai, 2012; Gerrish, 2000; Halpin et al, 2017; Hunter and Cook, 2018; Johnson et al, 2015; Kapborg and Fischbein, 1998; Leong and Crossman, 2015; Mawson, 2020; Price et al, 2018). Arrowsmith et al, (2016) and Kapborg and Fischbein (1998), found that NQNs were frustrated at not being able to give the care to patients that they felt they had trained to do. Due to level of workload, NQNs were expected to delegate care to nursing assistants, which left them dissatisfied with the level of care they were able to provide (Kapborg and Fischbein, 1998). Similar findings were reported by Duchscher (2001), when participants reported that workload expectations were such that they did not have the focus or energy to deliver the individual care their pre-registration education had prepared them for. Instead, they had become task orientated in the approach to care and their development, as finishing tasks on time took priority; a finding supported by Hunter and Cook (2018). This left them feeling frustrated and lacking confidence to become independent practitioners. Arrowsmith et al (2016) suggested that consequentially NQNs desired greater clarity and understanding of their qualified role. However, Johnson et al (2015) suggested that whilst NQNs were frustrated that key parts of their role took them away from their patients, they understood and appreciated the need to delegate to, and supervise healthcare assistants. Within the studies by Delaney (2003), Mawson, (2020) and Ross and Clifford (2002) this frustration also included an element of fear of the realities they faced. They felt under immense pressure from their workload and did not feel that their student experience had sufficiently

prepared them for this. A finding supported in a review of the literature by Arrowsmith et al (2016).

In her follow-up study, Duchscher (2008), found that the heavy workload expected of the NQNs left them feeling their contributions to the delivery of care were not valued, and their idealistic expectations of their role had left them feeling dissatisfied. They had adjusted their focus to completing tasks on time without harming anyone, rather than providing individualised care. They reported the professional identity they entered the workplace with, had quickly disintegrated, leaving them anxious and lacking in confidence. This challenge to professional identity on entry to the workplace was also reported by both Kelly and Ahern (2009), and Feng and Tsai (2012), when participants reported that their nurse education had not prepared them for the realities of the nursing culture they were expected to work in. The sudden increase in the number of patients they were expected to care for had left them frustrated and caused them role conflict. The professional values of patient centred care, intrinsic to their professional identity as a qualified nurse, had to be replaced by the organisational values of task-orientated care, to manage their time and workload. In their systematic review, Arrowsmith et al (2016) confirmed this finding, identifying that NQNs had needed to amend their professional identity on entry to the workplace, to reflect the role taken by their qualified colleagues, and align with the expected identity of the workplace. Leong and Crossman (2015) found that NQNs in their study reported the professional identity they had developed throughout their nurse education programme did not align with the professional identity expected of them in their workplace. The NQNs reported that to acquire the professional identity expected of them by their colleagues and their organisation, they had to adjust and adapt their perceptions and expectations of their role. This misalignment of professional identity and expectations of them caused difficulty in transitioning to their new role, and some participants considered leaving the profession as a result.

The issue of retention to the profession was identified in the 2018 study by Price et al. Although participants in this study reported that they were proud to be a nurse, they felt the excessive workload expected of them was leading to burnout. NQNs reported that the burnout and exhaustion caused by their excessive workload was challenging their ability to provide the standard of care they had been educated to deliver. If they were not able to deliver the standard of care they felt was required of a 'good' nurse, they would consider leaving the profession to gain a better work-life balance, a finding supported by Aldosari et al, 2021.

Preceptorship has been identified within UK Government and Professional Body reports (discussed earlier), supported by Edwards et al, (2015) and Whitehead et al, (2013), to be an effective way to prevent attrition of NQNs from the workplace. However, whilst there is consensus across the literature that effective preceptorship can have a positive impact on the NQNs' transition experience, Odelius et al, (2017) and findings from the STaR Project (Watson et al, 2020) argue that there is little evidence to confirm that preceptorship is effective in improving retention of NQNs and advise that more research is needed into this.

Hunter and Cook (2018) reported that participants idealistic professional identity on entry to the workplace caused tension and made them feel vulnerable. To adapt to their workplace environment, they had to move away from the best practice they had been taught as students. However, they were able to acknowledge that positive role models in their workplace helped them to maintain the professional identity they had developed. Hunter and Cook (2018) suggested that there is a powerful 'hidden curriculum' within the workplace that can be very influential to the NQNs' professional identity. Whilst educationalists can do little to influence this hidden curriculum, Hunter and Cook (2018) recommended that they prepare NQNs for the challenges they can expect in the realities of nursing practice. Within the UK, preceptorship has been seen to support students to negotiate this hidden curriculum. When effective structured support is available to NQNs,

complemented by pastoral support and feedback from colleagues, NQNs report a more positive transition to their qualified role and new professional identity (Arrowsmith et al, 2016; Child, 2015; Clark and Holmes, 2007; Darvill et al, 2014; Edwards et al, 2015; Gerrish, 2000; Mawson, 2020; Mark-Maran et al, 2013; Odelius et al, 2017, Owen et al , 2020; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2013). However, when preceptorship programmes are poorly resourced or not individualised to the needs of the NQN, they can be ineffective or contribute to a negative transition (Aldosari et al, 2021; Child, 2015; Clark and Holmes, 2007; Darvill et al, 2014; Gerrish, 2000; Mawson, 2020; Marks-Maran et al, 2013; Odelius et al, 2017; Ross and Clifford, 2000; Whitehead et al, 2016).

From their findings, the authors of the thirty-three papers reviewed made several similar recommendations relating to reality shock. However, given the timespan between the first and last study reviewed, it may indicate that these recommendations are still not effective. Their first recommendation focuses on the preparation of NQNs during their pre-registration education. Students enter their nursing studies expecting to focus on care delivery (Duchscher, 2008), and their perceived professional identity as an NQN starts to form even before they commence their nursing education (Price et al, 2018). Professional identity then develops throughout their pre-registration studies and the idealistic ideas can form from their academic studies if students have limited exposure to the realities of clinical practice (Hunter and Cook, 2018). Haplin et al (2017) and Watson et al (2020) suggested that students who enter their pre-registration education with prior healthcare experience have a more realistic expectation of their qualified role and therefore find the transition to the workplace less stressful and more easily managed. The education students receive to enable them to provide bedside care combined with the protection given by their mentors in clinical practice leads to role conflict as a qualified nurse (Kelly and Ahern, 2009). Whilst it is acknowledged that NQNs are well educated for their professional role (Kapborg and Fischbein, 1998), there needs to be a greater focus on preparing the NQN

for the realities of workplace practice. Although their professional identity will be affected by a number of factors, greater preparation for the realities of workplace culture and the influence of socialisation needs to occur (Boyle et al, 1996; Duchscher, 2001; Kelly and Ahern, 2009; Ortiz, 2016). In addition, Hunter and Cook (2018) suggested that to better prepare students for the realities of qualified practice, the teaching of holistic care could be supported with a greater focus on work organisation to better prepare students for their multifaceted complex role as a qualified nurse, and to help to reduce the role- conflict. A recommendation in both the international and UK literature is that providing students with a final placement in their preferred area of employment may better prepare them for the realities of the workplace. In addition, this allows the final placement students to start to familiarise themselves with the environment and commence their socialisation into the team and workplace culture. All of which can make the transition to qualified practice and easier and quicker process (Clark and Holmes, 2007; Irwin et al, 2008; Price et al, 2018; Ross and Clifford, 2002; Watson et al ,2020; Whitehead et al, 2016). Additionally, Child (2015) and findings from the STaR Report (Watson et al, 2020) suggested that HEIs and workplaces working together to develop an individualised transition plan for the NQN can alleviate some of the stress and concern for both the NQN and the workplace team. In their naturalistic inquiry research Whitehead et al (2016) also identified that greater recognition needs to be given to the impact of an unfamiliar workplace if the NQN is also new to the organisation, as more time will be needed for them to adjust to their new role.

The second recommendation focused on managing the 'Reality Shock' that occurs on entry to the workplace. This is significant because as Price et al (2018) suggested, the shock that comes with the realities of qualified practice can make some NQNs rethink their career choice. NQNs often enter the workplace with high expectations, feeling prepared to engage with their newly forming professional identity. However, their perceptions are changed almost immediately, leaving them with feelings of inadequacy about managing the realities of practice (Boyle et al 1996; Kelly and Ahern, 2009). Duchscher (2008)

suggested that at the beginning of their qualified journey NQNs need to have greater awareness and understanding of their changing identity. They need to realise that the changes expected of them in their socialisation to the workplace, will affect their professional and personal identity. Recognising this will help the NQN prepare for the reality shock of entering the workplace and enable a more successful transition to qualified practice. Monaghan (2015) argued that NQNs are less prepared for the realities of autonomous qualified practise since the removal of the traditional apprenticeship model of nurse education, but this is disputed by Irwin et al (2018) who suggested that NQNs are better prepared for qualified practise than they were 30 years ago. Dearmun (2000) and Davill et al (2014) purported that NQNs recognise that they cannot be completely prepared for the start of their qualified journey, and they need to adapt their mindset to accommodate the requirements of their new role. Providing NQNs with support through their transition is important (Edwards et al, 2015; Watson et al, 2020) and effective preceptorship programmes can help NQNs to deal with the emotional challenges of that reality shock (Arrowsmith et al, 2016).

The final recommendation focused on greater recognition of the significance of the start of the NQN career journey. Delaney (2003) argued that the very beginning of the qualified journey is crucial to the transition period into the workplace. Because of the significance, it is important to understand that starting point of the journey from the NQNs perspective. As Delaney (2003), identified, whilst all NQNs will have achieved the professional standards expected of them, their perceptions of who they are as qualified nurses will be unique. Duchscher (2001) argued that the professional identity at the point of qualification is not that of a qualified nurse. Because of the number of unknown factors facing the NQN on entry to the workplace, professional identity can only develop over time. She endorsed this point in her follow up study (Duchscher, 2008), when she suggested that at the point of entry to the workplace, NQNs lack the nursing experience to deal with the multiple expectations of them. She purported that it is not realistic to expect NQNs to gain all the

necessary attributes to fulfil their new professional identity from their nursing education programme. Instead, they need to have greater awareness that their perceived identity will develop as they become settled into the workplace with support of colleagues; she calls this the Transition Period. Leong and Crossman (2015) concluded that the professional identity NQNs had developed on qualification did not transfer well to the realities of practice. They recommended that NQNs need greater awareness of the realities of the workplace and need the skills to adjust once in their workplace. This would then enable them to continue the development of their professional identity within their organisation's expectations. Providing support at this crucial time can assist them to have a more positive entry into their qualified career. The value of effective preceptorship programmes is well documented in the Government and Professional Body reports discussed earlier, and in the UK literature (Aldosari et al, 2021; Edwards et al, 2015; Gerrish, 2000; Marks-Maran et al, 2013). However, preceptorship programmes should be tailored to the individual needs of the NQN (Darvill et al, 2014; Ross and Clifford, 2002) and preceptors should be well prepared with managerial and organisational support (Child, 2015). Other formal support should also be made available to the NQN through a thorough orientation and induction (Watson et al, 2020) to help them to familiarise themselves with the organisation and expectations of the workplace.

2.4.2 Concept two – Role Identity and Belonging

In their review of the literature around student acceptance in clinical placement, Levett-Jones, Lathlean, Maguire and McMillan (2007), emphasised the term 'belongingness' and its significance to the development of student nurses' confidence and professional identity. However, O'Kane (2011), suggested that this issue of belongingness is not limited to student nurses but is also a factor in the transition to the workplace for NQNs. Indeed, the concept of belonging and its influence on role identity emerged from all the papers reviewed for this research project except for Monaghan (2015).

Gerrish (2000), Johnson et al (2015) and Kapborg and Fischbein (1998), found that NQNs had no issues developing relationships with qualified staff, but had difficulty communicating and establishing relationships with nursing assistants. Delegating to nursing assistants was problematic as the NQNs lacked confidence in knowing what tasks it was reasonable to expect nursing assistants to undertake and lacked authority in delegating those tasks. By comparison, four of the studies identified that anxiety in the NQNs related to working with senior nurses or medical staff (Duchscher, 2001; Feng and Tsai, 2012; Halpin et al, 2017; Leong and Crossman, 2015), although Halpin et al (2017) suggested that this was less common for NQNs who had previous care experience. NQNs felt that their newly qualified status and uniform led to expectations from senior nurses and medics of knowledge and skills competence in line with other more experienced nurses. These opinions and expectations were significant to them as the senior nurse and medics were viewed as authority figures whose opinions were not to be questioned (Duchscher, 2001).

Although NQNs expressed job dissatisfaction in not being able to deliver direct care (Arrowsmith et al, 2016; Duchscher, 2001; 2008; Feng and Tsai, 2012; Hunter and Cook, 2018; Kapborg and Fischbein, 1998; Maben, 2003; Mawson, 2020; Price et al, 2018) they reported that of greater priority to them was fitting in and being accepted by the team. They had been taught to deliver holistic care but, they identified that being part of the workplace culture took priority. Despite this conflict with their newly developing professional identity, several studies (Delaney, 2003; Duchscher, 2001; Feng and Tsai, 2012; Hunter and Cook, 2018; Leong and Crossman, 2015) reported that NQNs took a task approach to their delivery of patient care. This ensured that they were able to complete their workload on time and meet the expectations of colleagues. In Duchscher's early 2001 study, she discussed how the need to fit into the team and belong had affected NQNs ability to develop their independent practice and confidence in their professional

identity. The NQNs perceived that their need to ask questions and request support was viewed as a sign of weakness by their team. Consequently, the NQNs were fearful of asking questions or challenging practice as they would not be accepted into the team. This left NQNs feeling alone and not valued. This finding reflected the earlier findings of Dearmun (2000) and was supported by Delaney (2003), when NQNs recognised the importance to them, of being accepted by the team, and the negative effects on their confidence when they perceived that they did not belong. So significant was this to the NQNs that they chose to conceal their fear and anxieties to be accepted into the workplace. Similarly, Clark and Holmes (2007) reported that NQNs felt they needed to develop the specialist skills and knowledge required of their workplace before they were accepted into the team and expectations of some staff increased their anxiety and undermined their confidence.

The unrealistic expectations of some staff around the NQNs' specialist skills and knowledge were subsequently reported by Aldosari et al (2021), Irwin et al (2018) and Mawson (2020), with Mawson suggesting that the expectations of NQNs from employers does not align with the expectations of the NMC. Child (2015) advised that the arrival of the NQN can have an impact on the established team. There is often an expectation within the team that the NQN will not be safe to practice unsupervised and so staff will test the NQN to ensure they meet the required standards before accepting them into the team. However, Child cautions that NQNs need to feel valued and accepted into the team, with regular feedback if they are to continue their development.

The benefits of individualised structured preceptorship programmes and support from the wider team were reported within the UK literature (Darvill et al, 2014; Edwards et al, 2015; Gerrish, 2000; Halpin et al, 2017; Marks-Maran, 2013; Mawson, 2020; Owen et al, 2020; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2013; Whitehead et al, 2016), but issues with acceptance and the potential consequence of attrition were reported

across both the UK and the international literature. Aldosari et al (2021) and Mawson (2020) suggested that when NQNs did not feel valued and supported they changed jobs or left the profession. Anxiety around acceptance was reported in the 2009 study by Kelly and Ahern. The hostility felt by NQNs in this study and difficulties in trying to be accepted were referred to as 'Eating their Young'. NQNs felt strongly that they had been prepared for their professional role as a nurse, but not for the power relations and oppressive practices they were exposed to in the workplace. Rather than developing a feeling of belonging, these NQNs felt unwanted, something they had not experienced as students. Similar oppressive practices were reported by Feng and Tsai (2012), when NQNs expressed concern that if they did not learn and conform to the workplace rules and norms they would be chastised and isolated.

In common with the UK studies around effective preceptorship, more recent international studies (Hunter and Cook, 2018; Price et al, 2018), suggested that some advances appear to have been made in supporting NQNs acceptance into the workplace. Whilst belonging continued to be a source of anxiety at the beginning of the qualified journey, NQNs were more positive in their perceptions. Within both studies positive role models and encouragement had enabled them to maintain and continue to develop their professional identity. Although they recognised their vulnerability in their role, and felt like a burden in the workplace, positive support and role modelling from some staff had been beneficial.

Similar conclusions relating to the concept of belonging were drawn across the studies reviewed. Duchscher (2001) contended that feedback received from senior nurses impacts on NQNs decision making abilities. When NQNs do not feel supported by senior nurses they are less likely to develop their clinical judgement making and practice learning. She suggested that NQNs can experience a sense of loss and abandonment if they are not welcomed into their workplace, which can affect their confidence and perception of their new role; a finding also reported by Child (2015), Maben (2003) and Ortiz (2016).

Duchscher (2001) recommended that allowing senior students a placement opportunity in their potential workplace can help them to gain greater insight into the realities of qualified practice, so they start to develop those important working relationships. She strongly emphasised the need for senior nurses to promote supportive relationships in the workplace for NQNs and cautioned against allowing oppressive behaviour to continue. She advised that negative behaviour should be challenged by workplace managers, a point supported by Leong and Crossman (2015), and Price et al (2018). In her follow-up study, Duchscher (2008) developed this still further and advised that positive, supportive role models for NQNs can help them to address their anxieties around belongingness, and in doing so can support their developing professional identity.

Boyle et al (1996) and Watson et al (2020), acknowledged that acceptance into the workplace can be a complex process; but recommended that good role models and support mechanisms can be positive influences in the development of the NQNs' professional identity. On-going professional development for staff can enable them to act as positive role models and effectively support the NQN (Delaney, 2003; Edwards et al, 2015). Delaney (2003) suggested that support groups for NQNs can be useful during the early period of acceptance into the workplace and peer support was reported as important by Child (2015), Odelius et al (2017) and Watson et al (2020). Kelly and Ahern (2009) and Feng and Tsai (2012) drew attention to the bullying culture repeatedly reported in the literature. They argued that one reason for this bullying may be cyclic perpetuation of bullying from one generation of nurses to the next. Kelly and Ahern (2009) recommended that both experienced nurses and managers need to be more proactive in reducing oppressive practices and supporting NQNs so that they have a greater sense of belonging. Feng and Tsai (2012) acknowledged that providing one to one support for NQNs may not be viable in the challenging nursing environment. However, they argued that if senior nurses ensure a supportive team is available this will enable NQNs to develop positive relationships and adapt to the requirements of their new professional identity.

By acting as positive role models, experienced nurses can help the NQN to continue to develop a positive professional identity and aid retention to the profession (Arrowsmith et al, 2016; Child, 2015; Hunter and Cook, 2018; Watson et al, 2020; Whitehead et al, 2016).

2.4.3 Concept three – Taking Responsibility

The transition to registered practice can be a daunting experience for the NQN. Internationally the NQN enters the professional register at different times following graduation from their educational programme. However, the attainment of that professional status, and the responsibility that comes with registration, can be stressful at whatever time it occurs. Within the studies reviewed the concept of responsibility was not as strong as the previously discussed concepts and linked closely to 'Reality Shock', but it was an area that caused concern and anxiety for some NQNs. Despite increased exposure to decision making and management during the latter stages of their pre-registration education programme; some NQNs did not feel prepared for the sudden responsibility they had on entry to the workplace as a registered professional. Participants discussed the safety net or cushion they felt supported them as a student. With the responsibility of qualified practice came the removal of this buffer which left them feeling frightened (Clark and Holmes, 2007; Delaney, 2003; Duchscher, 2001; Feng and Tsai, 2012; Gerrish, 2000; Hunter and Cook, 2018; Kelly and Ahern, 2009; Leong and Crossman, 2015; Mawson, 2020; Monaghan, 2015; Ortiz, 2016; Ross and Clifford, 2002).

Leong and Crossman (2014) suggested that wearing the uniform of a qualified nurse reinforced to others that the NQN was now accountable and responsible for their actions and decisions. There was a perception that qualified status meant they must always be accountable and responsible, and accountability could not be shared with or passed on to others. In a number of studies (Delaney, 2003; Duchscher, 2001; Feng and Tsai, 2012; Hunter and Cook, 2018; Kelly and Ahern, 2009; Ortiz, 2016), participants expressed that

they felt overwhelmed by the sudden responsibility. The realisation that there was no longer anyone to oversee their practice made them feel vulnerable, with an awareness on entry to the workplace that the management experience they had gained during their student placements did not reflect the realities of practice.

Whilst NQNs recognised the importance of making clinical decisions and working as an independent practitioner, this was a daunting prospect when it became a reality. NQNs began to realise that when given opportunities to take control as a student, they were still protected from some of the challenges of registered practice. Duchscher (2001) reported that the protection NQNs had received from mentors when they were students had disadvantaged them. The shock reality of the extent of responsibility they now faced, had left them frightened and reluctant to develop their independent decision-making skills. Although participants within the studies reviewed were keen to develop their independent practice and autonomy, they were held back by the fear of making a mistake or harming someone (Duchscher, 2001; 2008; Gerrish, 2000; Mawson, 2020; Monaghan, 2015; Ortiz, 2016). However, Dearmun (2000), Gerrish (2000) and Kelly and Ahern (2009) acknowledged that for some, there is an appreciation that full responsibility can only occur once qualified status is attained. Hunter and Cook (2018) purported that if positive support is made available to NQNs, their confidence in taking responsibility quickly develops and the professional identity of the NQN can be maintained. When participants in their study felt supported, they also felt able to act as advocates for their patients to identify and act on poor practice. This may be a significant and important consideration in the improvement and development of future clinical practice and patient experience.

Across the studies that identified responsibility and accountability as an emerging theme (Clark and Holmes, 2007; Delaney, 2003; Duchscher, 2001; Feng and Tsai, 2012; Gerrish, 2000; Hunter and Cook, 2018; Kelly and Ahern, 2009; Leong and Crossman, 2015; Mawson, 2020; Monaghan, 2015; Ortiz, 2016; Ross and Clifford, 2002) there was a

consensus around how this could be improved. The importance of ensuring NQNs receive positive, consistent support and preceptorship in the workplace was promoted by all authors. Ortiz (2016) argued that NQNs need to have an opportunity to develop their independence and confidence with their responsibility and accountability. This can only be done if the individual's readiness to practice independently is recognised and nurtured.

There needs to be greater recognition that on entry to the workplace NQNs often lack professional confidence and greater preparation for this needs to be done during the pre-registration nursing programme. Delaney (2003) suggested that greater focus needs to be given to exposing students to the realities of caring for multiple patients and the responsibility and accountability that comes with this. However, Ortiz (2016), recognised that this can sometimes be difficult to achieve within clinical practice. She suggested that simulation can be a vehicle for allowing students to develop these elements of their practice; enabling them to make mistakes and learn from those mistakes within a safe environment. Through this, students can build their experience and confidence to better equip them for entry into qualified nursing practice.

2.5 **Discussion and critical analysis of concepts emerging from the literature review**

The studies reviewed came from both an international perspective (Australia, Canada, New Zealand, Sweden, Taiwan, United States of America) and a UK perspective; acknowledging that approaches to nurse education and exposure to clinical practice during the pre-registration education phase varied. Despite the different approaches to health care internationally, and variations in nursing programmes and student experiences, findings across the studies were consistent. The importance of providing a positive

transition to the qualified workforce and preparing student nurses for the realities of qualified practice were factors identified as requiring further action and understanding.

It is widely acknowledged that excessive workload can lead to high levels of stress and burnout (Parker, Giles, Lantry, McMillan, 2014; Missen, McKenna, Beauchamp, 2014). When this occurs, there is greater likelihood of NQNs becoming dissatisfied and leaving the nursing profession, as they have not had time to build up resilience and coping strategies. Zhang, Wu, Fang, Zhang and Wong (2017), identified that NQNs make up a large proportion of the nurses leaving the profession, citing reality shock and poor role models as influences in that decision. However, if NQNs are effectively prepared for the realities of the workplace and the challenges to their newly formed professional identity, they are more likely to adapt to the demands of the workplace (Sabanciogullari and Dogan, 2015).

Willetts and Clarke (2014) suggested that one of the difficulties in describing the professional identity of nurses lies in the diverse range of contexts within which nurses work. They purported that to understand and define the professional identity of nursing, greater consideration needs to be given to the workplace settings and organisational requirements of nurses. Whilst academic education can go some way to preparing NQNs for the workplace and their professional identity, the effects of socialisation in the workplace must also be considered (Lave and Wenger, 1991; Wenger, McDermott and Snyder, 2002). Significantly within this is the NQNs feelings of acceptance and belonging to their workplace group (Willetts and Clarke, 2014); their Community of Practice (Wenger, 1998).

From the reviewed literature, NQNs appeared to develop greater confidence when they felt welcomed and supported in their workplace, with positive role models to learn from (Boyle et al, 1996; Child, 2015; Clarke and Holmes, 2007; Darvill et al, 2014; Dearmun,

2000; Delaney, 2003; Edwards et al, 2015; Feng and Tsai, 2012; Gerrish, 2000; Hardyman and Hickey, 2001; Hunter and Cook, 2018; Irwin et al, 2018; Maben, 2003; Marks-Maran et al, 2013; Mawson, 2020; Odelius et al, 2017; Ortiz, 2016; Owen et al, 2020; Price et al, 2018; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2013; 2016). By comparison, when NQNs felt constantly criticised or isolated, their confidence reduced significantly, and surviving, fitting in, and following the workplace culture became more important than delivering holistic care or developing their professional identity (Aldosari et al, 2021; Arrowsmith et al, 2016; Darvill et al, 2014; Duchscher, 2001; Hunter and Cook, 2018; Irwin et al, 2018; Leong and Crossman, 2015; Maben, 2003; Mawson, 2020). Kelly and Ahern (2009) found that participants had not noticed the enculturation of the workplace as students or the 'cliques' they perceived to exist once they entered qualified practice. They had expected to be welcomed into the team as an NQN but instead often felt ignored and alienated. The NQNs perceived a power culture where experience of the culture and processes of the workplace was used by some nurses to maintain a hierarchy over the NQNs who felt they were seen as a threat. Traynor and Buus (2016), cautioned that the vulnerable position of the NQN on entry to the workplace can significantly affect their attitudes and beliefs because of their desire to fit in and be accepted. If the socialisation experiences of these vulnerable new nurses are not positive and supportive, they may become cynical and accepting of poor practice in an effort to survive.

From the literature reviewed it appears that the belongingness Levett-Jones and Lathlean (2008), identified as being so important for student nurses, continues for the NQN, with entry and enculturation into the workplace. During socialisation the NQN learns the 'covert rules' (Maben and Griffiths, 2008), and the accepted values and cultures of the workplace. Fagermoen (1997) and Marañón and Pera (2015), suggested this socialisation is significant to the development of the professional identity of the NQN. Cowin, Johnson, Craven and Marsh (2008), discussed the significance of this socialisation and argued that this is important in the development of professional identity and job satisfaction. Yet,

Willetts and Clarke (2014), cautioned that acceptance into the workplace culture and development of professional identity can be a complex activity. It is concerning therefore, that this period of socialisation is repeatedly reported to be as Traynor and Buus (2016:188) stated, often “deeply problematic”.

Acceptance and support from workplace colleagues are key factors in the NQNs’ confidence and professional development. The horizontal violence documented in literature (Lea and Cruickshank, 2007; Parker, et al, 2014; Spence Laschinger, Grau, Finegan and Wilk, 2010), is less likely to occur if NQNs have support and guidance from positive role models in their workplace. Horizontal violence is described as bullying by group members towards another member of the group (Duffy, 1995). McKenna, Smith, Poole and Coverdale (2003) suggested that this usually takes the form of psychological harassment and within nursing is usually instigated by a more senior member of the team. This can be significant for NQNs on entry to the workplace. When they are keen and enthusiastic to contribute to their profession, bullying and a negative reception can undermine their confidence and lead them to question remaining in the profession (Curtis, Bowen and Reid, 2007). Their idealistic expectations may well be challenged by the realities and complex demands of contemporary practice. However, the unacceptable hostility and bullying reported by some NQNs does not help them to adapt and develop their professional identity in a positive manner. Further, it breeds a cycle of enculturation that is not good for the profession or the patients accessing the care services (Curtis et al, 2007). If NQNs are not supported to question poor practice or encouraged to introduce up to date evidence-based practice, the quality of care delivered cannot improve, and the professional identity of nursing cannot continue to develop (Francis, 2013; Willis, 2012).

Where studies reviewed identified difficulties in developing relationships with senior colleagues; NQNs often reported concerns around developing professional relationships with senior nurses and doctors. Yet Kapborg and Fischbein (1998) suggested that

difficulties relating to socialisation and acceptance can occur with unqualified staff too. Healthcare support workers are key members of the caring team, and NQNs can find their developing identity challenged if they are not accepted by the whole care team. Findings from the literature suggested that horizontal violence is not always perpetuated by more senior qualified staff. Unqualified nursing support staff are reported as being challenging for the NQNs to work with. NQNs often perceive that support workers resent having tasks delegated to them by junior nurses. Some experienced support workers consider that their years of experience give them greater knowledge and understanding of what needs to be done and processes to follow. As a result, they are reluctant to comply with the requests of the NQN (Sneltvedt and Bondas, 2016). This can lead to disempowerment for the NQN and further undermine their confidence and professional identity, as they feel they lack authority to fulfil the delegation element of their role.

In addition to the changes to their professional identity, Duchscher (2008) suggested that on entry to the workplace, the NQN will also experience significant changes to their personal identity. The way that the NQN is perceived by society, their family and friends, and the wider expectations of them are not always anticipated by the NQN. As a professional nurse the NQN will be expected at all times to behave in a manner defined by the professional body, and there is often an expectation by those closest to them, that they can be called upon at any time for help and care. A point reinforced by Watson et al (2020) when they advised that transition is multi-dimensional including the impact of personal factors. Duchscher (2008) argued that NQNs need to have an awareness and understanding of their changing identity, to enable them to make the necessary adjustments for successful transition to the role of a qualified nurse. She considers that the changes that occur to the identity of these NQNs will affect others who are significant to them, which can in turn affect their well-being.

On entry to the professional register and the workplace, awareness of accountability and responsibility becomes heightened (Darvill et al, 2014; Dearmun, 2000; Delaney, 2003; Duchscher, 2001; Feng and Tsai, 2012; Gerrish, 2000; Hunter and Cook, 2018; Kelly and Ahern, 2009; Leong and Crossman, 2015; Monaghan, 2015; Mawson, 2020; Ortiz, 2016). NQNs start to identify with the significance of belonging to the professional community and fear of losing membership to that community can become excessive (Leong and Crossman, 2015; Hunter and Cook, 2018). As students, they received opportunities to take control and manage care with mentor support. However, on entry to the workplace they realise they need to reassess their strengths and areas for development (Hunter and Cook, 2018; HEE, 2018). The sudden exposure and realisation of areas to develop can negatively affect the NQN's confidence, leaving them feeling overwhelmed (Dyess and Sherman, 2009). When this is coupled with fear of professional accountability, the result can be anxiety provoking and stifle their development as an independent practitioner.

Whilst some of the exposure and associated feelings around responsibility and accountability cannot occur until qualification is reached, (Odland et al, 2014), how this is managed in the lead up to qualification and on entry to the workplace can be significant. There needs to be greater exposure for students during their final placements, with experienced nurses affording less protection from the realities of practice. Alongside this, academic establishments need to encourage an open discourse about the realities the NQN will be exposed to, and simulation may be a way to facilitate and explore some of the key issues.

2.6 **Chapter Summary**

International and UK work has investigated practice readiness, professional identity of NQNs and preceptorship. However, as Watson et al (2020) observed, there has been little change in NQNs' experiences when entering the qualified workplace. Within UK Government and Professional Body reports, and literature reviewed, there is acknowledgement of this issue and the need for further research and understanding (Aldosari et al, 2021; Beech et al, 2019; Gerrish, 2000; HEE, 2018; Willis, 2012). The studies reviewed span a period of twenty-five years and yet similar themes continue to emerge. NQNs continue to enter the workforce with idealistic expectations of what their role will involve (Arrowsmith et al, 2016; Mawson, 2020) and how they will be welcomed into the workplace. The literature suggests however, that the reality of excessive workload, responsibility and accountability can be overwhelming and the lack of time to deliver direct patient care can lead to job dissatisfaction (Duchscher, 2008). Horizontal bullying and a desire to fit in and be accepted can lead NQNs to focus more on their own survival than the standard of care they deliver (Duchscher, 2001; Kelly and Ahern, 2009). Without positive role models and support, NQNs lose confidence in their abilities and decision-making capabilities (HEE, 2015; 2018; NHS Improvement, 2019; The National Improvement and Leadership Development Board, 2016; Ortiz, 2016). Their lack of resilience to challenge poor practice often leads them to consider leaving the profession when they are not able to develop and reinforce the professional identity that they believe they should have as a qualified nurse (HEE, 2018). The current challenging climate relating to nursing shortages and attrition is a significant factor in nurses' burn-out and contributes to these issues (Buchan et al, 2019). However, findings from the studies recommended that more realistic preparation during the pre-registration education of student nurses, and greater support for NQNs during transition can help them to adjust their perceptions of their professional identity (Boyle et al, 1996; Child, 2015; Duchscher, 2001; Edwards et al, 2015; Kelly and Ahern, 2009; Marks-Maran et al, 2013; Mawson,

2020; Odelius et al, 2017; Ortiz, 2016; Owen et al, 2020; Ross and Clifford, 2002; Watson et al, 2020; Whitehead et al, 2013; Whitehead et al, 2016).

To support retention to the profession, there needs to be a greater understanding of the preparation needs of NQNs, to encourage a positive transition and entry to the qualified workplace. The literature review identified that NQNs experience shock associated with the transition to their qualified role, and the stress this can cause. There was acknowledgment that as the NQN enters their new role and working environment some transition shock is normal and inevitable; the NQN having to adjust their professional identity and adapt to new boundaries and expectations. However, there is a lack of information around the influence of generational and personal background factors on NQNs' development of practice readiness and transition to qualified practice. Whilst these factors were acknowledged in some of the literature (Beech et al, 2019; Child, 2015; Duchscher, 2008; Halpin et al, 2017; HEE, 2015; 2018; Hunter and Cook, 2018; NMC, 2020; Price et al, 2018) they were not explored or discussed in any detail. Within the UK literature there was a recognition of the value of transitional support in the form of preceptorship, and whilst individual preceptorship programmes were recommended, there was no exploration of how generational or personal habitus expectations should be accounted for. This suggests that further research around UK NQNs' experiences of practice readiness may provide greater understanding of factors that influence a positive transition to qualified practice.

Moving on from the body of knowledge established through the literature review, the next chapter discusses the philosophy and theory underpinning the current study, and the epistemological and ontological assumptions used.

CHAPTER THREE PHILOSOPHICAL AND THEORETICAL UNDERPINNINGS

3.1 Introduction

This chapter aims to consider the philosophical and theoretical assumptions that underpinned the current study, my own epistemological stance, and challenges to my existing preconceptions and assumptions. Cohen et al (2011) suggested that an individual's preferences and assumptions will be factors in their choice of research topic and investigative approach. Likewise, Burrell and Morgan (1979) argued that the researcher's assumptions (ontological, epistemological, human, and methodological) will influence their choice of research methods. Consideration should always be given therefore to the role of the researcher within any research project, their potential influence over participants and the value of reflexivity as part of the process. The aims and objectives for the current study were to explore the perceptions of practice readiness and professional identity; this chapter will critically analyse the significance of the theoretical, epistemological, and ontological assumptions in relation to those aims and objectives.

3.2 Transition

On successful completion of the pre-registration nursing programme and registration with the NMC, UK nurses enter their professional career as qualified nurses. This move from student status in an HEI to qualified nurse status in a workplace environment is a transition for each individual's role and professional identity. Chick and Meleis (1986) suggested that transition is a normal process that encompasses the start and end of a life phase and relates to a change for the individual. A transition, Chick and Meleis (1986) advised, may be anticipated or unexpected, but will usually last for a finite period. However, they

cautioned that how the individual perceives that transition, will affect the outcome. They suggested that if the individual is aware of why the change is occurring and is prepared for it, their perceptions and responses may be more positive. Chick and Meleis (1986) acknowledged that the individual's journey through the transition may not always be positive, as the individual must reconcile a loss of their familiar reference points and some of their expectations with reality. A point supported by Ashley, Halcomb and Brown (2016) when they advised that transition could lead to loss of role familiarity, increasing stress levels and reducing self-confidence. However, transition is likely to be a more successful experience if the individual understands what to expect, as they are more likely to actively engage in the process by seeking support and role models (Meleis, Sawyer, Im, Messias and Schumacher, (2000).

As part of the transition to the qualified role, Meleis et al (2000) argued that the individual needs to accept that a number of changes will occur, in the way they are feeling, the way they are perceived and their perceptions of others. It is important to be aware of the multiple factors that may influence the transition into the new role, and consideration should also be given to changes in personal needs and wider social experiences (Meleis et al, 2000). Important to this is the preparation received in readiness, the more prepared the individual is, and the greater their knowledge and understanding of the experience they will undertake, the more positive the outcome of the transition is likely to be (Chick and Meleis, 1986). With regards to the current study, this links to the NQNs' perceived readiness for practice on entry to the qualified workplace. If the reality reflects the knowledge, understanding and awareness gained during preparation in the pre-registration programme, the NQN is more likely to perceive that they were ready for qualified practice. However, Meleis et al (2000) cautioned that individuals will often compare their new role to their old one, to make new meanings and develop new perspectives. This can be a more successful process if they have been prepared for this and are able to consider who they are now, and why they are in their new role.

As part of preparing student nurses for their transition to qualified practice, they need to appreciate that on entry to the qualified workplace they will not have immediate mastery but will have peaks and troughs in the development of their new identity and role (Meleis et al, 2000; Murray, Sundin and Cope, 2019). By preparing the student nurse to link newly developed skills and knowledge as an NQN with those developed as a student, mastery is more likely to develop in the qualified role (Meleis et al, 2000). Key to this mastery is the expectations of those in the qualified workplace and their support of the NQN (Chang and Daly, 2016; Regan, et al, 2017). Chick and Meleis (1986) purported that key to a person's transition is the changed environment. Recognition needs to be given to the removal of the individual's usual support sources and their need to adapt to their new environment and development of new support structures. Chick and Meleis (1986) cautioned that this can be more difficult if the environment the individual is entering is not stable or is undergoing frequent change. This is particularly relevant to NQNs starting on their qualified journey. The support structures that were available to them as a student have now been removed and positive supportive role models in the workplace are required to help them to adjust to their new environment. When the workplace is having difficulties due to service demands, staffing issues or negative cultures, this can greatly impact on the NQN's ability to make a successful transition to their qualified role (Francis, 2013; HEE, 2017; NHS Improvement, 2019; The National Improvement and Leadership Development Board, 2016; Willis, 2012).

Meleis et al (2000) argued that stereotypical views can facilitate or inhibit the transition of an individual to their new environment. If the NQN is perceived as a burden or threat to the workplace, the reception they receive is more likely to inhibit their transition to the qualified role; however, the opposite is likely to occur if the NQN is perceived as a positive addition and welcomed as a member of the team (Meleis et al, 2000). Although each NQN will have a different and unique transition to their new qualified role; when the NQN is

supported to reflect on their changing role and new relationships, and is encouraged to develop their self-confidence, this will facilitate a better transition (Meleis et al, 2000; Wall, Fetherston and Browne, 2018). By preparing them for that role and recognising the multiple factors affecting each NQN at the start of their qualified journey, a more positive entry to their professional career is therefore likely.

3.3 **Epistemology and ontological perspective**

For research to be credible, the methodological approach taken, and the epistemological positioning of the research must align with the purpose and focus of the research (Morse and Field, 2002). Nursing is a profession guided by evidence-based practice and approaches to care and treatment change based on the findings of up-to-date research. Traditionally nursing research came from the influence of the positivist paradigm (Parahoo, 2006), where cause and effect can be tested from a scientific perspective such as randomised control trials, and findings can be generalised to the wider population. Early learning and interests for me sat within scientific and mathematical subjects where clear scientific and mathematical laws could be used to explain given phenomenon. It was not surprising therefore that my initial view of research sat comfortably within the positivist paradigm and linked well to the concept of a hierarchy of evidence, where randomised control trials are considered the 'gold standard' method of research (Gray, 2001, Sackett, Richardson, Rosenberg and Haynes, 2000).

Nursing education was historically based on a medical model of care, when the more holistic approach to person-centred care was in its infancy (Parahoo, 2006), serving to reinforce my early career views of positivism. However, as my nursing and midwifery career developed, questioning of whether the objective view of positivism was always the most appropriate approach began to take shape. This challenge to my thinking and

preconceptions continued as an interest in education generally (and curriculum development specifically) increased. My longstanding ontological assumption that there is one reality which can exist and can be known (Polit and Beck, 2012), became more difficult to align with. My personal experience of teaching and supporting students, and later inexperienced teachers, led me to question this positivist assumption. From my observations of how people learn and manage the knowledge they develop, I concluded that each experience and interpretation was individual, as was the sense they made of their new knowledge. This led to the development of an interest in constructivist theories of education (Bruner, 1966; Piaget, 1977; Vygotsky, 1986) and the interpretivist research perspective. Consequently, the interpretations that individuals have, to make sense of their experiences, led me to acknowledge that my beliefs and views lay more within this interpretivist paradigm. The acknowledgement of social constructivism (Amineh and Asl, 2015) reinforced my epistemological and ontological positioning with the current study; that learning and 'making sense' of new knowledge is unique and personal, based on previous experiences, beliefs, and perceptions. Whilst recognising that as a researcher I must identify and negate any potential preconceptions or bias, this matched with the belief that my interaction with participants can assist with understanding individuals' complex realities and experiences.

The current study was completed from the interpretivist perspective, taking the belief that everyone creates their own social reality from their experiences and the social contexts within which they interact (Cohen et al, 2011; Creswell, 2013). Although a group may be exposed to the same experience, individual understanding and interpretation of that experience will be influenced by each person's unique perception. When an individual socialises within a new arena, they must recognise how their beliefs and perceptions align with the beliefs and culture of their new environment. The socialisation that subsequently occurs within that environment will, to a greater or lesser extent, depend on the degree of

alignment between the different beliefs and the willingness of the individual to adapt and change to fit into the environment's expectations and norms (Mackintosh, 2006).

Through open questions and an inductive approach, verbatim responses were captured, and themes were developed from those responses. This enabled the voices of participants to drive the research forward. I recognised as an insider in the research, my own views and perceptions could influence the research process, so used reflexive practice and supervision meetings to challenge the potential subjectivity I brought to the research. This is recommended in interpretivist research to reduce subjectivity and strengthen the authenticity of the participants' voices (Braun and Clarke, 2013; Denzin and Lincoln, 2011; Polit and Beck, 2012).

If experiences are interpreted in an individual and unique way, then arguably knowledge is a subjective concept, and this too is developed differently within everyone (Cohen et al, 2011; Creswell, 2013). As educationalists, to develop the learning of others, recognition must always be given to how individuals perceive the knowledge shared with them, and the social contexts in which they use that knowledge. In line with phenomenological theory, by studying the experiences and perceptions of individuals, greater understanding can be gained about how they interpret the knowledge they develop within their social contexts (Creswell, 2013; Saks and Allsop, 2013).

The in-depth data generated from qualitative research cannot be generalisable in the same way that more traditional positivist research can. However, this type of research can provide greater holistic understanding of an individual's experience of a given context and can help to develop an explanation or theory for the phenomenon under consideration. Theory can be developed from deductive reasoning (what is known) or from inductive reasoning (developing knowledge from observed evidence) (Morse and Field, 2002). Using an inductive approach where insights emerge, develop, and are explored, a new understanding to a given context can be gained and then be considered within similar

contexts (Morse and Field, 2002; Saks and Allsop, 2013). Rather than starting with an assumption that is proved or disproved using a deductive approach, the inductive approach allows for greater exploration of individual preconceptions and beliefs, to provide understanding of issues and factors important to the individual (Morse and Field, 2002). As I identified in Chapter two, more research into NQNs' perceptions of their readiness for qualified practice and professional identity would inform the current body of knowledge. An inductive approach to the current study would, therefore, enable exploration of the NQNs' perceptions, and contribute to the current knowledge and understanding of this subject.

As a nurse, midwife, and lecturer, my experience highlighted that an individual's interpretation of education could be positive, negative, or even destructive. Within nurse education this is significant, as key attitudes and values are considered essential to the professional identity of the qualified nurse, and all newly qualified nurses are expected to possess such attributes (NMC, 2018). The learning that occurs from formal education is often measured through the achievement of practical and written assessments, judged by more experienced and qualified nurses. However, assessment of this learning may not explore the perceptions and beliefs of the individual student and the professional identity that they will take to qualified practice. From the epistemological and ontological positioning of this study, the unique learning of the NQN participants can be better understood and can assist in the ongoing development of nursing curricula to develop professional identity and practice readiness.

Ultimately the work of Pierre Bourdieu and his concept of habitus and capital (Bourdieu, 1992) was chosen as a framework for exploring and explaining the phenomenon under investigation in this study. However, this followed a review of both Bourdieu and Social Learning Theory.

3.4 **Social Learning Theory**

Social learning theory suggests that learning of the individual is affected by their social contexts and social interactions (Walker, Payne, Smith, Jarrett, 2007). Socialisation is a key factor in social learning theory and Bandura (1977) argued that role modelling is influential in the socialisation process. He purported that individuals often model their behaviour on those perceived to be more experienced than themselves, to fit in and conform (Bandura, 1977). Walker et al (2007), used Bandura's thinking around role modelling to explain the significance and importance of practice base learning. They argued that Bandura's (1977) theory of self-efficacy helps to explain why learning in practical settings so influential, and why organisational behaviours is can be difficult to change. Bandura (1977) purported that once the individual has learnt to copy a behaviour or skill, they then adjust their performance through comparison with others, until they have developed self-confidence in its mastery (self-efficacy). He argued that this links to self-esteem and the need to have self-reassurance that they are performing in the expected way and to the expected standards.

This theory is relevant to the current study as student nurses spend 50% of their learning and assessment in clinical practice. The influence and impact of those learning experiences then affect the expectations and preparedness of the NQN for qualified practice (CoD, 2016; Francis, 2013; HEE, 2017; 2018; NHS Improvement, 2019; Willis, 2012; 2015). However, as 50% of the learning also occurs in the HEI, the learning that takes place across the different environments may lead to cognitive dissonance (Festinger, 1957). Cognitive dissonance occurs when the individual holds conflicting or inconsistent beliefs; and this can be seen in the practice-theory gap leading to reality shock (Al Awaisi, Cooke, Pryjmachuk, 2015; Kramer, 1974; Yang, Chao, Lai, Chen, Shih, Chiu, 2013). Aronson (1988) suggested that the individual may deal with this by changing their

behaviour to fit in, as could be seen in the findings from the Francis Report (Francis, 2013). Walker et al (2007) suggested that the level of influence of this socialisation is also linked to self-esteem and self-confidence. They advised that if the individual does not have a high level of self-esteem, they are more likely to be swayed by the peer pressure to comply with the culture of the environment. This again resonates with the impact of the workplace on the NQN. The literature in Chapter 2 identified that NQNs will often conform to the culture of the workplace to fit in and be accepted. This suggests therefore, that social learning theory could provide a relevant framework to underpin the current study.

3.5 **Bourdieusian Concepts**

The French sociologist Pierre Bourdieu suggested that as individuals and groups, each have ideas, perceptions, beliefs, and habits that are of particular relevance (Bourdieu, 1992; 2000). He referred to these as Habitus and argued that an individual habitus develops from a person's upbringing, education, and socialisation (Morberg, Lagerström and Dellve, 2012). Whilst habitus may be deep rooted and difficult to change (Morberg et al, 2012), Bourdieu argued that personal habitus can be altered to enable the individual to 'fit' more into their social space (the field) (Johansson, 2014; Mahar, Harker and Wilkes, 1990). These changes and adjustments to the habitus occur because those engaging within the field are frequently changing their position within that social space. Changes of position arise, according to Bourdieu, due to power that influences habitus, he termed this power, capital. Bourdieu (1992) identified four types of capital (cultural, economic, social, symbolic) and argued that the link between habitus and capital is very strong. The greater the individual's or the group's capital, the stronger the influence on the habitus. However, the value of capital is determined by the context, and capital that has great value in one field may have less value in another. Additionally, some forms of capital have greater value than others, depending on the field and the habitus of that field. Bourdieu suggested

that capital is the basis of domination, which can be significant within a hierarchical structure.

A workplace will have its own collective habitus (Wacquant, 2004) based on collective experiences and historical context. Within the workplace (the field) the workforce will have commonalities and shared habitus that links to the structures and beliefs in that social space. Individuals within that field will have different levels of capital which will influence the powerbase in the workplace (Bourdieu, 1993; 2000). Bourdieu's concept suggested that domination within a field comes from those individuals who have the most capital, and a habitus that aligns with the habitus of that field (Bourdieu, 1993, Grenfell, 2014). When the concepts of habitus and capital are applied to the hierarchical structure and ethos of the NHS, greater understanding can be gained around the power and identity challenges that often occur within and between the different care related professionals.

When applied to nursing, habitus is the values, attitudes, and behaviours that nurses have. These are often gained and developed through the learning and experiences in the pre-registration period. Throughout this period student nurses develop the common characteristics expected of nurses and linked to their professional identity. The development of these general characteristics, such as moral and ethical values, compassion, and care, are referred to as Secondary Habitus (Carter, 2014). Doxa, according to Bourdieu (1992), are the rules (written and unwritten) and the expectations of a workplace. By complying with the doxa, which is maintained by those with the power, new nurses can become accepted into the social space. Bourdieu identified a form of habitus known as Nursing Habitus (Bourdieu, 2006) and argued that nursing habitus occurs because nurses develop and internalise skills, attitudes and behaviours that are expected of them. He proposed that by developing the nursing habitus, the individual would develop the expected characteristics of that group, and this would enable acceptance into the nursing identity. For the NQN this links closely with socialisation into

the workplace, belonging and acceptance by colleagues. However, it should also be acknowledged that the entry of the NQN into the workplace will impact on those already working there. The teamworking dynamic will be altered by the inclusion of the NQN into the team. In a demanding and busy working environment this change to the team dynamic can be unsettling, particularly if some of the cultures and doxa of the workplace are questioned or challenged. Support and professional development opportunities need to be in place for workplace staff to help to reduce the stress that can occur when NQNs enter the environment and help with the management of the change. Strong management and leadership in the workplace alongside support and development opportunities for the workforce will help staff to feel valued and promote a positive and welcoming workplace culture (Child, 2015; Edwards et al, 2015; HEE, 2017; 2018; NHS Improvement, 2019; Odelius et al, 2017; The National Improvement and Leadership Development Board, 2016; Watson et al, 2020; West et al, 2020).

Bourdieu (Grenfell, 2014) suggested that habitus occurs at a micro, meso and macro level. When related to the NQN, on a micro level the student nurse will bring to the profession the habitus developed from their upbringing, educational experiences, perceptions, and beliefs. They will enter a profession that on a macro level has its habitus based on its history, its development and its recognition and acceptance by other professions. As they progress through their pre-registration education, some of their ideas of what a nurse should be, will be challenged, and some of their ideas will be reinforced and strengthened. Within the pre-registration period the student nurse will gain academic knowledge, but 50% of their learning experience will come from clinical practice. Bourdieu (Jenkins, 2002) argued that the developing habitus is influenced more by experience than by explicit teaching, making the student experience in clinical practice particularly significant. Students need exposure to the full range of challenges experienced by the qualified nurse, with supervised opportunities to engage in the multitasking and prioritising that is fundamental to the role. Through opportunities to delegate and time manage what would

be a normal qualified workload, and exposure to the challenges and negotiations that form part of team working, students will have opportunities to develop skills and coping strategies to increase resilience in preparation for qualified practice. Consideration should also be given to the life experiences the students bring to their pre-registration programme and the skills they can use in their nursing role. Through opportunities to reflect on and explore their range of experiences, students will be enabled to consider how expectations may not align with the realities of their experiences, and the support needed to gain greater alignment. If the experiences gained in clinical practice during this time are not reflective of the habitus of qualified practice, and students are not encouraged to reflect on, explore their expectations of and learn from those experiences, the lack of 'reality' experienced could contribute to the lack of preparedness often reported by NQNs, contributing to their reality shock.

As an NQN, on entry to the workplace the professional identity and habitus developed through the pre-registration period may be challenged if it does not align with the realities of the workplace itself. At meso level, within the workplace, habitus develops from the culture and practices in that area, but also from the value and recognition that that clinical area has within the wider organisation. If the doxa of the workplace does not align with the professional habitus of the NQN it can lead to confusion, stress, and job dissatisfaction for the new nurse. Akgün (2019) argued that the secondary professional habitus developed by the NQN through their pre-registration education enables them to act in the manner expected of their profession and unifies them as part of that profession, to allow them to share a common habitus. When this does not align with the habitus of the workplace it may go some way to explain the stress and dissatisfaction frequently documented in relation to reality shock on entry to the qualified profession. As the NQN becomes more familiar with the doxa of their workplace and their knowledge and understanding increases, so too does their power to either reinforce or change the workplace and their personal habitus, as enculturation occurs. However, if the NQN has

not built up the resilience and confidence to remain in the workplace during this period of transition there is a risk of the NQN moving to another area or leaving the profession completely. An issue that is currently contributing to attrition issues for the NHS (Collard, et al, 2020; HEE, 2014; 2018). The concepts of Bourdieu have clear relevance to the current study. Bourdieu's consideration of socialisation and professional identity provide a relevant framework to explore and analyse the findings from the current study; to address the study aims and objectives around practice readiness and professional identity.

3.6 **Research in the Qualitative Paradigm**

Saks and Allsop (2013) suggested that quantitative research is not always appropriate when researching within the social sciences, as often there is a need to understand the participants assumptions and perceptions, rather than objectively measuring attitudes or predicting behaviours. When exploring the perceptions of individuals with an inductive approach to data generation, qualitative research can be more beneficial (Morse and Field, 2002) as a methodology for capturing the voice of participants in an authentic manner. Through this approach rich descriptive data can be generated to allow analysis of individuals' assumptions and perceptions, conveyed through their own words. Whilst findings from quantitative data may allow for generalisation to a wider population, qualitative data provides greater insight into each individual participant (Saks and Allsop, 2013). Creswell (2013) advised that within qualitative research, the researcher forms part of the data collecting process and it is important to acknowledge the effect that the researcher's assumptions and subjectivity can have on the interpretation of the data. Quality and rigor must be demonstrated throughout the research process but indicators of this can vary depending on the methodological approach used. Whilst quantitative research determines rigor through validity, reliability, and generalisation; within qualitative research these indicators are not always seen as relevant or appropriate, due to the

purpose of and approaches used in the research. Whilst Mason (1996) and LeCompte and Goetz (1982) argued that the indicators can be applied to qualitative research in a similar way to quantitative research, Lincoln and Guba (1985) suggested that an alternative approach to validity and reliability can be more beneficial using criteria they refer to as Trustworthiness; discussed in Chapter 4.

Power can be a key influence in research and consideration should be given to the balance of power within the research process. Foucault (1972) suggested that some groups have more power than others allowing them to control the discourse. Habermas (1984) and Eagleton (2007) both argued that an unrealistic powerbase frequently occurs with research undertaken in the positivist paradigm where the researcher controls the knowledge and the power. By comparison, qualitative research can address the power balance, allowing the participants to lead the direction of research, through their rhetoric and their perceptions (Cohen et al, 2011). Through a more equal partnership within the research relationship, there is more opportunity for the participant's voice to be heard. The NMC recognises the significance of this in their requirement for service user and student involvement within the development of the curriculum (NMC, 2018b), but this can be further extended to involve those who are able to evaluate the appropriateness of the curriculum on entry to the workforce, the NQN.

When considering the 'sense' individuals make of their experiences, acknowledgement should be given to the social context and culture within which the experience resides. Creswell (2013) suggested that qualitative research takes a more focused view of the research topic rather than the broader more generalised view taken in quantitative research. Unlike quantitative methodology, qualitative research recognises that 'truth' is influenced by individuals' perceptions and is what the individual perceives it to be. The reality of the individual is constructed to some extent by their perceptions and that

constructed reality then enables them to bring meaning to their experiences and the social context in which they operate. Savin-Baden and Howell Major (2013) argued that researchers need to understand the 'truth' of the individual to gain insight into their perceptions and reality. They suggested that language is a key factor in qualitative research, and the rich data that can be captured can lead to new insights into the interpretations of individual's experiences. Within the current study the aim is to capture the perceptions of the NQNs experiences relating to practice readiness and development of professional identities; to understand their 'truth' and the influences on that truth. Taking a qualitative approach to the research will, therefore, allow me to explore the NQNs' experiences and the realities they have constructed as a result.

3.7 **Chapter Summary**

The epistemological and ontological positioning for the current research came from the interpretivist perspective, with an acceptance that 'truth' can mean different things to different people and that no one absolute truth exists (Lincoln and Guba 1985). To underpin the study's focus on practice readiness and professional identity, theories linking to socialisation and social learning were explored; and ultimately Bourdieu's theories of habitus and capital (Bourdieu, 1992) were chosen as the theoretical underpinning. Bourdieusian concepts link well to the transitions experienced by NQNs on entry to the qualified workforce and Bourdieu's work on nursing habitus (Bourdieu, 2006) links directly with the profession and expectations of the NQNs in this study.

Within Chapter 4 the methodological approach and methods used for the research study are discussed, underpinned by the theoretical and philosophical underpinnings considered

and addressed in this chapter. There is explanation of how using an inductive approach, the research was guided by issues considered important to participants.

CHAPTER FOUR METHODOLOGY AND METHODS

4.1 Introduction

This chapter details the methodological approach that was used for the research study, supported by the theoretical and philosophical underpinnings discussed in Chapter three. It outlines the overarching methodological approach, and the methods used to collect and analyse the data produced, to fulfil the study's aims and objectives, including reference to ethical considerations.

The focus of the study was to explore NQNs' perceptions of their practice readiness and professional identity, on entry to the workplace. The literature review in Chapter two indicated a commonality in data collection methods used and several common themes nationally and internationally, with recommendations for further research in this area.

4.2 Research Methodology

When considering the methodological approach for a research study, attention should always be given to the aim of the research, the research questions which need to be answered and previous work undertaken in this area (Braun and Clarke, 2013). For the current study, a review of the literature revealed that a greater understanding of the period immediately following qualification for NQNs would inform the pre-registration curriculum and developing readiness for qualified practice. At the start of the study, new professional standards had recently been introduced within the UK by the NMC (NMC, 2010) (which were then renewed in 2018 (NMC, 2018; 2018a)). In consideration of the standards introduced at the beginning of the study (NMC, 2010), the sample group was the first

cohort in a specific English HEI to have completed their undergraduate studies, using the new curriculum based on those changed professional standards. For this study, my aims were to explore perceptions of practice readiness and professional identity from a cohort of NQNs, from one English HEI, at the point of, or shortly after initial registration with the Professional Body and entry into the qualified workforce.

With the objectives of answering the following questions:

1. From the NQN perspectives, what themes around practice readiness and developing professional identity emerge from the study?

2. What are the key influencing factors for practice readiness?

3. How can the emerging themes inform future undergraduate pre-registration nursing curriculum and student nurses' readiness for qualified practice?

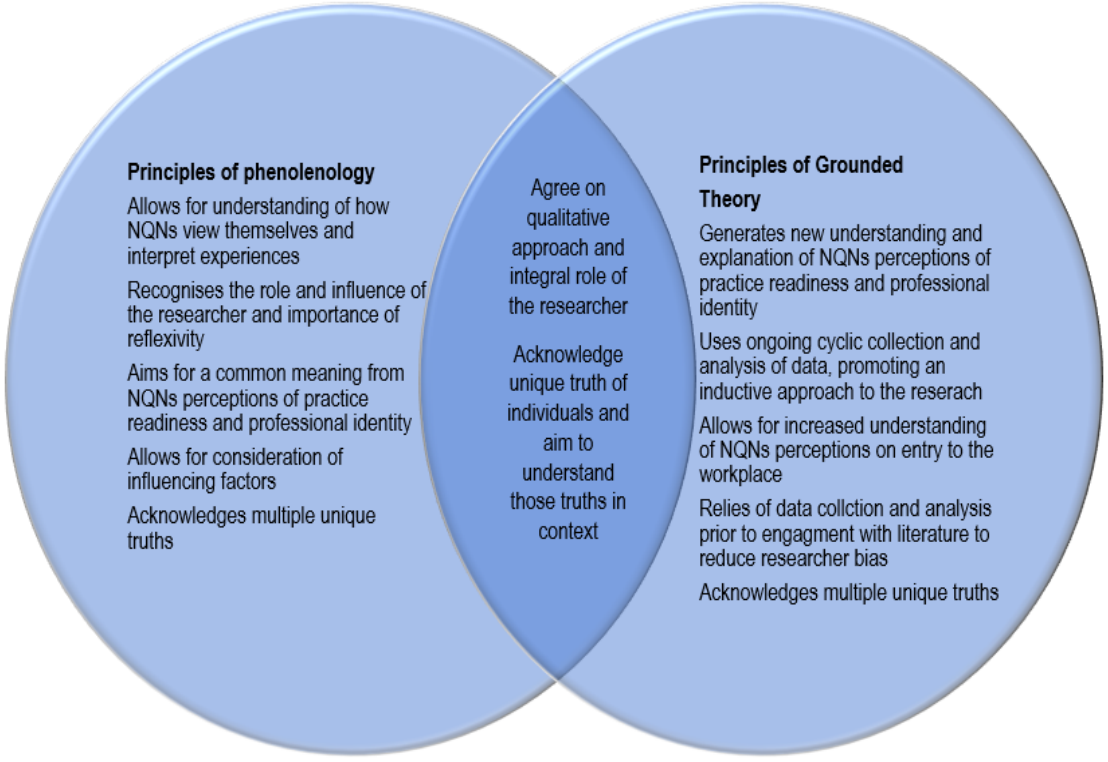
Qualitative research allows participants to describe their experiences, providing insight into their perceptions and assumptions (Saks and Allsop, 2013). This methodological approach enables the collection of detailed textual data and allows for greater recognition and capturing of the participant's voice (Saks and Allsop, 2013). Analysis of that data can then bring new understanding of the way individuals make sense of their experiences and develop new learning from their interpretation of the knowledge they gain. If the participant's voice can be heard when transcripts are reviewed, the perceptions of individuals are more likely to be heard as the participant intended (Bird, 2005). By allowing the voices of participants to lead the direction of the research, an inductive approach can be adopted; allowing the theory or concept to develop as the research progresses, enabling new insights and understandings of the participants' perceptions to emerge (Morse and Field, 2002; Saks and Allsop, 2013). The inductive approach to the research

was fundamental in this study as it enabled the participants to drive the direction of the questions and the conversation.

4.2.1 Influence of Phenomenology and Grounded Theory

As the focus of this study was to explore perceptions of a specific group of people within a given context, I considered that both phenomenology and grounded theory were approaches worthy of consideration (Figure 4.1).

Figure 4.1: Contribution of theory to the research design



Robson and McCartan (2015) suggested that phenomenology focuses on understanding how individuals view themselves. Through this approach greater insight into participants' understanding and interpretation of their experiences can be gained. However, acknowledgement needs to be given to the role and influence of the researcher within the phenomenon under investigation. Because of their connection to the phenomenon, it is important to identify any assumptions or preconceptions the researcher has about that phenomenon (LoBiondo-Wood and Haber, 2017). As such, reflexivity is an important part of the process. Robson and McCartan (2015) advised that the researcher should 'bracket' their assumptions and preconceptions, in acknowledgement of them, to help to prevent the pursuit of issues researchers feel are important to them, rather than those introduced by the participants.

The principles of phenomenology were attractive for the completion of this study; the key intention of phenomenology being to discover the 'essence' of a phenomenon (Polit and Beck, 2012). Creswell (2013) advised that phenomenology aims to provide a common meaning for several individuals' lived experiences of a given phenomenon. That by gathering data from a group of people who have experienced a phenomenon, a description of the essence of that experience for all the individuals, can be gained. It has two main interpretations; descriptive phenomenology, developed by Husserl (1962), and interpretive phenomenology, developed by Heidegger (1962). Descriptive phenomenology focuses on describing the ordinary conscious experiences that individuals have, whereas interpretive focuses on interpreting individuals' experiences rather than just describing them. Exploring a given phenomenon within the qualitative paradigm can help to explain how it developed and provide explanations for that development. Saks and Allsop (2013) argued that research within the qualitative paradigm can help to avoid particularism (the idea that everything is unique) whilst acknowledging that not everything is the same (universalism). Phenomenological approaches allow for consideration of factors that have influenced the chosen phenomenon and how those factors could be connected.

Phenomenology linked well with the ontological and epistemological positioning of this research, and the belief that there are multiple truths based on an individual's experiences. I therefore determined that the basis of phenomenology would be a suitable approach for exploring participants' experiences and would inform the final approach to the study.

As greater understanding of the perceptions of NQNs in the immediate period following qualification and entry to the workforce was identified as an area for further research in the literature, the approach of grounded theory was also considered, as this approach develops theory through the research process. Although grounded theory was originally developed by Glaser and Strauss (1967) there are now several versions including more constructivist approaches from Charmaz (2006) and Corbin and Strauss (2015). Creswell (2013) advised that the intention of grounded theory is to generate a theory which explains the actions of individuals following a common experience. The views of participants are captured, and analysis of those views will identify common categories from which a theory is generated. Within grounded theory the main form of data collection is often through interviewing participants. A constant comparison is undertaken whereby data collection and analysis are cyclic and ongoing (Creswell, 2013; Polit and Beck, 2012). Once data from a participant has been captured it is analysed and compared to the findings from previous data sources. This allows for identification of areas of commonality which may indicate emerging categories. It also allows for the identification of areas for further investigation with future participants.

Creswell (2013) suggested that grounded theory can be a useful approach when little is known about how people experience a specific phenomenon. It can help to explain how people respond to a given experience, to increase understanding of their actions and behaviours. This again sits well with the epistemological and ontological positioning of this research, that truth is constructed from an individual's experiences. Braun and Clarke (2013) recommended that grounded theory is best suited to questions exploring

influencing factors relating to a phenomenon. However, to achieve sufficient data for the emergence of a theory, many participants are usually required (Braun and Clarke, 2013; Creswell, 2013). To achieve this a process of theoretical sampling is used. Within theoretical sampling there is no fixed sample size or sample group, and participants are recruited until data saturation is achieved and a theory emerges (Creswell, 2013). I determined that this approach provided elements desirable for the current study including the cyclic approach to data collection and analysis. However, the focus of this study was with a specific group of people in a defined context, which would not have fulfilled the requirements of theoretical sampling for a full grounded theory approach.

Data analysis in grounded theory relies on analysis and coding of data before engaging with the literature. Cohen et al, 2011) argued that engaging with the literature before the coding of the data may in fact pre-determine what the researcher sees within the data. Whilst I found this approach to coding of the data appealing for the current study and considered non-engagement with the literature before the analysis process, I felt the overall approach to data analysis was too rigid. There was too much focus on generating theory and insufficient opportunity to describe the perceptions of participants. Denzin and Lincoln (2011:364) made the point that with grounded theory:

"Detailing conceptual categories takes precedence over participants' accounts".

As a result of the review of both grounded theory and phenomenology, I decided that an exploratory study incorporating elements of both, but with an initial review of the literature, would be the most effective methodological approach to address the aim of this study. Qualitative exploratory studies allow for an eclectic combination of approaches, in both data collection and data analysis. Polit and Beck (2012) suggested that the descriptive element of a qualitative study can be useful for providing a comprehensive summary of an event. Within the context of the current study, this facilitated a description of the lived

experiences of the NQN as they entered the qualified workforce. Sandelowski (2010) recommended that description within the study can be valuable for producing findings that are closer to the data than phenomenology or grounded theory alone, but that there should still be interpretation of the data. Through this approach clustering of common themes from the participants would enable interpretation of the data to occur.

Braun and Clarke (2013) argued that the impact of the researcher in the research process cannot be completely mitigated against. They suggested that in qualitative research the process is subjective, and the influence of the researcher is inevitable. Rather, they advised that a reflexivity process can help to identify how the research may have been influenced by the researcher and steps that were taken to minimise those factors. By making the researcher visible within the research, it can become a method of quality-control within the study. Polit and Beck (2012:179) suggested that

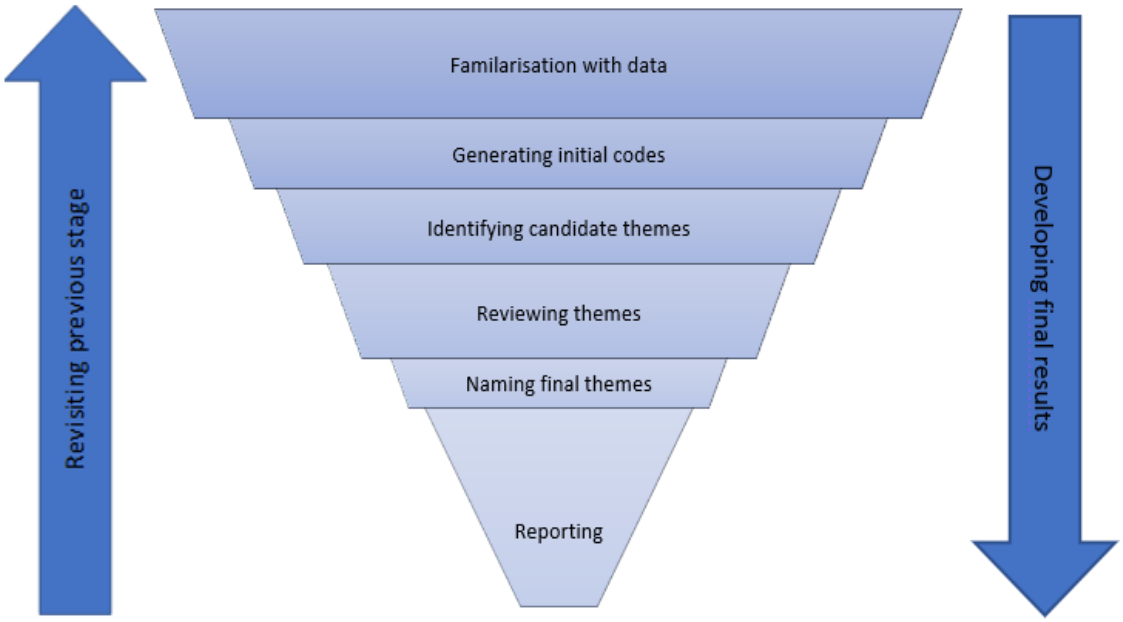
"reflexivity is the process of reflecting critically on the self and of analysing and making note of personal values that could affect data collection and interpretation".

Denzin and Lincoln (2011) proposed that by engaging in the process of reflexivity, the researcher provides a contextual aspect to the research. Through qualitative research, tacit knowledge and information can be gained from participants. In the interpretation of the data collected, the tacit assumptions and biases of the researcher may influence the process. This cannot always be avoided, and recognition should be given to the subjective nature of the process. However, reflexivity can help to identify some of those assumptions and biases and go some way to mitigating against their influence.

4.3 **Research Methods**

To identify key themes emerging from the data, a thematic analysis approach was utilised (Braun and Clarke, 2013). Harding (2019) advised that a criticism of thematic analysis is that by looking for broad areas of similarity and difference, the findings can be quite distant from the individual experiences of participants. However, Gibson and Brown (2009) argued that thematic analysis can link diverse experiences together. Whilst the thematic analysis may not represent the individual views of the participants, through the linking together of the experiences, new interpretations and understanding of the data can emerge. To develop skills in this area, I became familiar with Braun and Clarke's 6-stage approach to data analysis (Figure 4.2), as they suggested that this is a useful method of data analysis for novice researchers, providing a broad framework (Braun and Clarke, 2006). On completion of the data analysis, the data and emerging themes were reviewed by my supervisors for accuracy.

Figure 4.2: Representation of Braun and Clarke's (2006) 6-stage approach to data analysis



4.3.1 THE RESEARCH STUDY

The pre-registration undergraduate nursing curriculum can be influential to the developing professional identity of the NQN (Johnson et al, 2012; Maginnis, 2018). It is therefore important to capture the perceptions of those who have undertaken such a curriculum, to identify if they perceive their readiness and professional identity to be effective for the realities of qualified practice. As well as providing valuable evidence for curriculum evaluation, the voice and agency of the NQN can be influential in the development of future curricula and is an important part of curriculum development. As Flanagan (1999) identified, when voices are heard accurately, involvement of users in curriculum development places the curriculum in the reality of those experiencing it.

I undertook this exploratory qualitative study to describe the perceptions of NQNs' practice readiness and professional identity following successful completion of their three-year pre-registration programme, as they commenced their journey in qualified clinical practice. Following ethical approval (Appendix 4), discussed in greater detail later in the chapter, the target sample size was to include representation from all fields; aiming for data saturation to facilitate achievement of the study's aims and objectives. To ensure that participants had experienced the phenomenon and were central to it, a purposive sample was taken. This then allowed for extensive detail about individuals' experiences and perceptions to be captured. Polit and Beck (2012) suggested that a purposive sample allows for examination of an area of interest with a group which is representative of individuals who have had a specific experience. Although there are several strategies that can be used for purposive sampling, maximum variation sampling ensures that the sample is selected from a diverse range of backgrounds and perspectives. Within the study, all members of the cohort (n=98) were invited to participate via a short discussion with me on the last day of their pre-registration programme. Anyone potentially interested in participating in the study was asked to forward their preferred contact details to me, and

the cohort was reassured that there was no requirement for them to participate if they preferred not to. This gave opportunity for members from all fields of nursing, both genders, and traditional and non-traditional entry students to contribute their voice to the data collection. Although Cohen et al (2011) suggested that this type of sampling is deliberately selective, it enables identification of individuals who fulfil the specific selection criteria required, to capture the relevant information-rich data, and can still allow for the inclusion of a range of people with differing viewpoints (Polit and Beck, 2012).

Whilst generalising the study findings to a wider population was not the intention of the research, the context and the individual experiences and characteristics of participants meant that some conclusions could be drawn that may be applicable to further research studies. However, the key aim was to understand the NQNs' experiences of entering the workforce and contribute the knowledge and understanding gained to the development of future nursing curricula within the HEI.

Using a phenomenological approach, semi-structured questions helped to focus participants whilst allowing them to take the discussion in their preferred direction. The initial literature review was completed at the start of the project, and this was reviewed and updated on completion of the data analysis, to ensure that an inductive approach was used to collect and analyse the data, in line with principles of grounded theory. Through personal reflection on my role as an insider in the research I was able to recognise my personal assumptions and biases, from my experiences as a nurse lecturer and personal tutor to pre-registration students. Therefore, throughout the research process a reflective journal was maintained. Using a reflective journal, enabled me to continually identify and challenge my personal assumptions and preconceptions through the research process journey. However, as Bryman (2012) advised, there was awareness of occasions when my personal values may not have been completely mitigated against and may have unconsciously affected the data. This is where the objective checks during the data

collection and data analysis processes became important, to ensure rigour and quality within the research as detailed later in this chapter. The reflective journal, written after every episode of data collection, before initial analysis of the data occurred, therefore allowed me to record moments of surprise or realisation.

One challenge with the data collection element of the study was the timing of the data collection process. It was important to capture the views of the NQN during their initial few months in their new role as qualified nurses, before socialisation and enculturation influenced their perceptions (Zarshenas, Sharif, Molazem, Khayyer, Zare, 2014). NQNs should be supported by an experienced staff member through a preceptorship period (DH, 2010; HEE, 2018; NMC, 2020) when they first enter qualified practice. Within the main geographical area of the study, this preceptorship period was often identified as the first six months of qualified practice. As it was important to capture the NQNs' views as soon as possible following entry to the workplace, it was determined that data collection must be concluded before the preceptorship period ended.

A second challenge arose when capturing data from participants who had chosen to leave the local area to take up a qualified position. It was just as important to capture the views of NQNs working in areas that were unfamiliar to them, as their under-graduate programme was designed to prepare them for qualified practice anywhere in the country. To facilitate data collection with these participants, arrangements were made to conduct interviews using Skype.

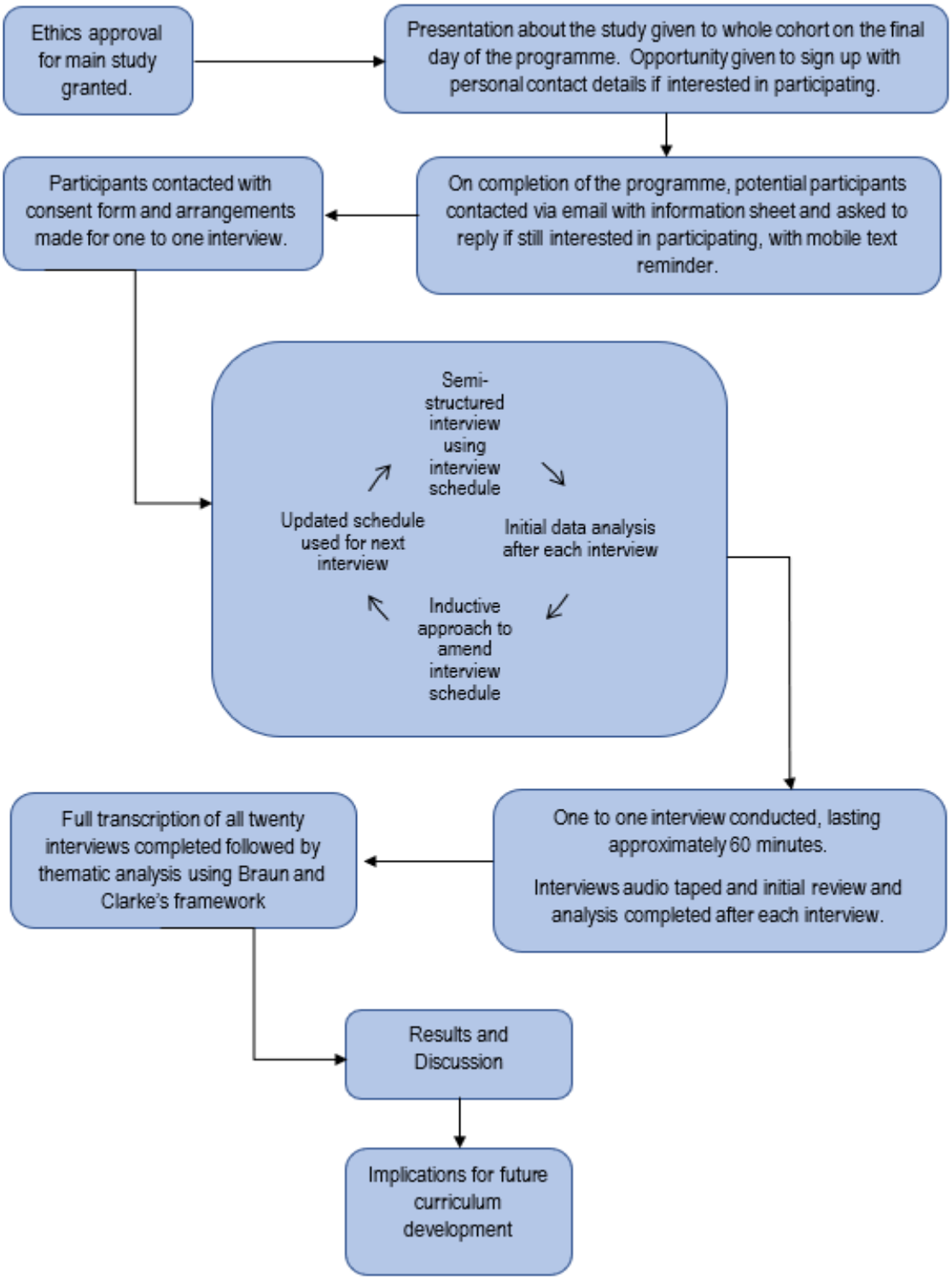
On completion of the pre-registration programme, initial contact was made to all those who had registered an interest (n=39) via their personal email address, with an information sheet (Appendix 5) sent with more information about the study. The NQNs were asked to reply to advise if they were still interested in participating with the study. The method of e-mail contact, chosen as it was felt to be less intrusive than using individuals' mobile

numbers, had limited success (n=6). However, a reminder was sent via text message to all those who had not responded. As a result, the final response rate increased (n=20) with individuals offering apologies and explanations that they did not frequently check their e-mails and were happier to communicate via text message. On reflection, this was a learning experience as an assumption had been made that text messaging would be construed as more intrusive than email correspondence by potential participants. Arrangements to meet were made with each participant and consent forms were sent (Appendix 6 and Appendix 7. Each participant was allocated a code to ensure that their data collection was anonymised, and a tracking spreadsheet of completed interviews was maintained in a password protected file on a secure server.

Following the review of the literature around data collection methods I determined that semi-structured interviews would be an appropriate method of collecting data to fulfil the aims of the research. Semi-structured interviews enable the interview to focus on a specific topic, whilst allowing participants to answer the questions from the perspective that is important to them. This approach also has the flexibility for exploration of issues raised by the participant (Arksey and Knight, 1999). Unlike focus groups where the collective perspective can often be more valuable than the individual perspective of the members (Gibbs, 2012), semi-structured interviews allow for more in-depth exploration of individuals' perceptions. This allows individuals to explore the topics presented from their own perspectives and in doing so allows for 'thick description' to be gained in a confidential safe space. Using open-ended questions participants can choose the vocabulary for their responses and it allows for areas of ambiguity to be explored further and individual responses to be recorded accurately (Barriball and While, 1994). This provided me with opportunities to explore individual perceptions and consideration of influences on those perceptions (Barriball and While, 1994).

Key principles from phenomenology and grounded theory provided direction for the development of an interview schedule (Appendix 9) to encourage participants to discuss their experiences and perceptions. The initial interview schedule was developed based on findings from a pilot study focus group and a review of the literature around transition for novice nurses. An inductive and constant comparison approach (Creswell, 2013; Polit and Beck, 2012) was used in the ongoing development of the interview schedule and the data collection process. As new areas for discussion were identified by participants, the interview schedule was amended to allow for the focus of the interview questions to be led by the participants. This enabled an inductive approach to the interview process, whereby the answers given by individuals often led to additional areas for exploration with future participants. I reviewed and developed the interview schedule following each interview and initial data analysis to ensure that any new areas for exploration or new perceptions could be explored as sub-questions with future participants (Figure 4.3). Regular review of the interview schedule and discussion of any changes occurred during supervisory meetings with my supervisors, to ensure there was clear evidence from participant data informing any changes and challenging any perceptions or assumptions I was bringing to the interview schedule.

Figure 4.3: Study design using inductive semi-structured interview approach



I invited each participant to attend for a confidential individual interview at a mutually convenient date and time. To ensure that participants felt comfortable to talk in the interview, they were asked to choose from a choice of venues; a private room in the School of Nursing and Midwifery, a private room in their place of work, or an alternate quiet area in a public space, such as the local public library. For those participants who were local and able to attend for interview, all chose the School of Nursing and Midwifery. For those whose interviews took place via Skype, the interviews were conducted in their homes. Within the School of Nursing and Midwifery the interviews took place in a private soundproof room away from the main teaching areas to provide as neutral an environment as possible.

At the beginning of each interview the consent forms were revisited (Appendix 6 and Appendix 7) and participants were made aware that they could end the interview at any time and could choose not to answer any questions they were not happy to answer. As there was a possibility that participants may disclose bad practice or a safeguarding concern during the interview, this was an issue that had to be considered. As a registered nurse I had a requirement to uphold a duty of care (NMC, 2018c). However, this could have presented a conflict with my researcher role from a confidential perspective. To mitigate against this at the beginning of each interview the participant was reminded of my professional obligations under The Code of Practice (NMC, 2018c). Available counselling and support services were also highlighted to participants in case they found anything they chose to disclose distressing.

Each interview was digitally recorded with written consent to ensure that responses were captured accurately. Participants were also asked if they agreed to their direct quotes being used within the final thesis, with all but one participant agreeing. Interviews were scheduled to last for up to 60 minutes, but some interviews continued for 90 minutes at the request of the participants who were keen to continue talking about their experiences.

As the interviews were conducted on a one-to-one basis, the individual voices of all participants were captured and the different nursing contexts where participants worked were explored. Prior to this study I had had very little interaction with participants during their three-year programme. Nevertheless, having been heavily involved in the development of the pre-registration curriculum, I was mindful of my insider role and my knowledge of learning opportunities participants had received and the programme assessment strategy. Maintaining a reflective approach to my engagement in the research process was therefore an important aspect of the study.

Reflexivity and the reflective journal (Polit and Beck 2012) enabled me to compare participants' learning opportunities and experiences compared to my more traditional training as a student nurse twenty-five years previously. I identified that I had personal assumptions that participants would be more knowledgeable about evidence-based practice, more confident to challenge poor practice and that they would feel better prepared for qualified practice, because of the learning opportunities that had been available to them. As these had been key areas of focus in the development of the curriculum, I expected that participants would identify relevant experiences and discuss how those experiences had been beneficial in assisting their development of professional identity and practice readiness. Reflection helped me to recognise and acknowledge these assumptions and biases (Polit and Beck 2012), based on my personal history, experience and position within the research. This enabled me to mitigate against researcher influence over the data collection to some extent (Braun and Clarke, 2013), by ensuring that leading questions were not asked.

An effort was also made to avoid encouraging participants to focus on areas within their responses which were significant to me as a nurse and researcher, but not necessarily significant to them. This enabled participants to focus on areas that had not been predicted to arise. Researchers need to be aware of the influence of their position within the social

arena and the phenomenon being explored (Coghlan and Brannick, 2005). Through reflection, their assumptions, values, and biases can be highlighted and the influence of those factors on the research can be challenged and acknowledged. For me this information proved valuable in helping to identify any assumptions that had not immediately been apparent when commencing the data collection process. It also reinforced to me that although I was not well known to the participants, my role as a lecturer within the HEI had the potential to influence participants, something I was keen to avoid.

As the data collection process continued, an inductive approach was used to develop and refine the interview schedule based on new areas of interest introduced by participants. Through the on-going development of the interview schedule an organic approach to the data collection evolved and there was clear evidence of how the participants were guiding the direction of the research. Whilst it is acknowledged that the interview schedule used with the final participants had some sub-questions not included in earlier interviews, this was evidence of the inductive process and the individual experiences of the participants. This became particularly evident when reflecting on each stage of the data collection and considering any assumptions or biases that may have inadvertently occurred during the process. A greater awareness of my researcher role and my potential influence as an insider within the research became apparent through this process and through reflexive practice following each interview (Coghlan and Brannick, 2005). This inductive constant comparison approach is often used in this type of research and allows for the inclusion of new perspectives as they emerge in the process (Creswell, 2013; Polit and Beck, 2012). Whilst I acknowledged that there were areas within some questions that had not emerged or been explored with early participants, the rich data that the inductive approach generated allowed for data saturation (Polit and Beck, 2012) to occur and allowed participants to drive the research process.

The interview schedule developed and changed over the course of the four months of data collection, with more focused questions being added (Appendix 9 and Appendix 10). On reviewing the data from previous participants, field notes, my reflective diary, and discussions with my supervisors, I was reassured that the more focused questions were an inductive result of the data collection process, rather than from my personal assumptions and biases. I developed an increasing awareness of several areas identified as important by the NQN, which I would not have previously considered. As the study continued it became clear from the developing interview schedule that there were common areas of perception and concern between the participants. Once there were no further developments to the interview schedule and responses did not generate any new information, I determined that data saturation had been reached. Braun and Clarke (2013) suggested that saturation can be a good indicator that the correct sample size has been used to ensure there is no additional data to be collected. There is no fixed sample size that is appropriate for qualitative data collection, instead this is dependent on the focus and sensitivity of the phenomenon under investigation. Polit and Beck (2012) advised that when there is a specific focus to the phenomenon and a purposive sample is used, there is usually a smaller sample required to reach saturation. In this study saturation appeared to occur with participant 18. However, as interviews had already been scheduled with participants 19 and 20, these interviews were included in the study and acted to confirm that data saturation had indeed been achieved.

4.3.1.1 Data analysis process

Data analysis allows for interpretation and understanding of the data collected (Creswell, 2013; Polit and Beck, 2012). Through analysis, reflection on the original aims of the research can help to determine how successful the study has been in answering the question posed (Holloway and Wheeler, 2010). For this study, data analysis was

completed using a form of coding, but this was done through thematic analysis to ensure that the voice of the participants was the focus of the analysis and the themes emerging.

Initial data analysis occurred following each semi-structured interview. By reviewing the audio file and the reflective field notes against the study aims and objectives, data gathered from each interview informed development of the schedule for subsequent interviews. This allowed me to check to ensure that the interviews were continuing to address the research aims of capturing participants' perceptions of their experiences on entry to the qualified workplace. It also allowed for early provisional identification of significant content and potential themes that had occurred unexpectedly (Corbin and Strauss, 2015). As a result, unforeseen issues considered important to the respondents were captured and assisted in establishing when data saturation had occurred. Final complete and thorough data analysis and coding did not occur until all the data had been captured, allowing for participants' voices to be heard with more clarity rather than through labels I imposed on the data (Mason, 2002, Creswell, 2013).

To ensure that the voices of participants were accurately heard, thematic analysis was used to look for similarities and differences within and across data sets (Spradley, 1979). Savin-Baden and Howell Major (2013) suggested that thematic analysis, although a potentially complex process, can be more insightful than other types of analysis as it takes a more intuitive form. Braun and Clarke (2013) suggested that thematic analysis is a recognised and accepted approach to data analysis, which, unlike other qualitative analytical approaches, focuses solely on analysis of the data and is not prescriptive about the data collection process or the epistemological framework underpinning the research. This according to Braun and Clarke (2013) is one of thematic analysis' key strengths, as it is flexible in its use and can develop a detailed description of the phenomenon under investigation. However, they cautioned that it has limited power for interpretation unless it is used within a theoretical framework. It was important therefore for me to constantly

reflect on my epistemological and ontological assumptions during analysis of the data. Once all data had been captured, the detailed process of data analysis began, using the Braun and Clarke (2006) 6-stage framework (Figure 4.2).

Stage one - Familiarisation with the data

The initial stage of familiarisation with the data was completed through transcription. This was a long process that far exceeded the anticipated timeframe. I undertook manual transcription for half of the interviews including the first and last 5, but the remaining half were sent to a confidential transcription service due to time pressures. However, those that had been sent to the transcription service were then checked for accuracy and closely scrutinised, to ensure that there was familiarity with all aspects of the interviews. Whilst this was a long process, it was important to ensure that the transcriptions were an accurate account of participants' thoughts and perceptions (Bird, 2005). By accurately transcribing the interviews, to include any slang words or pauses, awareness of my personal assumptions was heightened, and this ensured that the participants' voices were heard (Appendix 11).

Whilst reviewing the audio files for all the interviews, reflection of my position within each interview occurred, to enable recognition of any points of impact on the research to be noted. Kearns and Ardle (2012) suggested that reflexivity is vital for the researcher, so that they are aware of the impact their own experiences can have on their interpretation of the data. To ensure that transcriptions were an accurate representation of participants' views, seven participants volunteered to check their transcripts and confirm that their experiences and perceptions were accurately portrayed in the transcription. This is referred to as member checking (Polit and Beck, 2012) and is a useful way of validating the credibility of the data collected. Through the review of the transcripts, I gained a deeper

familiarity with the data, with greater immersion in the data set as a whole. This was important, to ensure that the process had addressed the research questions and produced relevant data.

Despite a detailed exploration of ways to transcribe data, awareness of the most effective way to do this did not occur until sometime after the transcription process was completed. Although discovery of an efficient process was serendipitous, learning from this was a useful skill for future transcription and led to an awareness that sometimes answers come from the least expected place. This awareness was a significant learning point that was returned to frequently during the data analysis process.

Stage two - Generation of initial codes

Harding (2019) suggested that coding is a process that allows for meanings within data to be captured while reducing the volume of content; whereas Saldaña (2016) advised that coding is the process of identifying a word or phrase within the data that can be translated into a meaning. However, Saldaña (2016) suggested that because of our personal assumptions and preconceptions, coding is a subjective process. This subjectivity can influence the way we view the data, alongside our ontological, epistemological, and methodological approaches (Creswell, 2013). Within the study, to ensure that the analysis was driven by the data, a process of complete coding (Braun and Clarke, 2013) was conducted, whereby all data relevant to the study question was coded. This ensured that I did not actively look within the data for only specific information. The desired approach was to use data-derived (semantic) codes to help to develop the analysis process through the explicit content of the data (Braun and Clarke, 2013). However, early reflection on the coding process suggested that my process was in fact researcher-driven (latent coding), based on personal assumptions from my work on curriculum development, particularly in

relation to clinical skills. This awareness enabled me to return to the data set with a greater focus on allowing the data to define the codes.

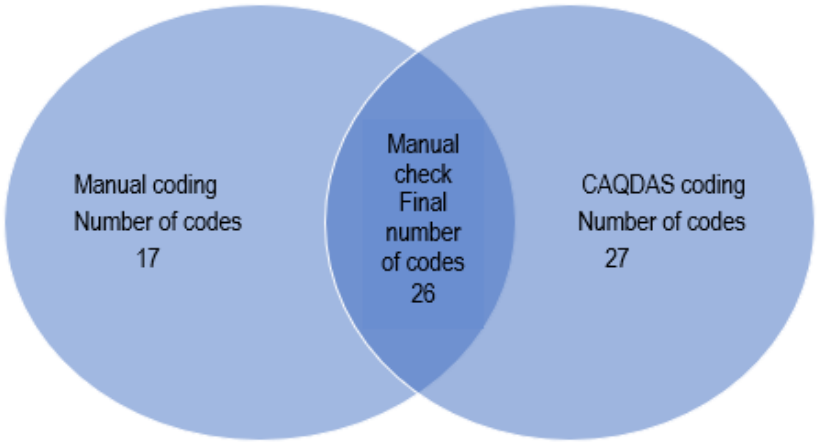
Saldaña (2016) recommended that data analysis is a cyclic process whereby data can be filtered, and salient points identified. From this cyclic process, analysis of the data can develop, and patterns or concepts (themes) can emerge. Braun and Clarke (2013) suggested that as the researcher progresses through the data set a situation of data drift can occur. They purported that as an increasing amount of data is reviewed, new codes may appear within the data that were overlooked in the earlier part of the data set. For this reason, they recommended that all data should be coded twice to ensure a robust process and consistency across the data set. Within this study the first round of coding was performed manually using different coloured and patterned post-it notes to identify codes within each transcript. Initially there were 13 codes identified across the data set, however when areas originally coded as 'miscellaneous' were then refined, the total number of manual codes was 17. Although this was a time-consuming process it provided greater familiarity and immersion across the whole data set. However, I was concerned that additional codes may have been missed and that manually reviewing and interpreting the codes could be an unmanageable process. I decided therefore to use Computer Assisted Qualitative Data Analysis Software (CAQDAS) to assist with the coding of the data set.

NVivo 11 software was uploaded with each of the transcripts and the coding process was completed for a second time. The electronic coding of the transcripts used the original manual codes as a basis for the process. However, the use of CAQDAS enabled a more rigorous coding of the data to occur as a clear coding process could be facilitated within the data. Demographic information was coded as part of the electronic coding process and the manual codes were reviewed and again refined. At the end of the first round of electronic coding, 20 codes had been identified, including the demographics. The

demographic data was then extracted for use later in the analysis process. A final electronic review of the transcripts was completed to refine the codes, to accurately reflect the data extracted. At the end of the process there were 27 distinct codes (not related to the demographics) and all transcripts had been coded to the 27 codes.

CAQDAS can be useful in managing large volumes of textual data and can enable researchers to view all parts of the data set easily (Blismas and Dainty, 2003). It enables codes applied to the data to be retrieved quickly and efficiently later, to ensure that no coding is overlooked (Bazeley, 2007). However, Bazeley (2007) also argued that the efficient way that CAQDAS manages coding of the data, can lead to researchers taking a more quantitative approach to the findings if they are not careful. Bryman (2012) cautioned that CAQDAS allows for easy separation of data which can lead to fragmentation and a change of focus from its original context. Blismas and Dainty (2003) advised that whilst CAQDAS can impact on the management of qualitative data, it is no substitute for the judgement of the researcher. This point was supported by Gibson and Brown (2009) who purported that whilst CAQDAS may help to manage the data, analysis of the data must still be done by the researcher. During the reflective process in the coding stage, I was mindful that at times my coding approach appeared to become more quantitative. When CAQDAS identified coded areas within the data set it was not always easy to check the context of the data being identified. To counter this, once the CAQDAS coding was complete, a further manual review of all the codes across the whole data set occurred, to refocus on voice and context of the participants and the research questions and 26 codes were finalised (Figure 4.4).

Figure 4.4: Integration of manual and CAQDAS coding processes.



Stage three - Identification of initial potential (candidate) themes

Stage three of the Braun and Clarke (2006) 6-stage analysis process is the reviewing of codes to sort into potential or candidate themes. Once the coding process is complete, different codes can be brought together when they relate to a particular issue. By reviewing each cluster of codes, a candidate theme can be identified. Clarke and Braun (2015) advised caution at this stage as the candidate themes may change or be rejected as the thematic analysis progresses. The use of CAQDAS had been valuable during the coding of the data to ensure a robust coding process was completed. However, once all the codes had been confirmed, manual review and analysis of those codes was completed to identify the candidate themes. Clarke and Braun (2015) argued that CAQDAS can be useful for thematic analysis during the early coding phases of the process, but it is less helpful during the later stages of the thematic analysis. CAQDAS had proved useful during the early analysis of this study; however, greater analysis of the data and more contextual

consideration of the clustering of codes was achieved through manual application of this stage of the process. By returning to the original transcripts during the clustering of codes, a check was made to ensure that the developing candidate themes reflected the data and the voices of the participants. Clarke and Braun (2015) emphasised the importance of returning to the data set once the candidate themes have been developed. They advised that by reviewing each candidate theme against the relevant identified codes in the data, a check can be made to ensure that the candidate theme accurately represents the data, and the analysis is relevant and meaningful. During this process, some codes were moved between different candidate themes as associations and links between different codes started to emerge.

Stage 4 - Reviewing themes

Braun and Clarke (2006) referred to this stage of the analysis process as the quality control stage. At this point it is important to review the candidate themes and the codes that make up those themes. By revisiting the themes within the context of the full data set, a check can be made to ensure that the themes are an accurate representation of the participants' voices (Braun and Clarke, 2006).

As the process developed each theme and its associated codes were reviewed; some theme names were amended to reflect the codes and their context more accurately within the data set and two similar themes were merged. At the end of this stage there were 6 themes and a number of sub-themes as illustrated in Chapter 5.

Stage 5 - Defining and naming final themes

At this stage it is important to have a clear understanding of the scope and boundaries of each theme. The focus of the theme and its relationship to the research question should be clear (Braun and Clarke, 2006).

I undertook a final review of all codes and themes within the context of each transcript. Following discussion with my supervisors, final adjustments were made to the codes within each theme, and the names of the themes. Ultimately a thematic map was developed to illustrate the links between four themes and the research focus as illustrated in Chapter 5.

My supervisory team then checked the data analysis process and reviewed the final codes and themes against a random sample of two transcripts as a quality check for trustworthiness.

Stage 6 - *Reporting on the findings*

The final stage of the Braun and Clarke (2006) 6-stage approach is to report on the themes that emerged from the data with extracts from the data set to "tell the 'story' of each theme" (Braun and Clarke, 2006: 249). However, Braun and Clarke (2006) acknowledged that the story told will be individual to the researcher. The findings (results) of this study are reported in Chapter five.

Ensuring rigour and accuracy of findings within research is a key element of the process. Braun and Clarke (2013) advised that reflexivity within thematic analysis is important for addressing potential issues of reliability. As previously identified in Chapter 3, Lincoln and

Guba (1985) recommended that trustworthiness indicators can be appropriate to use in qualitative research. These indicators can be more relevant than the validity, reliability and generalisation indicators commonly used in quantitative research. Trustworthiness reflects the rigour and quality demands required in quantitative research, but through the four criteria of credibility, transferability, dependability, and confirmability (Lincoln and Guba, 1985). Lincoln and Guba (1985) argued that the absolute 'truths' sought within quantitative research do not transfer well to qualitative research where truth is the interpretation of the individual. Instead, trustworthiness uses participant validation to bring credibility to the findings to ensure that the researcher has understood the data, as perceived by the participants. Although generalisation of findings is not always possible due to the small sample sizes often used in qualitative research, the depth of rich text data collected can aid in the consideration of transferring the findings to other contexts, a process known as transferability (Lincoln and Guba, 1985; Polit and Beck, 2012). Peer review of all elements of the research process can evaluate if the research and the findings are dependable and can confirm if the researcher's subjectivity has been reduced as much as possible. The ongoing use of reflection throughout the research process can aid the researcher in challenging their subjectivity and can bring an honesty to the research by demonstrating the researcher's values and potential influence over the research.

Within this study, member checking of the transcripts by participants ensured that the data collected was accurate and represented the perceptions of the participants, to bring credibility to the findings. A sample of the data collected, transcribed, and analysed was reviewed and confirmed by the doctoral supervisors to ensure that the research and findings were dependable. This checking of the research process combined with the reflective journal and reflective supervision meetings allowed for challenges to my subjectivity and values, reducing my influence over the research.

4.4 **Ethical Considerations**

A key part of the research process is due consideration of ethics. When undertaking research, it is imperative that all those involved in the research are fully informed and protected. Independent scrutiny from an ethics committee can ensure that the research focus is both sound and appropriate, and that the research is conducted in an appropriate manner. Research may leave participants feeling vulnerable or under duress to comply with the study, if they are not fully informed of what the study will involve and their right to withdraw without penalty (Burns, 2002).

As the data gathered during the research process may be sensitive in nature it is vital that it is handled in a confidential manner and only used for the purpose that it is intended for. To facilitate full understanding of the research focus, approach and data handling and reporting, detailed written information must be given to anyone who expresses an interest in participating in the study. Potential participants should then have an opportunity to review that information and ask any questions to ensure that they are fully informed prior to joining the research study. Informed consent should be established and documented with clear indication that the participant can change their mind or withdraw from the study at any time. For this study participants who expressed an interest were supplied with an information sheet and consent forms (Appendix 5, Appendix 6, Appendix 7). When consent forms were returned and when data collection commenced, all participants were reminded that they could withdraw from the process at any time, including once the collection period had finished.

Consideration was also given to the service-users that the study participants were working with. As registered professionals, attention needed to be given to the principles of nonmaleficence. This ensured that no service-users would be harmed by the research

being undertaken; participants were made aware that any disclosure of bad practice would need to be referred for further investigation.

Ethical approval for the study was gained from the University Ethics Committee (Appendix 4) and in line with National Research Ethics Service guidelines at that time, permission to access staff was not required from the employer (National Research Ethics Service, 2012). In recognition that participants may have chosen to disclose sensitive or personal data (Renzetti and Lee, 1993), support mechanisms from confidential counselling services were made available to all participants without compromising themselves or their role within their workplace.

Anonymity and confidentiality were guaranteed to participants and assurances were given that in line with The Declaration of Helsinki (World Medical Association Declaration of Helsinki, 2008) personal data would not be identifiable. To ensure that this occurred, data codes known only to myself were given to identify each individual. These were only made available to the doctoral supervisors if required during the review and clarification of data transcription and analysis.

All hard copy data was stored in a locked cabinet, within a locked room, within the university, and all electronic data was password protected and stored on a secure server. Access to the data was restricted to me and my supervisors, and all participants were made aware of this.

Consideration was also given to the potential danger of power inequality between myself (as the researcher and a lecturer) and the participant. Wengraf (2001) advised that this is a key issue which may lead to participants feeling vulnerable. I was not a personal tutor to any potential participants and had had little contact with them prior to the introduction of the research study. Nevertheless, I was a member of the academic nursing team and

could have been viewed as having greater power. Acknowledgement was given that I was an insider within the research and could have been viewed as influential to the participants' future career development and learning. To mitigate against this, participants were not contacted about the study until all academic and practice assessments had been completed. Through this, reassurance was given to potential participants, that should they choose not to engage with the research, their progress would not be compromised in any way.

During the final week of the cohort's undergraduate nursing programme, posters were displayed around the School of Nursing and Midwifery to advertise the research study. On the final day of the programme, I held an informal presentation and discussion with the cohort to explain the purpose of the study, and to give potential participants an opportunity to offer contact details for further information. At this point in their studies, the cohort had completed their assessments and most of them had secured employment as qualified nurses. Nevertheless, they were reassured that expression of interest was optional and there would be no consequences for anyone who did not wish to participate. This aimed to reduce any conflict that may have occurred between my roles of lecturer and researcher, and to reduce any potential perceptions of coercion. Butler (2003) identified that ethical problems can occur in these situations because potential participants may feel pressured into participating due to concern about their future career or study opportunities. Interested parties provided a personal email address and phone number that they were happy to be contacted on for further information about the study. This information was then securely stored in a locked cabinet within a locked room and was available only to me.

4.5 **Chapter Summary**

The purpose of this study was to explore perceptions of practice readiness and professional identity of newly qualified nurses on entry to the qualified workplace. To capture data that accurately reflected their views and assumptions, it was important to use a methodological approach that allowed for recognition of participants' voices (Saks and Allsop, 2013). Qualitative research has been recognised as a valuable method to gather rich descriptive textual data and is widely used in social science and nursing research (Saks and Allsop, 2013). Both phenomenology and grounded theory approaches to qualitative research can provide frameworks to gather and explore data which details participants' experiences, but these can be prescriptive in nature (Braun and Clarke, 2013). Individually these approaches were not suitable for this research study, but both had elements of value; when the basic premise of each approach was used together, they provided a structure which met the needs of the study

Following ethical approval, a purposive sample of twenty newly qualified nurses from an English HEI were interviewed using semi-structured interviews. An inductive approach (Morse and Field, 2002) was taken, and using Braun and Clarke's six-stage data analysis framework (Braun and Clarke, 2006) participants led the direction of the research. Through both manual and CAQDAS data analysis and coding, themes emerged from the data, as the analysis progressed. A key issue within the research process was my role as an insider and the potential influence and bias that I could bring to the study (Denzin and Lincoln, 2011). As a member of the teaching faculty within the organisation where the research took place, I acknowledged that I would bring an influence to the research. To mitigate against the effects of this influence, a reflective journal was kept throughout the

whole research process. In addition, the elements of trustworthiness (Lincoln and Guba, 1985) were applied to provide evidence of rigour, reliability and validity within the research process and the findings.

The next chapter discusses the finding from the study, and the themes and sub-themes that emerged are identified.

CHAPTER FIVE RESULTS – DATA ANALYSIS

5.1 Introduction

This chapter details the findings from the study data and how the final four themes emerging from the data were identified.

The epistemological positioning for this study came from the interpretivist perspective, that individual social reality is created from a person's experiences and social contexts (Cohen et al, 2011; Creswell, 2014). The ontological positioning was that reality is dependent on the way the individual comes to know that reality, and there can be multiple realities (Coyle, 2015). The qualitative approach to the research explored the experiences and perspectives of the participants; therefore, analysis of the data was undertaken from these perspectives, using a thematic approach. Thematic analysis was chosen as it is a flexible approach that can be used within most epistemological and ontological frameworks (Clarke and Braun, 2015). This type of analysis is the process of interpreting patterns within data through researcher analysis (Clarke and Braun, 2015). Gibson and Brown (2009) suggested that thematic analysis can examine commonalities, differences and the relationships between the different issues and themes. Braun and Clarke (2015) cautioned that although thematic analysis can be used with an inductive approach, the approach cannot be completely inductive. They advised that the researcher's ontological and epistemological standpoints will guide their approach to the analysis. The importance of my influence and assumptions about the data analysis process was recognised and reflexivity was maintained throughout, to reduce my influence over the data results. However, it is acknowledged that the analysis will be individual to me because of my unique standpoint and unique skills used to engage with the data (Braun and Clarke, 2015).

The aims of this study were to explore newly qualified nurses' perceptions of their professional identity and readiness for qualified practice. The objectives were to address the questions:

1. From the NQN perspectives, what themes around practice readiness and developing professional identity emerge from the study?

2. What are the key influencing factors for practice readiness?

3. How can the emerging themes inform future undergraduate pre-registration nursing curriculum and student nurses' readiness for qualified practice?

5.2 **Data Analysis of the Study**

To maintain confidentiality and anonymity the 20 NQNs who participated in the study were given a pseudonym (Saks and Allsop, 2013). The thematic analysis approach used is detailed in Chapter 4.

5.2.1 Demographics of the Study Participants

To consider the data through the lens of Bourdieusian concepts, the demographic data of the participants gathered included age, entry routes into nursing, previous care experience, family members who had attended university and fields of nursing. No participant reported a disability or specific learning need. A summary of their demographics is presented in Table 5.1 with further demographic details provided in

Appendix 8. Although a large proportion of the group were from the local area, there were four NQNs who had moved away from their UK homes to commence their studies at the HEI.

Table 5.1 Participant demographics for the study

PARTICIPANT	GENDER	GENERATION X OR Y	ENTRY QUALIFICATIONS	PREVIOUS CARE EXPERIENCE	FIRST IN FAMILY TO GAIN A DEGREE	DEGREE CLASSIFICATION	FIELD OF NURSING	FIRST NON POST LOCAL OR NATIONAL
Andrea	Female	Generation Y	Traditional	Over 5 years' experience as a healthcare support worker	No	1st	Learning Disability	Local
Becky	Female	Generation Y	Traditional	18 months volunteering at local hospital	Yes	3rd	Adult	Local
Carla	Female	Generation X	Non-Traditional	Two years' experience as a healthcare support worker	No	2:2	Adult	Local
Donna	Female	Generation X	Non-Traditional	Over 20 years' experience as a care worker	Yes	2:1	Adult	Local
Elsie	Female	Generation X	Non-Traditional	No previous care experience	Yes	2:2	Adult	Local
Flynn	Male	Generation X	Non-Traditional	5 years' experience as a healthcare support worker	Yes	2:1	Adult	Local
Gaynor	Female	Generation Y	Non-Traditional	One month's experience as a healthcare support worker	Yes	2:1	Adult	Local
Helen	Female	Generation Y	Traditional	3 months hospital volunteering	No	2:1	Child	National
Isabella	Female	Generation Y	Traditional	3 months volunteering in a nursing home	Yes	2:2	Adult	Local
Julie	Female	Generation Y	Non-Traditional	Over 3 years' experience in health and social care	No	1st	Adult	Local
Kylie	Female	Generation Y	Non-Traditional	Over 4 years' experience as a healthcare support worker	Yes	3rd	Adult	Local
Linda	Female	Generation X	Non-Traditional	4 years' experience as a healthcare support worker	Yes	2:1	Adult	Local
Michael	Male	Generation X	Non-Traditional	4 years' experience as a healthcare support worker	Yes	1st	Mental Health	Local
Nora	Female	Generation X	Non-Traditional	18 years' experience as a healthcare support worker	Yes	3rd	Adult	Local
Olivia	Female	Generation Y	Traditional	18 months volunteering in a nursing home	Yes	2:1	Adult	Local
Peter	Male	Generation Y	Traditional	Two years with the Saint John Ambulance	No	2:2	Adult	National
Rachel	Female	Generation Y	Non-Traditional	Over 3 years' experience as a healthcare support worker	Yes	2:2	Adult	Local
Susan	Female	Generation Y	Traditional	No previous care experience	Yes	2:2	Adult	Local
Tracey	Female	Generation Y	Non-Traditional	No previous care experience	No	2:1	Adult	Local
Vivian	Female	Generation X	Non-Traditional	14 years care experience	Yes	1st	Adult	Local

Entry routes were determined as traditional (on completion of A-levels or BTEC) or non-traditional (on completion of NVQs or Return to Study). A number of the participants were the first in their family to go to university and gain a degree, and this was not something that had been expected of them. For most of these participants, completion of non-traditional qualifications to gain entry to university was perceived to be the start of their nursing journey. Participants were identified as either Generation X or Generation Y using the age ranges identified by Jones et al, (2017) and McCrindle and Pleffer (2008) (see glossary). From the demographics of the participant sample, 40% (n=8) of the participants could be categorised as Generation X, and 60% (n=12) of participants as Generation Y. 85% (n=17) of participants were female and of those females 88% (n=15) were from the field of adult nursing; however, this was indicative of the cohort overall. Within the sample 85% (n=17) of participants had previous experience of working in a care environment, prior to commencing their pre-registration nursing programme; this experience had been a factor in their decision to enter nursing and they had some awareness of the expectations and challenges of working in a caring profession.

The field of nursing and gender demographics of the participant sample broadly reflected the current makeup of the NMC register (NMC, 2021a). The sample had a 15% male representation (n=3), compared to 10.8% on the professional register (NMC, 2021a). Demographics by field were similar to the professional register (Table 5.2), although the small number of non-adult field students was a limitation within the overall data sample as there was only one participant from each of the three other fields of nursing. There was a higher representation of adult and learning disability nurses in the study, compared to the professional register, and a lower representation of mental health and child nurses in comparison to the professional register.

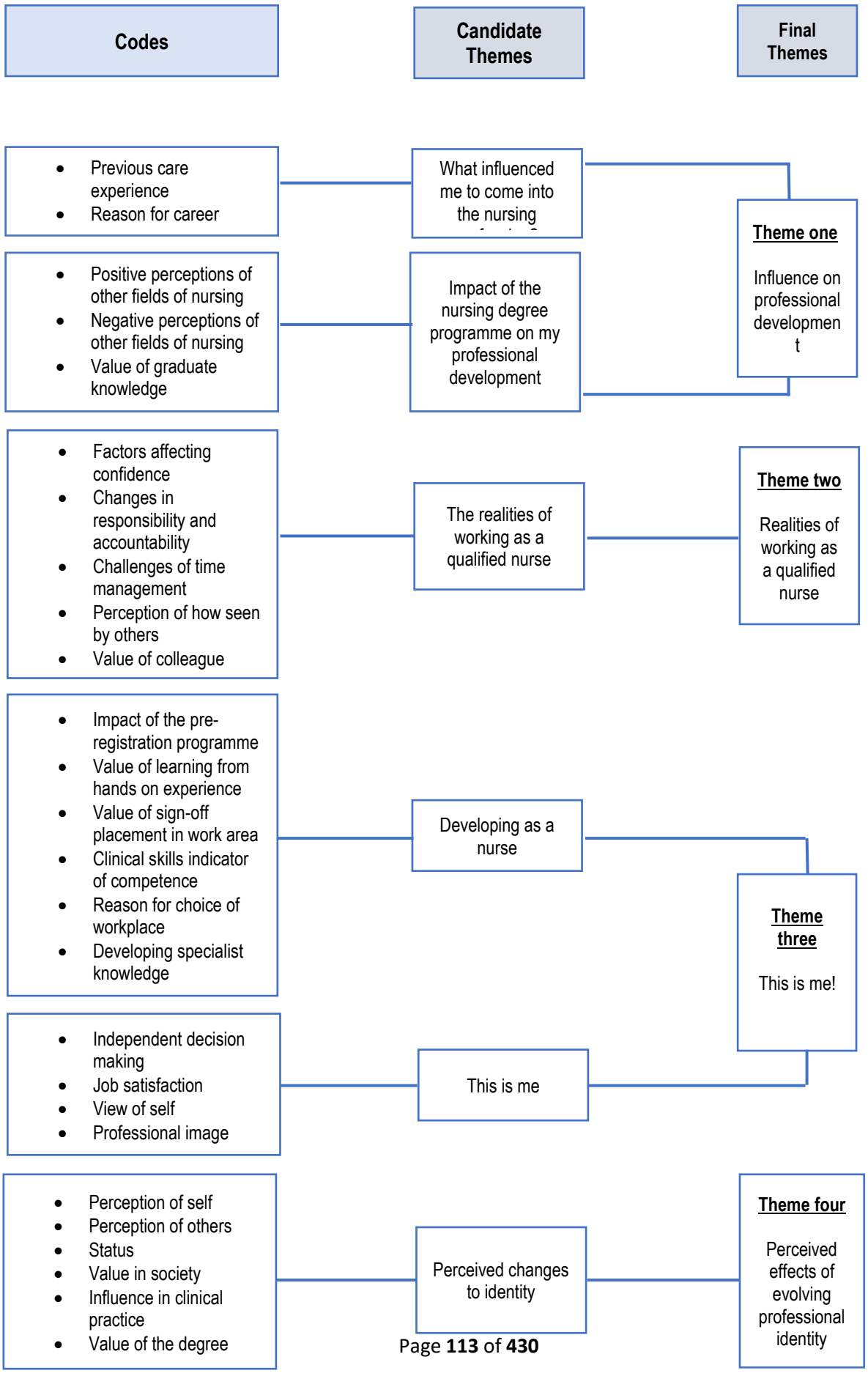
Table 5.2 Demographics by field compared to the professional register

Field of nursing	Demographics of NMC register (2021)	Demographics of sample group
Adult	71%	85%
Child	7.4%	5%
Learning Disability	2.5%	5%
Mental Health	13%	5%

5.2.2 Data Analysis Process of the Study

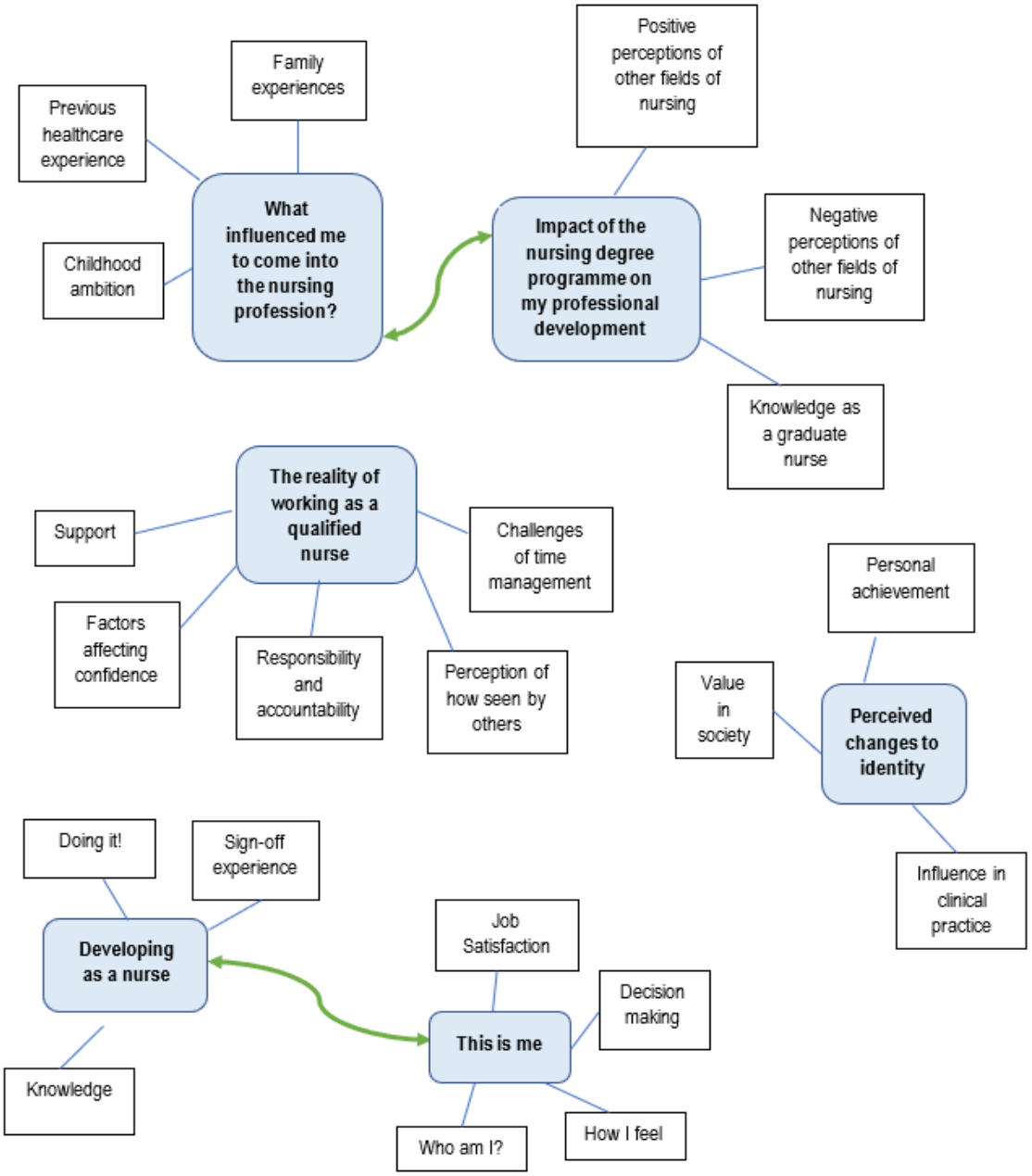
As detailed in Chapter 4, using Braun and Clarke's (2006) 6-stage approach, analysis was completed through coding and development of candidate and then final themes (Figure 5.1).

Figure 5.1: Process of development to final themes.



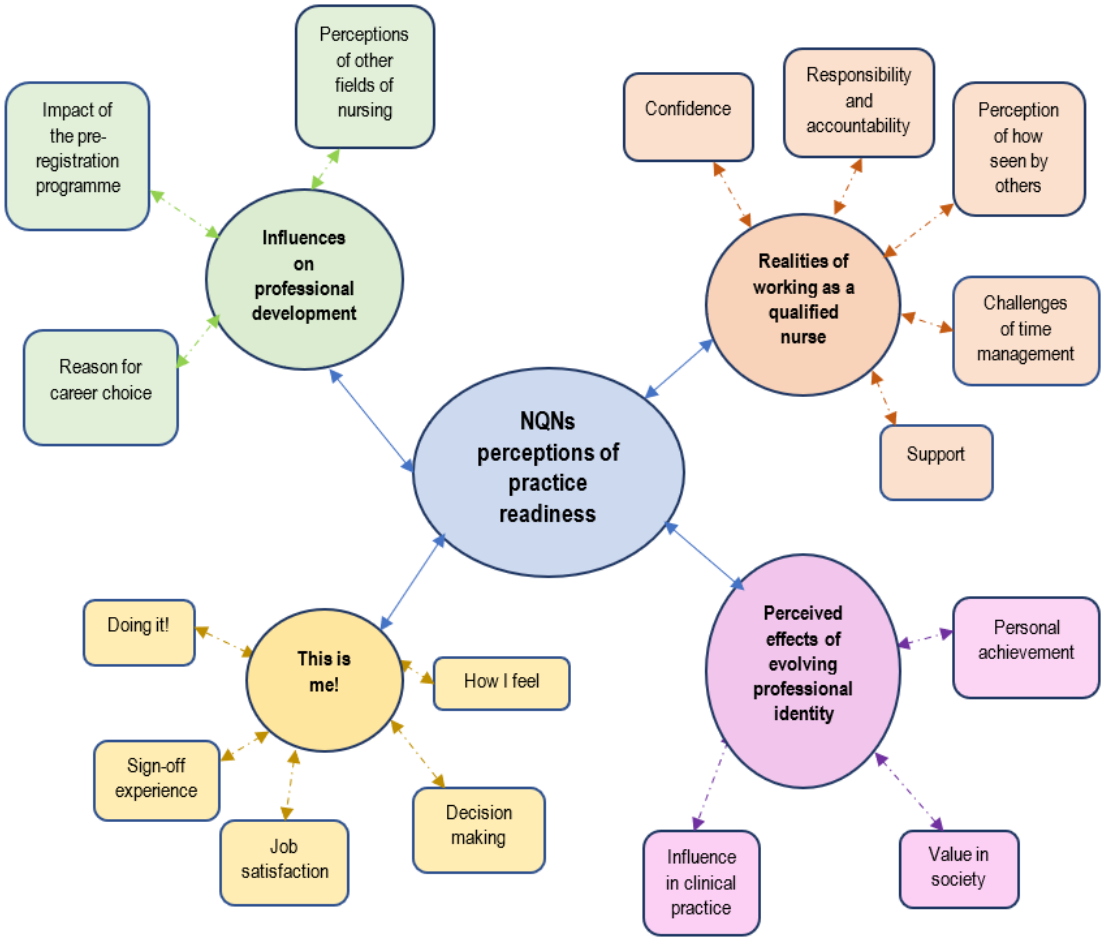
From the codes generated a thematic map was created of six provisional (candidate) themes (Figure 5.2) and 21 associated sub-themes.

Figure 5.2: Thematic map of candidate themes (highlighted) with sub-themes attached.



Following further review of the data, the candidate themes were amended, and four final themes with 16 sub-themes were identified; Figure 5.3 illustrates the thematic map of the final themes and associated sub-themes.

Figure 5.3: Thematic map of final themes and sub-themes.



5.3 **Results of the Study**

Following analysis of the data, four themes emerged; *Influences on professional development, realities of working as a qualified nurse, this is me,* and *perceived effects of evolving professional identity*. For each theme extracts from the data were able to illustrate its relevance to the participants and its link to the research question. On review of the data when demographics were included, there were no issues raised by participants relating to gender and no issues raised specific to either gender. As a result, gender was not considered in the final analysis and reporting of the data. The results below are discussed by the final themes, with consideration of both generational and field differences, where appropriate.

5.3.1 Theme One – Influences on Professional Development

This theme considered how the participants' professional development had occurred and what had influenced that development. Participants discussed issues across three sub-themes:

Sub-theme 1.1 - career choice

For some participants the motivation to commence their nursing studies had come from a desire to advance their knowledge and skills from their healthcare assistant role. As Vivian explained:

I wanted to be the one that made the decisions, and then because I've had so much experience I could see things that were going on and I didn't like it, and as a healthcare

you can only do so much, your hands are tied, and then as a nurse you've – you obviously step up a little bit, and I think you are more respected [line 227].

However, for half of the participants their motivation came either from a long held personal ambition or from witnessing qualified nurses as role models, as illustrated by Elsie and Linda:

Elsie:

I had always wanted to be a nurse, that's why it wasn't about the degree, you know it was just what I wanted to do [line 220].

Linda:

I'd had a couple of bad experiences with my dad and sister when they were like, they were poorly, and I think it sort of highlights the way care shouldn't be, and it sort of drove me to think I want to make a difference and if I can make a difference to just one person's life then I've achieved what I wanted to achieve [line 160].

Sub-theme 1.2 - perceptions of other fields of nursing

All participants recognised that they had very little knowledge and understanding of the different fields of nursing. For participants qualified as adult nurses, they felt they were more competent with clinical skills; but 94% (n=16) recognised that they did not always take a holistic view of the patient. Consideration of physical symptoms and needs were often prioritised, whilst mental health and social needs were, on occasions, overlooked, as Tracy described:

You're treating the physical side of adults the majority of the time and the mental health bit, it, it does get a bit forgotten about sometimes [line 861].

Participants felt that compulsory placements in adult settings for mental health nursing students, and compulsory placements in mental health settings for adult nursing students would increase understanding of the different fields and improve patient care. For Isabella the learning gained from alternative fields was important to her professional development:

Any experience within different fields is going to teach you at least one thing. So that is beneficial in itself. Whether or not you use the skills that you learnt within that area erm, is another thing entirely. But the attitudes that you develop within there and how you, even if it's just a development in communication with different patients because you've not come across that patient group before, is beneficial [line 1051].

Sub-theme 1.3 - impact of the pre-registration programme

Participants were asked to consider how well the pre-registration programme had prepared them for qualified practice. All participants felt their pre-registration studies had equipped them with knowledge and skills and developed them professionally for qualified practice. They acknowledged that their university experience had taught them to be more analytical but that it had also developed ambition and resilience within them. As Gaynor explained:

I've got ambition I didn't have before, because before that I don't think I really had a pathway of where I was going. I just – because I'd been in many jobs, never really settled, erm, and so then once I sort of ended up on this pathway, I've – I feel like, 'oh yes, at last,'.

I feel a lot more content, like I said, I also feel a lot – a bit more pressure in general, if you know what I mean, but I feel like a better person, much better. Before you might wanna walk away from some things that are a lot harder, I think through the uni – the three years, I've become a lot more 'No we see this through. We'll get through and we'll deal with it the best way we can' [line 220].

However, all participants felt that the greatest impact on their learning had come from their experiences in clinical placements and the practical assessments undertaken, as can be seen from Helen and Peter:

Helen:

Being on placement also, you know, we were also able to see how the real life of nursing works and how it can be applied to being a qualified, er, a qualified nurse. So, I would definitely say it's been a significant part of my er, part of preparing me for where I am today definitely [line 522].

Peter:

The preparation with all the different sort of erm study groups and all the different erm clinical skills, labs and things like that, I think that they set you up so well that I was, I was well informed of what, what it was going to be like and the skills that I was expected to have [line 403].

The key influence on professional development appeared to be experiences and learning related to working in clinical practice. However, there was an awareness that knowledge and understanding of other fields of nursing needed to improve, to ensure that they were able to meet the holistic needs of individuals they were caring for.

5.3.2 Theme Two – Realities of Working as a Qualified Nurse

Theme two explored how the reality of qualified practice compared to the NQNs expectations on entry to the workplace. Participants were asked how they felt they had adapted to their new role as an NQN, and if it had been as they had expected; across the participants experiences and perceptions were both positive and negative.

Sub-theme 2.1 - responsibility and accountability

All participants (n=20) raised the subject of responsibility and accountability. They acknowledged that they had been prepared during their pre-registration programme for the change in responsibility and accountability but 95% (n=19) of them felt that nothing could have prepared them for the reality of qualified practice. These nineteen participants explained this in relation to understanding the rules and expectations of the workplace and increased workload. They discussed that applying the increased accountability and responsibility in a specific context, alongside an increased workload was something that they could only fully appreciate once they were working in qualified practice. Within the adult field of nursing, concerns about the additional responsibility and accountability were most noticeable in NQNs working within the community or surgical areas. Participants who were Generation X predominantly identified that although this was a big change to their practice, they felt able to manage the additional responsibility and accountability. As Michael noted:

They've actually let me take charge of, uh, of shifts. Which is quite a challenge as well in itself but it just sort of makes you feel part of the team [line 97].

However, by comparison, some participants (n=7) categorised as Generation Y found the additional responsibility and accountability difficult to manage. For some this was a frightening and stressful part of their role, as raised by both Julie and Becky:

Julie:

I have this kind of anxiousness there that's just underneath the surface if it's with a patient that I've not cared for before and it might, it could be you know the simplest of patient to care for and I'll still have that like underlying because I don't know them, I don't know what needs to be done [line 588].

Becky:

It's your PIN, if something happens and you end up in coroner's court, your neck's on the chopping block, but I'd like to never end up there [line 454].

Sub-theme 2.2 – confidence

Confidence was a factor introduced by all participants, with most identifying that their confidence levels had initially been good on entry to the workplace. There were no clear generational or field differences relating to levels of confidence; for some, their confidence levels had continued to climb with their introduction to qualified practice. However, for others, they felt that their confidence had been negatively affected by the realities of being a qualified nurse. Factors affecting the NQN's confidence related to experience, being accepted, self-belief, doubt and feedback.

Most participants (n=17) acknowledged that although they had felt prepared for the realities of qualified practice, they realised that they needed to develop greater knowledge and experience within their workplace, to be confident in their role and their practice, as illustrated by Julie:

I just want the knowledge, I want the knowledge and the experience to be able to have the confidence to be able to say you know this is what I want to do for my patient because it's in their best interest [line 478].

However, their views were more conflicting when discussing how their opinions in the workplace were received and how that affected their confidence. For Elsie, being part of the qualified team meant that her views were heard and appreciated; whereas for Julie, there was a fear that she may become unpopular if she offered opinions.

Elsie:

When they're asking you about your patients, I feel like more confident to speak to the consultants and say well actually this … [line 516].

Julie:

Sometimes you know as newly qualified nurses we feel a bit you know frightened of speaking up or you don't like rocking the boat or putting noses out of joint and things like that [line 476].

When considering the impact of the pre-registration programme on their confidence most participants perceived that their pre-registration experiences had prepared them to deal with the challenges of qualified practice (n=16) and they had more self-belief in taking on

the qualified role. For Peter, his experiences with simulation within the pre-registration programme and his qualification had confirmed to him that he was prepared for qualified practice and that gave him a level of confidence in the workplace. As Peter said:

I think it's the fact that we were able to train in such a controlled environment in terms of when we were at the erm, [name of the HEI] the sort of safe environment there enabled us to get the confidence to deliver that practice. It's the confidence that you've gained from the three years and then obviously having a piece of paper that says that you can do it [line 804].

Yet, by comparison, for Andrea and Donna the realities of qualified practice led them to doubt their abilities and self-confidence was negatively affected. As they noted in their discussions, they sometimes found it difficult to believe that they were ready for the challenges of qualified practice:

Andrea:

That doubt barrier sometimes that stops me from being confident [line 199].

Donna:

I've got to sort of believe in myself a little bit more and think about what I do know, stop worrying about things I don't know because I'm quite capable of asking and, and go from there really and sort of just believe in myself. But I am absolutely frightened to death of doing something wrong, that's my biggest fear, and being in front of the NMC [line 79].

All participants felt that their confidence developed and improved when they received positive feedback on their performance. That feedback was equally effective if it came

from patients, relatives or staff members. They felt that this gave affirmation that they were doing a good job and were valued as highlighted by Susan and Nora:

Susan:

One of the sisters commented, "you know, you've done really well there", so makes you feel a lot better [line 402].

Nora:

I think patients, like, the patient feedback, the nurse, and the nurses as well saying you know, "you've done really well today" things like that. It just sort, it gives you a little boost and helps you with your confidence a bit and helps you think do you know what, I'm not a total waste of time am I because I can do some, I can do this [line 736].

Sub-theme 2.3 - perception of how seen by others

Participants discussed how they felt they were seen now they had the title of staff nurse or wore the uniform of the qualified nurse. Some perceived that they were treated differently as a qualified nurse (n=14); at times this was a positive experience (n = 5), but for nine participants they perceived that they were seen less favourably than when they were a student. This was particularly noticeable in Generation Y participants when 42% (n=5) appeared to have negative perceptions of the way they were viewed. For Isabella, her value within the multidisciplinary team was perceived to have increased on qualification:

As soon as I stepped on to the ward in that uniform it was, doctors were coming up to me and talking to me for the first time. Which was [laughs] a bit like, oh I see you actually want my opinion or to know about these patients now [line 261].

However, by comparison, for Julie, Susan, Donna and Linda, the way they had been received by peers and the public was not as positive as they had expected:

Julie:

They'll [other nurses] roll their eyes at you, you've got to grow a thick skin …… [sighs] and it's just like do you have to make it so obvious that you know ah. But yeah it just doesn't make you feel very good [line 279].

Susan:

I think there's just been a little bit of frustration that, you know, you can tell if someone's annoyed if you're asking a lot of questions, if you're struggling someone does get annoyed [line 593].

Donna:

Think the blame culture has taken the shine off a profession that at one time was very much looked up towards and commended, the nurses were there to care for you and look after you and they gave you advice and you followed that advice. Whereas now you're there to care for them and look after them, give them advice, but they don't particularly want to take that advice [line 536].

Linda:

I don't think as a nurse you're ever off duty, if people know you're a nurse they're always looking at you as a nurse. My neighbours now still look at me as a nurse and they won't think twice of stopping me in the street and asking me something even when I'm not in uniform, and it's the public perception that you are always on duty and so you've got to be respectful all the time. You've got to treat people with respect and act as a nurse really even though you're not in your uniform you've still got to have that image about you because people know what you do [line 220].

Sub-theme 2.4 - challenges of time management

Managing their time effectively was seen as a challenge for half of the NQNs. Participants discussed how prior to qualification they had considered their time management skills to be good, particularly in their sign-off placements. However, on entry to the workplace they had discovered that they were expected to complete additional tasks that they did not feel prepared to do. They explained that as students, their mentors had protected them by completing several time-consuming tasks behind the scenes, to enable them to focus on bedside care and organisation. That protection had now been removed and they were expected to amend their practice to encompass the additional time-consuming activities within their role. This led to frustration for the NQNs as they did not then feel an effective member of the team. They felt they were no longer able to spend time at the bedside with the patient, which their pre-registration programme had prepared them to do. This frustration was illustrated by the following three participants:

Rachel:

As a student you, you're wrapped up in cotton wool. You're shielded. I know in the third year you're given your bay of patients and your mentor says get on with, you look after these patients and she'll, she'll leave you to it. But in the background she's secretly working, doing, filling in discharges and getting TTO's ready and that's things that you don't get to see sometimes and as a qualified nurse, you know, when you haven't got that sort of back, that backing, that's it. You have to do everything [line 310].

Nora:

I just wish there was more time and you could just spend a little bit, well quite a bit longer with each patient [line 583].

Vivian:

Delegation was a massive thing for me as well, huge. So, I found myself taking on loads of things that maybe I could have passed over - oh god, I don't think anything can prepare you [line 188].

Sub-theme 2.5 – support

Participants were asked about their support on entry to their workplace. When asked about preceptorship 45% (n=9) of participants discussed how they had not yet received any information about their preceptorship programme or had been given preceptorship documentation but no specific preceptor to support them. When talking more generally about the support they had received from their workplaces, responses were mixed but 65% of participants (n=13) felt supported. 67% of Generation Y participants had commenced their preceptorship programme and had an identified preceptor, and 75% felt

well supported in their workplace. By comparison, only 37.5% (n=3) of Generation X participants commenced their preceptorship programme and had an identified preceptor, and only half of the Generation X participants (n=4) felt they had enough support.

NQNs wanted to be seen as effective team members and they were concerned that needing support could undermine the team's view of them. Participants were able to associate their perceived level of support with both their confidence and stress levels. This was particularly apparent from Rachel and Michael. For Rachel the busy nature of the ward and lack of preceptorship meant that she did not feel that anyone was available to support her, as she described:

The amount of pressure that you're working under was just immense, it really was. And it was knocking my self-confidence as well. Because I was asking people for help and they were busy as well and it was just like no one had the time for you, whatsoever [line 325].

By comparison when Michael was allocated to work within one area of his workplace, he felt well supported, but this caused anxiety when he was then allocated to the alternate area of his workplace:

I even dread now work, going across to the other ward, is that going to be the same support [line 633].

The impact of the perceived lack of support was so great for one participant, that she had submitted her resignation. For Nora, the impact of a lack of support had resulted in her deciding to terminate her employment with the Trust and seek employment in a different hospital:

It's a bit unnerving. and that's why I'm leaving and moving on [line 147].

However, some NQNs (n=13) felt the support they received from their workplace had been very positive, and for some an invaluable source of support had come from their peers.

Donna:

I couldn't have wished for a better supportive manager, she's brilliant and she's really thought about, erm, she's really thought about how, how she's eased me into the role [line 565].

Vivian:

I've chosen to work on a ward where there is actually a really nice team and they will help you out [line 602].

Michael:

It has always been nice actually working with someone from same cohort and cus we just sort of, how are you finding this, how hard did you find this? We discuss that and you sort of feel that you share the sort of same [sigh] the same level of thinking in terms of you know, this can be quite scary but come on we are doing it [line 978].

Within all these sub-themes there were mixed perceptions from participants. Whilst generational differences were noted in some, there was no consistent pattern across all sub-themes and the differing responses demonstrated the individual perceptions of the participants in relation to their unique experiences.

5.3.3 Theme Three – This Is Me!

Theme three focused on the NQN that participants felt they had become. They were encouraged to consider their role as a qualified nurse, how that role was different from their student role and how they felt about being an NQN. Within five sub-themes participants discussed the value of their sign-off experience in helping them to determine where they wished to work as a qualified nurse. They reflected on how their theoretical and practical experiences had prepared them for the role they were now undertaking. Finally, they considered how they felt about their new role and their readiness for their qualified career.

Sub-theme 3.1 - sign-off experience

As part of their pre-registration programme students were required to complete a longer final placement, known as the sign-off placement. During this placement students were expected to develop their management skills and demonstrate achievement of the proficiencies required for entry to the professional register (NMC, 2010). Placements were allocated by the placement office; however, Shelton and Harrison (2011) and Whitehead et al (2016) suggested that completion of the final placement in the area where the student was subsequently employed helped with the transition process and enculturation into the workplace. Within the current study only a quarter of participants (n=5) felt that the final sign-off placement was significant in preparing them for qualified practice, but those participants had found the experience valuable in aiding their transition. Both Rachel and Becky were keen to praise the impact that their sign-off placement had on them:

Rachel:

During my sign-off period I absolutely loved it. Did three and a half months there. And I loved it, really did. I really thought that was for me [line 67].

Becky:

I never thought about orthopaedics before, but it was my sign-off and I loved it. I loved the ward. I couldn't ask for a better team [line 25].

Sub-theme 3.2 - doing it!

Participants were asked to consider what had been most influential and effective in preparing them for qualified practice. The NQNs were able to discuss their knowledge and practical experiences that were situated in, or simulated clinical practice, as detailed by Helen and Kylie:

Helen:

The practical side showed me, the skills lab sessions erm we can make as many mistakes as we can in there before we go into, into the real world [line 529].

Kylie:

I think learning on a real person on the wards does help a lot and I think to, the placements you do get put on are appropriate for the skills that you learn that year. I think you're, as you go through your, your training you look at the people that you wanna be like and try

and be like them, and then you see some people and think 'no. I don't wanna be like them [line 1299].

Sub-theme 3.3 - how I feel

Participants were asked how they felt now they were working in qualified practice. Their responses fell broadly into two categories – not going well and getting there. Nora explained how the way she was feeling had contributed to her decision to terminate her employment.

I just feel left to it and it just feels unsafe to me and I'm, that isn't why I've done five years in education to feel like that, to dread going to work every morning and that's how it is at the minute [line 191].

Similarly, Rachel explained that she too had decided that she needed to look for another job.

As a newly qualified I hated it. I know hate's a strong word, but I wasn't enjoying it. I was getting up in the mornings and I was dreading going to work. And that's not – that - that shouldn't be – that - that's not, that's not what nursing's about. I enjoy what I do, and I think when you feel like that it's time to move on [line 566].

By comparison some of the NQNs felt they were settling and starting to develop as qualified nurses. This was well illustrated by Gaynor, Isabella and Julie:

Gaynor:

I have more good days than bad days. I feel that I'm much – a better – a proper nurse, that's the way to put it. A proper nurse [line 488].

Isabella:

I just didn't know what to expect and how big the change would be. Everybody all has their different perceptions of how their own transition went in to being a staff nurse and I've been told some horrific stories and I had it pounded in to me that for the first six months all you're going to do is come home from shift and cry. And it wasn't the case at all, and I've cried, I think, twice. So, I think I'm doing pretty well [line 658].

Julie:

When you do get a bit upset ….. or they've asked how do you think that's gone and I've said how I was feeling they'll always say to you like how long have you been here like, just give yourself a break it's going to take you a good eighteen months to feel comfortable with any patient that comes through that door like you've just you know giving yourself a hard time [line 730].

Sub-theme 3.4 - decision making

An area that all participants felt prepared for was independent decision making. Although this was a challenging part of the job for some of the NQNs, they all felt that their pre-registration programme had provided them with the knowledge and skills to make decisions in the best interest of their patients. As Julie explained:

Making decisions that you feel are in your patient's best interest yourself, er, and like I say having the courage and the confidence to – to speak up, I feel that that's probably one of the most important things [line 471].

Andrea also felt that she had been sufficiently prepared to have the confidence to advocate for her patients now:

I'm not on the side-lines any more watching, I'm the one that's doing, sort of making the decisions, think about, thinking more thoroughly about things [line 255].

For Gaynor, whilst she felt able to make decisions independently, she did however find this aspect of her role particularly challenging when working in the community:

Being on my own, being completely isolated in a way. Well you're not cus you've got your phone, but, erm, you are the one that has to resolve the issue. You can't pass the buck. There's none of that. It's – it's – you have to deal with it, really [line 418].

Sub-theme 3.5 - job satisfaction

Where job satisfaction was mentioned by participants (n= 14), some of the NQNs felt that they had job satisfaction (n=6), but this was not the case for the majority of the participants categorised as Generation X (n=5) and some of those categorised as Generation Y (n=3). Both Donna and Isabella felt that their job satisfaction came from knowing that the smallest things could make a difference to the patient and that what they did mattered. However, for those who were dissatisfied, there was a frustration that they could not deliver the standard of care they had studied to do and that they could not provide the bedside patient care they had perceived nursing to be. A point raised by Julie, Michael and Rachel:

Julie:

I feel a bit more, I hate to say it but a little bit more negative because even though I was aware coming into my training that it was a tough time for nurses, er, you don't actually realise how tough it is until you start the job. And there are, there have been times when I've just thought why have I done this again? You know because the stresses on you, the demands of you as a team are just shocking sometimes you know. I feel rubbish at the end of the shift because it's just been so busy that I've not been able to do those basic things for my patient [line 323].

Michael:

When you are looking at the care, the care field, from the healthcare, from the nurses, most people will say it's always a shock to the system when you realise that you know, you can't even have that patient care once you actually train. It just goes out of the window [line 371].

Rachel:

When I started this training, I thought a nurse is somebody who's, who's really hands on and spends a lot of time with their patients but that's not the case, at all. Now I've graduated it's more, you're spending more time filling in paperwork than you are actually looking after your patients. It's the healthcare that has more interaction with the patients than the nurses, which is sad [line 230].

Within this theme, participants were able to consider their professional identity as an NQN with some recognition that they were prepared and coping well, but also with areas of concern and anxiety.

5.3.4 Theme Four – Perceived Effects of Evolving Professional Identity

The final theme focused on how the NQNs felt they had changed as a person and how their professional identity was continuing to evolve. The sub-themes sat within three areas, (personal achievement, value in society and influence in clinical practice), but all linked together representing the NQN.

Sub-theme 4.1 - personal achievement

Achieving the degree and becoming a registered nurse was a significant achievement to most of the participants (n=16). They were proud of who they had become and what they had achieved. For Donna and Vivian, they were the first generation in their family to go to university, and that was seen as an achievement:

Donna:

I don't know whether it's because I don't come from an academic family, I'm the first person out of the family to go to college and university and I'm really proud of what I've achieved, and I've achieved a degree and I never thought I would ever say that [line 443].

Vivian:

I never thought I'd go to university – university's kind of got a status about it that only clever people go to university, so I always thought, 'I could never do that.' And the fact that I've done it and I'm – I'm living my dream, kind of thing, it's – yeah, it's – it's dead weird. So, I'm – yeah, I feel really proud [line 886].

As graduates they felt their career prospects were improved within the health service and their graduate attributes had prepared them well for the management roles they would be expected to have. Alongside their degree, there was a sense of pride in being able to call themselves a nurse and this was echoed by their families:

Vivian:

My mum's dead proud. My mum is always saying, 'Oh, my daughter's a nurse now' [line 935].

Sub-theme 4.2 - value in society

Participants also expressed a perception that they now had greater social status and were seen as more valuable to society. The NQNs discussed how family and friends were impressed when they found out that the NQN was a qualified nurse, and how they would ask for advice and help. As Olivia observed:

Your family or your friends, if they've got anything, they'll be like, oh you're a Nurse, like, could you help me? [line 626].

Michael felt that he was now viewed by the public as a professional with a higher standing in society, but Donna felt that as a nurse she was judged more harshly by the public and that she was still trying to work out her role in society with her new identity. Overall, of the 13 NQNs who discussed their value in society, 12 felt that as registered nurses they were seen as more valuable to society and were therefore held in greater esteem.

Sub-theme 4.3 - influence in clinical practice

An important difference for the NQNs was the impact they perceived they could make in clinical practice now that they were registered nurses. As Michael explained:

From my healthcare support worker role, knowing that, you know, if you are working on a shift you've got a nurse to look up to, you've got a nurse to run all your queries by, anything to do with patient care through, and you're just thinking god this is me now [line 300].

The NQNs felt that they now had much greater involvement with the multidisciplinary team and were able to be effective advocates for their patients and represent their needs.

Throughout this theme, participants discussed that now they were qualified nurses they were more influential in clinical practice and had greater social standing. Whilst this was a rewarding and positive feeling, for Gaynor it was a big change that she was still coming to terms with. When asked how she was different now that she was a qualified nurse, Gaynor replied:

Still finding my way with that one! [line 162].

5.4 **Chapter Summary**

Thematic analysis of the data was completed using the Braun and Clarke (2006) 6-step approach. The data for the study was also considered in relation to the participants' demographic data and generational differences. Using both manual and CAQDAS approaches, coding of the data was followed by identification of four final themes relating to NQNs' perceived readiness for qualified practice.

The first theme identified influences on the NQNs' professional development. Within this theme it became apparent that reasons for career choice and previous care experience had had an early influence on how NQNs perceived the profession and their development. The impact of the pre-registration nursing programme had then directed the individual's professional development, with individual realities being created for each NQN.

The second theme around the realities of working as a qualified nurse identified that NQNs had a level of preparedness and readiness for entry to the workplace. However, the challenges of time management and increased levels of responsibility and accountability were greater than expected and had, for some, negatively affected their confidence in their role. Acceptance by colleagues, and a sense of belonging were important to the NQNs and perceptions of how they were perceived caused anxiety for some.

The theme of 'this is me', identified factors that were affecting the NQN in their new role and how prepared they felt for dealing with those factors. Whilst NQNs felt that they had a knowledge and skills base to make independent decisions and fulfil the basics of their role; for some there was anxiety in meeting the expectations of the workplace and frustration and job dissatisfaction about what being a qualified nurse entailed.

The final theme identified the impact the change to qualified nurse status had on NQNs both within the workplace and the wider society. NQNs had a sense of pride in their achievement on becoming qualified nurses and felt that their status in society and the workplace had increased as a result. For some, they perceived that they were not always viewed favourably by more experienced colleagues and some members of the public, and for some, understanding their new identity and place in the workforce and society was an ongoing issue.

In relation to the research questions:

1. Four themes emerged from the study around influences on professional development, the realities of working as a qualified nurse, factors that were influencing their performance as an NQN and the wider impact of qualified status on them as individuals.
2. Key influencing factors were their experiences of support and expectations of them in the workplace, how the realities of being a qualified nurse compared to their expectations, how well they felt their pre-registration programme had prepared them, their ability to adapt and align their habitus with that of the workplace, generational and demographic differences
3. The themes identified and the influencing factors provided greater understanding of individual needs during the pre-registration programme and the transition to qualified practice, which can inform initiatives both within the pre-registration and preceptorship programmes to support practice readiness.

The findings of this study will be discussed and analysed further in the next chapter.

CHAPTER SIX DISCUSSION

6.1 Introduction

This study set out to explore how newly qualified nurses perceived their readiness for qualified practice and their professional identity on entry to the workplace. Readiness is an important factor in the preparation of students for contemporary nursing practice and the retention of qualified nurses to the healthcare workforce. The objectives for the research questions were:

1. *From the NQN perspectives, what themes around practice readiness and developing professional identity emerge from the study?*

2. *What are the key influencing factors for practice readiness?*

3. *How can the emerging themes inform future undergraduate pre-registration nursing curriculum and student nurses' readiness for qualified practice?*

This chapter critically discusses, analyses, and debates the findings from the main study that were outlined in Chapter 5. It analyses the results in relation to the literature reviewed in Chapter 2 and relates the findings to the philosophical and theoretical underpinnings supporting the study (Chapter 3). The chapter concludes with a critical discussion of the strengths and weaknesses of the study.

6.2 **Discussion of findings**

Watson et al (2020) suggested the first few months of qualified practice continue to be a challenging time for NQNs. Findings from the current study suggest that issues around readiness for practice and the expectations of some colleagues in the workplace remain an issue. NQNs are gaining more confidence in negotiating the demands of qualified practice, but generational and demographic factors are influential to the individual needs of the NQN.

6.3 **Theme one – Influences on professional development**

The first theme emerging from the data captured NQNs' perceptions of influences on their professional development and identity. Acknowledging the epistemological positioning that perceptions were unique for each individual, some commonalities emerged from the data. All participants entered nursing to make a difference to the people they cared for, despite different incentives leading them into the profession. For all NQNs the perceptions of their professional development linked back to motivations for entering the profession and expectations of what it would mean to be a qualified nurse. Bourdieu's concept of habitus (Bourdieu, 2000) suggested that choices made by individuals linked to the perceptions and beliefs built up over their life journey; for each participant, their initial expectations of qualified practice were similar but unique.

Most NQNs (n=15) perceived that some adjustments throughout their student journey had helped to prepare them for more realistic expectations of qualified practice. Bourdieu (Morberg et al, 2012) argued that making such adjustments could be difficult for participants to do; but would enable them to transition better into their new social space (their workplace) (Johansson, 2014). For Julie, the adjustment in her expectations of the

qualified role had enabled a greater sense of self-belief and resilience when she started in qualified practice. Julie had been a mature student with previous health and social care experience, continuing to work on the hospital nurse bank throughout her pre-registration programme. She had gained an understanding of the challenges in health and social care prior to starting her studies and had used that experience and understanding to adapt and adjust her expectations as she progressed. Although Becky had commenced her nursing studies on completion of her A-levels, she had also gained healthcare experience for 18 months during that period, before starting her pre-registration programme. Becky explained that perspectives developed before entering her studies had provided a more realistic expectation of the challenges in contemporary nursing and of being an NQN. This had provided preparation for Becky and enabled her to adjust her perceptions and develop coping mechanisms during the pre-registration programme, which in turn had enabled Becky to start to develop confidence in her new qualified role and actively seek out support when needed. This was a positive finding supporting Haplin et al (2017) and Watson et al's (2020) suggestion that previous healthcare experience can aid the adjustment to the qualified role.

Using Bourdieu's concept of nursing habitus (Bourdieu, 2006), professional identity should be a gradual process that commences during the pre-registration programme to develop realistic expectations of qualified practice and support a positive transition to the qualified role. Thus, providing greater practice readiness where skills, attitudes and behaviours expected of the nursing profession, become the norm for the individual. For the 75% (n=15) of participants who had found the nursing habitus easier to embrace and were able to adjust it to the work setting habitus (Wacquant, 2004), their transition to the qualified workplace had been less traumatic. However, for the remaining five participants, their experiences conflict with other research findings and indicated that previous healthcare experience can become an obstacle for some NQNs.

For the 25% (n=5) of participants who did not feel the reality of qualified practice aligned to their expectations, they identified that they had a level of confidence and resilience as a student that they were not able to translate to qualified practice and experienced a sense of loss and anxiety during their transition (Meleis et al, 2000). Of those five participants, four were first generation graduates and all five of them had been healthcare support workers with between three and a half and eighteen years' experience of healthcare. These participants had entered nursing to further their career with the perception that they would have greater contact with patients and more influence as a qualified nurse. They all identified that they had a greater level of knowledge and skill but were unable to continue to provide more fundamental care now qualified. They all spoke about expecting to combine their newfound knowledge and skills with fundamental care and felt that they had not been supported to do so. They had found it difficult to meet the requirements of their new role whilst trying to continue with the bedside care they were so experienced in providing. For all these five participants, their prior healthcare experience had provided insight into the workplace environment but had developed perceptions of the nurse's role that had not been adjusted during the pre-registration programme, now proving to be a barrier to their transition to qualified practice. A lack of preceptorship support for them all had meant they struggled to understand the additional contribution they could make to providing quality patient care, without delivering fundamental care themselves.

More opportunities during the pre-registration programme to discuss previous experiences and expectations of the qualified role, followed by a bespoke preceptorship programme, with greater support could have helped to adjust their expectations and provided strategies for them to balance the multiple priorities of qualified practice. They brought a level of life and healthcare experience to the programme that had been valuable in helping them to develop confidence as students, but this experience had not then been adapted to enable them to make a smooth transition to the qualified role. This evidences the individual way that experiences are processed. Whilst the previous healthcare experience had been

advantageous to Julie and Becky, these five participants needed greater support and guidance to be able to adjust their learning and habitus from their experiences and transfer them to their qualified role. The process of transition will be different for each individual and the change from the familiar to the unknown will be more difficult for some to manage. Transition theory (Chick and Meleis, 1986) identified that if an individual has difficulty aligning their expectations to reality it can be difficult to gain confidence and move forward through the transition process.

If students are encouraged to identify their expectations at the beginning of their programme, and where those expectations come from, it can provide a starting point in supporting them to develop realistic expectations of the qualified role which continues into transition. Where students have previous healthcare experience to reflect on, this can be used from an early stage, as a tool to help them develop and adjust their understanding and management of the challenges of contemporary nursing. Where students do not have previous healthcare experience to reflect on, skills developed from their life experiences or previous careers can be transferred to develop their resilience.

The sharing of peer experiences and the use of simulated case studies to support the identification of any conflict in expectations and perceptions can introduce early opportunities to develop reflexive skills and solution focused approaches to students' studies and developing professional identity. These skills can then be built on throughout the pre-registration programme, as students are frequently encouraged to consider how their expectations compare with the realities of their experiences in clinical practice. Reflection, group and individual discussions with tutors, clinical practice supervisors and assessors, and peer group solution focused activities can support students to review their expectations at regular intervals throughout their studies. Support mechanisms can then be introduced from both the HEI and practice supervisors when students are having difficulties in aligning to the realities of practice. These support mechanisms can provide

good indicators for the development of individualised transition support arrangements and bespoke preceptorship programmes, as students become NQNs and enter qualified practice.

Engagement with both the practice and theoretical aspects of the pre-registration programme is important for development of resilience skills and student confidence, providing opportunities to challenge unrealistic student expectations. During the writing up of this thesis, the world experienced the Covid-19 pandemic. As part of the UK response to the pandemic, the NMC introduced new emergency standards for nursing and midwifery education (NMC, 2020). These standards were designed to be short-term, to support students in the final six months of their pre-registration period; to enable them to complete their education within clinical practice and support the NHS.

Findings from the Updated RePAIR report (HEE, 2020) identified that 60% of students who experienced extended time in clinical practice found their practice experience valuable to their development. However, they had concerns about their academic progress and completing the taught element of their programme. For students who had instead experienced a lack of placement experience during this six-month period, they had concerns about catching up with their clinical skills to prepare them for qualified practice. A lack of either academic or clinical exposure had led to a perceived deficit in their learning. This provides evidence of the importance of ensuring students are able to experience both the theoretical and practice elements of their programmes. Through close liaisons between the HEI and service providers, workshops and seminars during the pre-registration programme would provide opportunities to explore expectations of the qualified role. Students could meet with qualified staff to discuss and explore the realities of qualified practice, enhancing networking between the service providers and the HEI, whilst increasing more informal networks for students.

Within the latest professional standards (NMC, 2018) there is a greater focus on nurses having a more generic skills set. This recognises the common skills and attitudes that all nurses must possess regardless of the field of practice, including leadership, teamworking, communication and professionalism. Within this study participants identified their professional development had prepared them for qualified practice in their field of nursing, but they acknowledged that they were less developed in caring for people with needs outside of their field. The general characteristics of nursing, referred to as secondary habitus (Carter, 2014) had been increased and strengthened, but understanding of other fields of nursing was not as strong. Willis (2015) identified that nurses need to have a broader more generic skill set, a point supported by the National Confidential Enquiry into Patient Outcome and Death (2017). The NQNs could see that an increased knowledge and skills set relating to other fields of nursing, with greater exposure to patients with diverse needs, would increase their value to and acceptance in their team. They would be able to contribute more to supporting patients' needs, rather than waiting for advice from nurses from other fields. This was particularly evident for adult nurses working with patients with mental health needs or learning disabilities.

Using Bourdieu's concept of capital (Bourdieu, 1992), these wider generic skills would increase the NQN's cultural and symbolic capital within the workplace, allowing them greater influence than colleagues without these skills. The NQNs also identified that they are likely to work with a range of people with differing needs and they require greater professional development in this area to be effective in their role. As Gaynor described after caring for a patient with both physical and mental health needs:

there's big gaps. Like I felt confident – like I say with my schizophrenic patient, I felt confident to a level, but where do I go from here? Once he's – okay, his leg's healed now, what do I do now? Where do I need to go? What do I need to – that's where it starts getting a bit more tricky [line 783].

To support students to develop a greater understanding of the wide range of patient needs that cross different fields, more innovative approaches to placement experiences should be explored. In addition to the more traditional placement areas, opportunities should be sourced from wider population experiences, for example, charities working with the homeless, asylum seekers, refugees, victims of domestic abuse and drug rehabilitation facilities. These types of opportunity would enable students to take a more holistic approach to the care of their patients and deliver flexible care for the whole person (CoD, 2016). However, this can cause role conflict for some nurses. Individual perceptions of the needs of a patient may vary and some nurses may find it more difficult to address areas that have not been part of their professional development or nursing habitus (Bourdieu, 2006).

Within the current study, participants explained how, if they had an opportunity to visit a placement area in different field of nursing during their pre-registration programme, staff would often be unwelcoming and fail to see the value in the student being there. If student nurses are to develop more holistic skills across all fields, support will also be required to address the professional development needs of those in qualified practice who will be teaching and support the future nurses (CoD, 2016; Willis, 2015). Greater discussions between HEIs and the full range of placement providers could identify areas for alternative field placement experiences, including less traditional types of placements where additional support for staff and students in those areas could focus on the development and understanding of the different fields of nursing. Through this, the CPD of qualified staff and students could be enhanced to develop greater holistic care and understanding of differing patient needs.

Providing opportunities for qualified clinical staff to meet and explore their concerns or perceptions of other fields would also develop stronger networking opportunities between

fields. Identifying areas for further continual professional development learning opportunities would support qualified staff to understand the needs of students from different fields of nursing, and in turn enhance individual skills when working with patients from fields other than their own. Alongside this, in the pre-registration curriculum further opportunities for students from different fields to work together on problem-solving and scenario activities, would enable greater awareness and understanding of their different perceptions and the multifaceted needs and challenges for people in their care.

Within this theme, the greatest influence for all NQNs came from their 2300 hours of student experiences in clinical practice (NMC, 2004; 2010; 2018). The routines, rules and ethos of each placement area is different and this needs to be acknowledged in the pre-registration programme through preparation for placement sessions so that students do not enter a new placement experience with expectations from previous ones. Students need to be encouraged to reflect on and develop skills and resilience strategies from placement experiences to adapt and amend to future situations. Many rules and expectations of the clinical environment are tacit and difficult to articulate through an introduction or welcome pack. It is therefore important that students feel able to approach staff in the workplace for clarity and reassurance relating to the nuances of the area. Learning to quickly recognise and follow the rules of the different placement areas (the doxa) had provided participants with an understanding of differences between clinical areas and had helped to prepare them for enculturation on entry into the qualified workforce. Bourdieu (1992) argued that familiarity with and adherence to the doxa of the workplace is key to effective socialisation and acceptance within that workplace.

Throughout the pre-registration nursing programme, participants exposure to multiple clinical placements enabled them to see different approaches to teamworking in the various areas. They started to develop an understanding of the different doxas within workplaces and the different roles and levels of power within the different teams. However,

for the 25% (n=5) of participants discussed earlier in this section, despite a developing awareness of the different doxas in the workplace, they did not feel sufficiently prepared for their qualified role. They perceived that protection offered to them as students by mentors had prevented them from developing their resilience and habitus in preparation for the qualified workforce. Subsequently, they were shocked by the reality of the culture and demands on them when they entered qualified practice.

This was particularly evident for Rachel. She had chosen her workplace for the supporting and friendly environment she had experienced as a student. When her experience as an NQN exposed her to a team with expectations that she would practice autonomously with little support, she was not prepared for this and felt that her experience as a student did not align with the realities she was then exposed to as an NQN. The expectations of the workplace team can have a significant impact on the NQNs adjustment to their qualified role (Aldosari et al, 2021). Even when the NQN is familiar to the workplace their perceived readiness for that role can be challenged if they have not experienced as a student, the challenges they are now expected to deal with as a qualified nurse.

The balance between protection and developing practice readiness is important as students need to be equipped with the skills to ready them for the realities of qualified practice. It is important that qualified nurses in the workplace are supported and developed to provide high quality learning experiences for students, with discourse around the challenges that can develop if students are overly protected. As suggested by the RePAIR Report (HEE, 2018), staff need opportunities and support to explore reasons why they feel students need protection, with alternate ways to deal with concerns about the workplace environment.

6.3.1 Summary of theme one

Bourdieu (1992) argued that altruistic ideals are developed from life experiences. Within the current study all participants identified that they wanted to care and make a difference, and this had been a driver in their career choice. They discussed how, throughout their pre-registration programme, developing knowledge and skill had enabled them to increase the difference they were able to make, citing continuity of care, clinical decision making and advocacy as examples of their development. For 75% of participants, their perceptions of making a difference had adjusted to align with the realities of the contemporary qualified role. When this occurred the NQNs were able to see the various ways they could 'make a difference', besides delivering bedside care.

However, for the 25% (n=5) of NQNs who had previous healthcare experience but had not been supported to adjust their habitus, they had unrealistic expectations on entry to the workplace (Kramer, 1974). For these NQNs coping with the transition to their new role and new identity was more difficult as described by Chick and Meleis (1986). Three of these five participants were from Generation X and discussed how they were often perceived to have been qualified for much longer as they had entered the profession at an older age. This is an important finding, as it indicates that NQNs from all generations can have difficulty in aligning their personal habitus with the expectations of the workplace, and for Generation X NQNs their needs can be overlooked if colleagues in the workplace are not reminded of their novice status. There needs to be aide memoirs such as different coloured name badges for nurses during their first year of qualified practice, to remind all staff of the NQN's status and their individual need for support during their transition to the workplace. Whilst HEE (2018) suggested the provision of different coloured lanyards would be helpful, finding from this study suggest that this particularly significant for more mature NQNs.

Whilst acknowledging the need to have a greater holistic understanding of individuals' needs and the increased symbolic capital this would bring (Bourdieu, 2000), NQNs did not feel sufficiently prepared for this and recognised that further professional development was needed around other fields of nursing. Where it was provided, NQNs appreciated exposure as students, to the realities of nursing practice, as through this an awareness of potential socialisation and acceptance issues was developed. NQNs had become aware of the importance of the doxa of the workplace (Bourdieu, 1992) and its role in assisting their transition. Through adjustments to personal habitus (Bourdieu, 1993), 75% (n=15) of NQNs reported a level of practice readiness which empowered them with the confidence to challenge poor workplace cultures.

New findings relating to this theme were:

- Previous healthcare experience can help students to develop more realistic expectations of qualified practice and adjust to the doxa of the workplace. However, for some students making the transition from their healthcare role can be more difficult and greater support is needed throughout the pre-registration programme and the transition period to help them to recognise the additional contribution they can make and to realign their expectations with the reality of contemporary qualified practice.
- Mature NQNs are less likely to receive sufficient support during transition, particularly if they have previous healthcare experience.
- NQNs recognise that they need greater understanding of patients' holistic needs and more innovative placement experiences.

6.4 **Theme two – Realities of working as a qualified nurse**

When participants started to discuss their experiences of working as a qualified nurse, several common factors emerged (support; perception of how seen by others; confidence; responsibility and accountability; time management). Using Bourdieu's concepts of doxa and nursing habitus (Bourdieu, 1992; 2006), for NQNs to understand and comply with the culture and tacit rules of their workplace, they had adapted to accommodate new expectations of them, and hence their professional habitus developed. For the NQNs who did not feel welcomed within the workplace, they could not understand the culture and tacit rules and felt undermined and devalued.

Participants discussed support from the perspectives of their supernumerary period, initial experiences of preceptorship and the wider support from colleagues in the workplace. All participants received a period of being supernumerary, often linked to obtaining confirmation from the NMC that they had been entered onto the professional register as a qualified nurse. The period lasted between one and six weeks and was a valuable opportunity to shadow more experienced staff and start to become more familiar with the workplace.

However, preceptorship opportunities with identified preceptors were only made available to 55% (n=11) of participants and these were predominantly for Generation Y NQNs. For the other nine participants six had been provided with documentation relating to preceptorship but had no one to discuss that documentation with, and three had been told there would be preceptorship support but had yet to receive any information about their preceptorship programme or their preceptor. Generation X NQNs were particularly disadvantaged by a lack of preceptorship support (n=5), and this may have been related to a perception from the workplace that they were more able to cope with the transition due to their previous life experience. Where there was no preceptorship programme, but

support was available from other members of the workplace team, NQNs felt that support from their workplace colleagues generally was of more importance. Interestingly, for 65% (n=13) of participants in this study, the most valuable support reported came from colleagues, managers, and doctors, rather than from the preceptorship advocated in key drivers (DH, 2010; HEE, 2018; NMC, 2020; Willis, 2012; 2015).

Using Bourdieu's (2006) concept of nursing habitus to explain this, for the NQNs in the current study, their desires were to develop and internalise the skills and behaviours expected of them, and support for this came from several sources and was not perceived to be predominantly from preceptorship. However, when the NQN did not have preceptorship or workplace support, the impact was significant to their confidence and their ability to adjust to their new role.

The perceived lack of support and value from the workplace and senior staff had a negative impact on Rachel's confidence and self-esteem. Rachel's demographics categorised her as Generation Y, and her discussion of her expectations and needs aligned with the traits identified in the Mind the Gap project (HEE, 2015). Rachel expected support on entry to the workplace to fit with her individual needs and she required regular feedback and encouragement to develop. When she perceived that this was not happening her confidence and self-esteem suffered. She had entered the pre-registration programme with three and a half years of healthcare experience and was the first generation of her family to go to university. For Rachel, gaining her degree and becoming a qualified nurse were pathways to developing her career, but she did not feel that the reality of her early qualified experiences was supporting this to happen. As a result, she was looking to move jobs to something that would meet her needs more and provide her with better career opportunities.

This raises concern around the generational and individual needs of NQNs and the potential effects on attrition if those needs are not met. Current workload demands and staffing levels put workplaces under immense pressure, but Rachel's experience suggests that identifying the needs of individual NQNs and providing individualised transitional support can help NQNs settle and stay in the workplace, continuing to develop as qualified nurses. Senior managers need to recognise the value of ensuring support is available in the workplace for the NQN and experienced staff. They should work more closely with HEIs to develop individualised preceptorship programmes to ensure the needs of the NQN are identified and resources are made available to help more experienced staff to ensure those needs are met. This will then enable the NQN to feel more welcomed and help to remove the perception that the NQN is an added burden or threat to other staff in the workplace, hence reducing some of the power issues experienced by NQNs.

Bourdieu (Grenfell, 2014) introduced the concept of symbolic violence and suggested that this is an effective way for the more dominant to maintain their power. He suggested that by promoting the hierarchical systems that are in place and adhering to the doxa of the workplace, more powerful members of the group can maintain their dominance whilst encouraging others in the workplace to accept the status quo. As a result, those with less power, such as Rachel, comply with the culture of the setting to fit in, or suffer a lack of acceptance and belonging. In her 2008 study, Duchscher found that on qualification the solid grounding the NQNs had for their professional identity was eroded by the anxiety and self-doubt felt on experiencing the realities of qualified practice. Those realities linked closely to the symbolic violence described by Bourdieu (Grenfell, 2014). Kelly and Ahern (2009) argued that the hierarchical system common within healthcare is used by some to gain power over the NQN. Participants within their study perceived that some nurses are threatened by the NQN and use humiliation as a tool when the NQN is unfamiliar with the workplace processes. This resonated with Rachel and Carla within the current study. For

Rachel, when she asked a colleague for support, she was shocked at the response she received:

It's the way she spoke to me that made me feel, she be, belittled me [line 362].

Similarly, Carla described how she perceived that some colleagues saw her as a threat and were reluctant to accept her into their community:

They don't like new blood, is what it is, but I'm not threatening anybody, I don't want to take any of their jobs [line 445].

For Rachel, she had felt shocked by the lack of support and nurturing from some colleagues, whereas for Carla, she perceived the negative reactions she encountered were because she was seen as a threat. Carla was 17 years older than Rachel, had previously had a demanding international career and came from a strong family background of healthcare and academia. She felt more able to cope with the negative reactions she encountered, by drawing on her previous life skills and seeking out the support that was available to her in the workplace to develop her confidence and self-belief. Carla was able to recognise the frustration from some of her more experienced colleagues, when they saw that Carla was being given development opportunities that were not available to them.

It is important that when individualised preceptorship arrangements are being developed, they are not at the expense of the needs of staff already within the workplace. Senior managers have a key role to play in ensuring the development of all workplace staff, and greater liaison with the HEI may provide more CPD opportunities. The individualised preceptorship needs of NQNs may also be opportunities for the development of other staff within the workplace. Shared learning opportunities can help the NQN to develop their

relationship with colleagues and may help more experienced staff to see the NQN as a positive addition and benefit to their own development. Consideration of the needs of the NQN alongside the needs of more experienced colleagues, from their appraisals and informal discussions with managers, could identify commonalities where some CPD can be designed to enable engagement from all those with a similar need, or a process of dissemination amongst the workforce can be developed, supported by senior managers.

The current study suggests that the bullying culture in the nursing workplace described by Kelly and Ahern (2009) is starting to subside with a more positive culture change as recommended in policy drivers (Francis, 2013; HEE, 2017; 2018; NHS Improvement, 2019; The National Improvement and Leadership Development Board, 2016). Despite the shock and disappointment experienced by 45% (n=7) of participants on entry to qualified practice, they did not express concern that they were being bullied; rather there was a confusion around why they were not being made more welcome or provided with a more nurturing environment. This was clearly linked to what they perceived to be poor induction to their workplace and poor preceptorship arrangements.

The nursing habitus described by Bourdieu (2006) suggested that nurses have a set of similar professional characteristics, but the poor socialisation experiences of 45% of the NQNs in the current study did not resonate with that nursing habitus. This 45% of participants considered that the hostility they experienced was linked to a workplace perception that they would add to the workload rather than helping to relieve it, or that they would receive development opportunities that were not available to more experienced staff. Frustration demonstrated towards NQNs when they did not understand the habitus and doxa of the workplace, indicated the importance of recognising the impact the NQN addition can have within the environment.

Support is important and needs to be available not only to the NQN, but also to staff within the workplace, who need to help the NQN's transition. The changes to the dynamics of the workplace will be felt by all those within the environment and management need to be mindful that alongside the NQN, greater support may also be needed for some colleagues within the workplace to help them to adjust to the change. Good communication with all staff and opportunities for staff to meet and discuss their concerns or needs in relation to the addition of new staff members, can be positive ways to ensure that reassurance can be given about the forthcoming change, with unrealistic expectations of the NQN explored and discussed. By preparing the student nurse through the final stages of their pre-registration programme, and the workplace team in advance of the introduction of the new staff members, transition arrangements can be individualised. With support and awareness of the workplace team a more inclusive approach to change and potential development opportunities for those already within the workplace can be created. When experienced colleagues feel able to offer support and guidance to the NQN this has a positive effect on the NQN's transition and they are seen by the NQN as a valuable support and learning resource, as identified by 65% (n=13) of participants in this study.

For the NQNs who perceived that staff found them to be a burden or unable to perform to expectations, they questioned their knowledge and abilities and began to feel alienated from their workplace team; they had difficulty adapting to their new role and for Nora this had led her to decide to change her employer. Although Nora was categorised as Generation X and had 18 years of healthcare experience prior to commencing her studies, unlike Carla, she was not able to use her life experience to support her in her transition. Nora had not been able to realign her personal habitus from her healthcare support worker role sufficiently and felt that because of her age there was an expectation that she would easily make the transition, with little support. She had expected to continue to have the same type of contact with her patients that she had as a healthcare support worker and as a student nurse, and felt that trying to manage her new responsibilities in addition to

her previous role was difficult and at times dangerous. She was not able to see how her role needed to change and evolve and this had not been recognised by her employer or colleagues. Consequently, Nora experienced a level of stress and anxiety that she was not able to manage within the workplace. This demonstrates the importance of challenging student perceptions of qualified practice throughout the pre-registration period and providing individual preceptorship transition support to NQNs. Morberg et al, (2012) identified that changing individual perceptions and habits is a difficult process. Through continual opportunities to engage in reflexive practice, students can start to identify areas where their habitus is not adjusting and aligning to the realities ahead of them, and support can be offered that continues during the transition period through individualised preceptorship.

For 80% of the NQNs, such as Peter, when they had a strong sense of self-belief and self-confidence on entry to the workplace; they appeared more able to challenge any perceived lack of support or hostility. As a result, misunderstandings were quickly dealt with, and more effective support was made available to them. However, if the NQN had a weaker sense of self-belief or self-confidence on entry to the qualified workplace, they were less likely to speak out about lack of support. This was illustrated by Nora when she described how she dreaded going to work every day because she did not feel there was enough support and leadership in place. Kelly and Ahern (2009) argued that some NQNs feel that they have been 'thrown into the deep end' on entry to qualified practice. The change in role and expectations can leave the NQN feeling frightened and potentially dangerous if there is insufficient support to develop within their new role.

Resilience can be taught within the pre-registration programme and greater emphasis on the realities of qualified practice can be interwoven into the curriculum. However, each individual will have their own perception of the situation they are experiencing. As a result, their mechanisms for coping with and dealing with the challenges of that situation will differ.

Bourdieu (1992) argued that this will be part of their habitus, developed from their early childhood experiences and schooling. Student nurses enter their nursing programme from a range of social and educational backgrounds. Some have extensive life and career experiences to bring to their studies, and many continue to juggle family and financial responsibilities whilst studying for their degree. In addition, there are now three generations studying to become nurses, with their different generational traits (HEE, 2015).

This raises an important challenge for academics and practice partners when considering how best to support students and develop a curriculum for individuals whose needs and experiences are unique. The "flaky bridge" step in the nursing journey (HEE, 2018) emphasised the need for HEIs and healthcare providers to work together to provide opportunities during the latter part of the undergraduate curriculum that expose students to the realities and conflicts they will encounter in qualified practice. As part of this, the individual demographic and generational needs should be explored to ensure individual support for practice readiness and inform individualised preceptorship programmes (DH, 2010). The current study provides new evidence to identify that life experiences contribute to the personal habitus of the NQN and for some, those experiences can be beneficial in helping develop resilience and adaptation to their new identity and role. However, for some, greater support is needed during the pre-registration programme and transition period, to help them to challenge their perceptions and expectations and adjust their habitus accordingly. Generational differences can alter workplace expectations of NQNs with some expectations that Generation X NQNs will transition more easily due to their age and past experiences. However, their support needs may be different to the needs of their younger peers, but need to be addressed, if they are to have a positive transition to their qualified role.

The expectations and perceptions of workplace colleagues can help or hinder the NQN's transition to qualified practice, as identified in the RePAIR report (HEE, 2018). Bourdieu's (2006) concept of nursing habitus suggested that as part of their professional identity, the NQN needs to take on the characteristics expected of them by their profession and their workplace. This resonates with work by Levett-Jones et al (2007) and O'Kane (2011), when they argued that belongingness is significant to the development of professional identity and successful transition to the qualified role, and acceptance into the team is key.

For the NQNs in this study, how they were perceived by others in the workplace was a significant factor. When they received praise (particularly from senior colleagues), they felt reassured that they were doing well and had become one of the team. When welcomed into the workplace they found their transition to their new role more effective. However, when colleagues were unapproachable or critical, NQNs felt that they were not at a level of competence expected of them and were letting the team down. This was of particular importance to five participants who were all from Generation Y. A generational trait of Generation Y (HEE, 2015) is the need to feel part of the team and gain regular feedback that they are making a valuable contribution. When this does not occur, NQNs from this generation can feel anxious and unsupported. Fitting into the workplace can be significant for individuals and Bourdieu (Johansson, 2014) argued that individuals will adjust their beliefs and perceptions, (their personal habitus), if it allows them a greater chance to fit in and be accepted. Although participants discussed a readiness to challenge poor workplace cultures, they still measured their level of competence and acceptance into the workforce by the way they felt viewed by others.

A noticeable change for participants in this study was in relation to confidence. The drop in confidence experienced by all NQNs on entry to their workplace is a normal part of any transition process (Ashley et al, 2016). What was interesting within the study was how that drop in confidence was managed by both the NQN and their colleagues within the

workplace. A new finding in this study was the difficulty experienced by participants with extensive previous care experience. For Donna, Nora, and Vivian, they initially found that they struggled to cope with the changed expectations of them and their new professional identity within the workplace. For Donna and Vivian, the support they gained from their colleagues helped them to overcome their doubts, but for Nora, the reassurance she gained came only from patients and the lack of support she perceived she had in her workplace diminished her confidence still further.

As part of the transition to qualified practice there may be expectations that NQNs with previous experience of healthcare doxa and exposure to nursing habitus, will transition more easily. However, this study suggests that this is not the case, and whilst these NQNs may have additional experience that they bring to their qualified role, they need support and reassurance as they change their position within the workplace and adapt to the new capital that qualified status has brought. Integral to preceptorship support should be the adjustment to the changed capital and position of the NQN within the workplace.

Donna and Julie were able to recognise their drop in confidence as a normal part of the transition process and felt able to discuss this with colleagues to gain support and reassurance. They recognised that confidence would develop with greater experience in their workplace. The reassurance and positive feedback from their colleagues alongside their ability to recognise their knowledge and skills within the workplace, assisted these NQNs to raise their confidence levels, confirming findings by Hunter and Cook (2018) and Price et al (2018). By comparison, when the NQN did not feel able to discuss their drop in confidence with their colleagues, or they felt that expectations of them were unrealistic, this increased their self-doubt and belief in their abilities and readiness for qualified practice; supporting similar findings in previous research (Delaney, 2003; Duchscher, 2001; 2008).

For Rachel, feelings of not fitting in or being accepted by the team led her to doubt her ability and belief in herself. Here the drop in confidence appeared to have a cascade effect on Rachel's perceptions of how she was coping in her new role and how she was being supported. Consequently, the reality shock increased, and she was less able to align herself with her new role and working environment. From Bourdieu's concept of habitus (Bourdieu, 1992) if the NQN is unable to adjust their perceptions and assumptions to their new role and environment they are less likely to feel that they fit into the culture of their workplace. Within the current study, Donna and Vivian were able to recognise the need to adjust their habitus (Bourdieu, 1992), and were able to seek out support and reassurance. However, for Nora and Rachel, they were not able to recognise or make the adjustment to their habitus, leading to increased stress and reduced self-confidence.

This finding supports the importance of ensuring that as part of preparing students for qualified practice, consideration needs to be given to the individual doxa and habitus of different workplaces, and the personal habitus of the student. Through opportunities to network with qualified staff, reflexive practice and development plans, students should be encouraged to consider how previous experience has influenced their perceptions, how and if those perceptions are changing and what they can learn about themselves to aid in the development of resilience. For staff in the workplace, CPD opportunities should be available, to help them to develop their understanding of the change that occurs to professional identity and status on qualification, and the different ways individuals react to this. Through exploration and discussion of these factors they can be encouraged to explore their own expectations and perceptions and identify if there are factors that influence their expectations of NQNs (such as previous experience or age), and why those expectations may not be realistic.

Continued Professional Development for staff in the workplace and managerial support are necessary to ensure that expectations of NQNs are realistic and the importance of

preceptorship for all NQNs is understood. Practice areas, managers and senior managers in the organisation should understand the needs and value of the NQN and support the development of preceptorship programmes that aid the transition of the NQN into the workplace. Watson et al (2020) in the STaR Project suggested that supporting the NQN's transition to the workplace can be effective in empowering the NQN and reducing their stress during the transition period.

One factor that promoted confidence in all the participants, was in relation to their technical skills, particularly in comparison to NQNs in the workplace who had studied at other HEIs. Participants working within local trusts and those who had moved around the country to other workplaces commented on how their technical skills had made them stand out as NQNs. As an added extra to their pre-registration programme, participants had developed the skills of cannulation, venepuncture and catheterisation. Whilst they had not considered these to be significant during their pre-registration programme, they were now seen as commodities that made the participants stand out compared to other NQNs. Bourdieu (1992) explained this through the concept of capital. The additional technical skills that these NQNs had, gave them additional worth within the workplace, increasing both their cultural and symbolic capital. The NQNs were able to use that additional capital to demonstrate their usefulness within the team and Bourdieu (1992) argued that this gave them greater power and position within the workplace, compared to others. Whilst the development of additional technical skills can be a tangible commodity for NQNs in their qualified workplace, HEIs need to explore innovative approaches within the curriculum for the development of less tangible but important skills, such as resilience and ability to adapt to change and manage stressful situations. Students should be provided with exposure to the multifaceted role of qualified practice, with more opportunities to prioritise a full workload under supervision. Exposure to clinical supervision opportunities and sessions on stress management and personal well-being, will help to develop the reflexive and resilience skills needed for practice readiness. Additionally, supporting students to review

their changing capital to identify areas where they are struggling can form part of a personal transition support programme that can be continued through preceptorship.

As with previous research (Hunter and Cook, 2018; Ortiz, 2016) responsibility and accountability were of concern for participants in the current research. However, there was a growing sense of acceptance and achievement related to managing the new levels of responsibility and accountability, and a recognition of their new position within the workplace. Bourdieu (1992) suggested this new level of responsibility brings greater levels of status and respect for the NQN, known as cultural and symbolic capital within the workplace. For Donna, this became apparent when the responsibility she now had as a qualified nurse gave her a stronger voice when discussing patients' needs with doctors. She perceived that her opinion was not only valued now but was actively sort out. For Michael, this gave a sense of empowerment and agency, but for Becky this provided a level of fear.

Demographic data can provide insight here, worthy of further exploration in future studies. Whilst Michael and Becky worked in very different environments, they both felt their workplaces had been supportive in the development of their new role. However, Michael had greater life experience than Becky; he had family responsibilities and had used responsibilities from a previous career in local government to adapt to his new role. By comparison, Becky had little responsibility outside of her own learning and had moved away from home to enjoy the student experience before settling down into her qualified role. As a result, she had not yet been able to develop the same skills as Michael and was more fearful of how she would now deal with the responsibility she had. As Becky described, the new level of responsibility and accountability was perceived as a potential threat to the registration that she had worked so hard to achieve.

This perceived threat, is not a new phenomenon, and is identified in the literature (Gerrish, 2000; Hawkins et al, 2018). However, Becky did feel that due to the supportive environment in which she worked, she could ask for help when she needed reassurance that her practice was safe. Although 60% (n=12) of participants had started to manage the realities of their accountability and responsibility within a few weeks of starting their new job, this was not the case for Rachel. Rachel was unable to adapt to her new level of responsibility and accountability, and she had made the decision to leave her job and seek employment where she perceived the levels of responsibility to be more manageable. As she explained:

I know hate's a strong word, but I wasn't enjoying it. I was getting up in the mornings and I was dreading going to work. And that's not – that – that shouldn't be – that – that's not, that's not what nursing's about. I enjoy what I do, and I think when you feel like that it's time to move on [line 566].

In Rachel's case, although she had been able to develop some life skills to help with her transition, the lack of support or formal preceptorship in her workplace prevented her from applying those life skills to her transition experience. She was not yet ready for the level of responsibility expected of her, or the reduced level of support available. Although 60% of participants had been able to adjust to the demands of their new roles and felt well prepared to deal with the changes, the unique perceptions of each participant meant that this had not been the case for everyone, and for Rachel, the change had been overwhelming. Duchscher's (2012) transition shock model illustrates how Rachel's experience is not unusual amongst NQNs. Duchscher and Windey (2018) argued that the change in expectations for NQNs can be overwhelming during the early weeks of qualified practice and can lead to a fracturing of the professional identity and a substantial increase in anxiety and stress levels for some individuals. This highlights the complexities of the transition process for students, employers and HEIs. Whilst life experience can be

beneficial in aiding the transition to qualified practice, support from within the workplace is essential to help the NQN transfer that experience and adjust to their new context.

When discussing time management only 50% (n=10) of participants felt they were managing their time well. There was a frustration repeated by 50% of participants, that they had not been sufficiently prepared for the time management realities of their job role with concerns that this would be perceived negatively by their colleagues. Within the pre-registration programme there is a balance to be met around providing students with sufficient opportunity to develop time management skills and meeting the needs of patients and the service. There needs to be greater exploration of how students in their final periods of clinical practice can gain the skills of dealing with multiple demands and prioritising (Hunter and Cook, 2018), with consideration of how simulated experiences in the HEI can support this development in a controlled environment.

Qualified nurses in the clinical area need to have opportunities to develop their knowledge and understanding of the needs of students prior to qualification, through continued professional development, online support networks, updates and seminars. Through discussion of their perceptions of the needs of senior students and NQNs, there can be greater consideration of what are realistic expectations from students and NQNs, but also reasons why qualified nurses may be reluctant to expose the student to the full reality and demands of the qualified role. Using simulated wards, interprofessional learning activities and timed role play activities in the HEI, students can experience challenges of time management and prioritising, with opportunities to reflect and learn from those experiences. Whilst this cannot fully prepare students for the realities of working as a qualified nurse, it can provide opportunities for them to recognise the challenges and stress that comes with this element of the role, to start to develop resilience mechanisms and realign their habitus in readiness.

For Vivian, Linda and Donna there was a recognition that some of the challenges associated with the demands on their time could be associated with the workload placed on nurses in contemporary nursing practice and the shortage of nurses across the sector, rather than just an unrealistic expectation of them as NQNs. They realised that the level of workload they had been exposed to as students was not a true representation of the demands of their qualified role. They had expected to follow a set of rules and culture prepared for during the -pre-registration period, but the reality of the doxa was not what they had anticipated and caused stress and confusion as they attempted to adjust to it. They discussed how they felt they had been protected and cushioned by their mentors during their final clinical placements. This had allowed them to focus on some of the decision-making areas of the qualified role but did not enable them to balance that against the more bureaucratic elements of the role. Consequently, they felt underprepared for the realities of workload and time management in practice and less effective in prioritising and managing their workload effectively.

As Generation X or older Generation Y NQNs, they had time management skills and resilience from their life experiences that could have been developed to help with this adjustment. But these skills had been overlooked by mentors during their pre-registration journey and they were only now learning how those valuable skills could be transferred to their nursing role. The lack of preparedness in workload and time management for 50% of the NQNs in the current study had increased their anxiety around being a safe practitioner and an effective member of the team. As Isabella explained:

It was like the sheer magnitude of what you had to sort of achieve on each shift was so different [line 469].

The confidence in their time management skills developed as a student, did not translate and align with the realities of qualified practice. Consequently, the NQNs did not have the

level of capital (Bourdieu, 2000) they had anticipated, as part of their new professional identity. Similarly, the STaR project (Watson et al, 2020) concluded that despite investment into systems and processes, the transition experience of the NQN had not changed to any great extend and workload and time management continued to be an issue.

Findings from the current study suggest that through greater integration of pre-registration simulated HEI activities and exposure to the challenges in clinical practice, the protective cushion provided to students, could be gradually withdrawn as they develop their time management and resilience skills. For students where time management and workload were areas of difficulty or challenge, this would then highlight where greater support and development was needed during the preceptorship period. Close liaison between the Practice Supervisor, Practice Assessor and Academic Assessor during the pre-registration period, followed by similar liaisons between the HEI and employer on entry to the workplace could then enable development of individualised preceptorship programmes.

6.4.1 Summary of theme two

NQNs identified several factors they perceived formed the reality of their experience of qualified practice. Whilst some level of reality and transition shock (Kramer, 1974; Duchscher, 2012) was experienced by all participants, there were perceived to be differing levels of preparedness, some of which were linked to demographic or generational influences.

Socialisation into the workplace, with understanding of the doxa of the environment (Bourdieu, 1993), was a positive experience for 65% (n=13) of participants, which is an

improvement on the studies of Kelly and Ahern, 2009 and Hunter and Cook, 2018, where no NQNs found their socialisation into the workforce to be a positive experience. However, for the 35% (n=7) of participants in this study who had difficulty adjusting to the workload and demands of the nursing habitus (Bourdieu, 2006), the realities had caused high levels of stress, leading to two participants resigning from their roles and another participant considering leaving. For 85% (n=17) of NQNs, confidence was improving, and they perceived that they were coping well; but for NQNs having difficulty aligning to the realities of their new role, there was a sense of shock and disappointment (Kramer, 1974; Duchscher, 2012). Despite this, issues around oppressive practice appeared to be diminishing and the symbolic violence described by Bourdieu (Grenfell, 2014) was not experienced by any of the participants.

Accountability and responsibility were areas of stress for participants in the study, but 60% were able to adjust to the new expectations quite quickly. An area of frustration however, remained around time management and workload expectations. The level of preparedness experienced during the pre-registration programme was not sufficient for the nursing habitus (Bourdieu, 2006) expected of them as qualified nurses. For some NQNs their vast experience of time management and multi-tasking linked to their life experiences and skills, had not been sufficiently supported and developed for transference to their qualified nursing role.

Overall, within this theme there were indications of positive perceptions of practice readiness, but issues remained for 45% of NQNs around their need to develop greater resilience and align their personal and nursing habitus (Bourdieu, 1992; 2006) with the realities of qualified practice.

New findings relating to this theme were:

- NQNs perceive they are seen as a threat when they are provided with training opportunities that are not made available to other staff in the workplace.
- The introduction of the NQN changes the workplace dynamic and some staff can have difficulty managing this. When support is not available to staff in the workplace from managers, they may be less able to then support the NQN.
- Students need more opportunities during their pre-registration programme to explore their perceptions of qualified practice and consider how their perceptions may need to change.
- Life experiences contribute to the personal habitus of the NQN and for some, those experiences can be beneficial in helping them to develop resilience and skills of adapting to their new identity and role. However, some NQNs have difficulty adjusting the personal habitus developed from their life experiences and require greater support during the pre-registration programme and transition period, to help them to challenge their perceptions and expectations and adjust their habitus accordingly.
- Generational differences can alter workplace expectations of NQNs with some workplaces assuming that older NQNs will transition more easily due to their age and past experiences. However, the support needs of Generation X NQNs may be different to the needs of their younger peers, but need to be addressed, if they are to have a positive transition to their qualified role.
- NQNs with extensive previous care experience can struggle to adapt to their new professional identity and role within the workplace and need support to adapt to the more leadership and management role of being a qualified nurse. Whilst these NQNs may have additional experience that they bring to their qualified role, they need support and reassurance as they change their position within the workplace and adapt to the new capital that qualified status has brought.

- Staff in the workplace need CPD opportunities to develop greater understanding of the changes that occur to professional identity and status on qualification and influences on their perceptions of NQNs.
- Students need greater support during their pre-registration programme to develop resilience and stress management techniques.
- Students need greater exposure during the pre-registration programme to the multifaceted role of qualified practice.
- Students need greater support to understand and manage their changing capital as they move through their pre-registration programme and their transition to qualified practice.

6.5 **Theme three – This is me!**

This theme emerged from participants' perceptions of who they are now as NQNs. When participants were asked about their position within the workplace and how they viewed themselves; five sub-themes were identified that they associated with their current role and experience (sign-off experience, how I feel, doing it, decision making, job satisfaction). For 75% (n=15) the realities of qualified practice had come as a shock (Kramer, 1974), but they felt they were prepared to deal with those realities and were continuing to develop their role and their professional identity.

Hart (2019), Pearson (2009) and Whitehead et al (2016) suggested that the sign-off placement is a significant time in preparing students for their transition to qualified practice. However, for 70% (n=14) of participants in the current study, the sign-off period was not perceived to be an influencing factor in developing their readiness for the qualified role. When asked about their choice of workplace one participant had chosen an area unfamiliar

to them but with a good reputation for support and learning opportunities. Fourteen participants had chosen specialisms where they had a long-held interest, enhanced by a pre-registration experience, or specialism where they had developed an interest during a pre-registration placement. None of these placement experiences were the final sign-off placement but in all cases, participants explained how their interest had been piqued by the experience and they had been keen to return as a qualified nurse.

This new knowledge contradicts previous findings that suggest it is the sign-off placement that is significant, and instead suggests that it is the quality of the learning experience at any point during the pre-registration programme. 85% of Generation X participants identified that returning to an area where their interests lay was more important than remaining in the same area for their transition to qualified practice. Similarly for 58% of Generation Y participants, developing their early career in a specialism of choice was considered the most influential factor in their choice of workplace. This suggests that allowing students to choose their sign-off placement in an area of interest to them may be beneficial to allow them to continue to develop their early career focus with the continuity for transition suggested by Whitehead et al (2016); something that the STaR Project (Watson et al, 2020) suggested warrants further research. Findings from this study identify that for 70% of participants, and particularly Generation X participants, having choice is important, and students should be involved in the planning of final placement allocations, through an opportunity to identify preferred areas wherever possible.

Only 25% (n=5) of participants had chosen to return to their sign-off area for a qualified job, and this was linked to the sense of belonging they had experienced as a student and the perceived support that would be available to them as an NQN. Of those five participants, four were categorised as Generation Y, providing evidence that for this generation the reassurance of a supportive environment can be a key influence in their choice of workplace. For all the participants who chose to return to their sign-off placement

for their first qualified job, going to university and gaining a degree was a form of capital not seen before in their family. For this group, remaining in a familiar environment was important as they adjusted to their new levels of capital. This is a new finding, as it suggests that for some NQNs, they require an element of consistency as they adapt to the multiple changes they experience on qualification.

In addition to their new status within the workplace, these NQNs now had increased capital in their symbolic and personal habitus. The way they were now viewed in society brought a level of status they were not familiar with, and this was another factor they were having to learn to adjust to. The familiar and supportive environment of their sign-off placement provided a level of reassurance as they transitioned to their new professional and personal roles. For four of these participants the decision to return to the area as a qualified nurse proved to be a positive one; but for Rachel the change in expectations of her on qualification were not anticipated and she resigned within a few weeks of commencing in post. This suggests that the familiarity of the NQN to the workplace may bring a level of expectation from colleagues that the NQN does not feel able to meet. If the NQN has chosen the area because they need additional reassurance as they realign their habitus, but the workplace expects there to be less need for support due to a level of familiarity and understanding of the doxa, it can lead to conflict, stress and in some cases, like Rachel's, attrition from the role.

The transition process should start towards the end of the pre-registration period, with individualised preceptorship arrangements agreed between the workplace and soon to be NQN, with support from the HEI. Individual needs including support relating to their changing habitus can then be identified. Greater consideration needs to be given to the impact of the increased capital and status that the qualified role can bring to the NQN, outside of, as well as inside the workplace, as this is not something that has been evidenced before in the literature. Through understanding of the impact of changes such

as being the first in the family to gain a degree, the NQN can be reassured that whilst their changing habitus and social status can be difficult to adapt to, with support they can adjust and recognise that their achievement will provide them with future social, professional, and personal opportunities.

For the 75% (n=15) of participants who felt they were making good progress and coping well, there was a sense of surprise and pleasure when they identified this verbally. They acknowledged that some days were difficult and challenging, but this was seen in a wider context and viewed as an opportunity to learn. For these participants there was a recognition that their role and identity had changed on entry to qualified practice. Chick and Meleis (1986) suggested that understanding and appreciating that the change was a normal part of their transition allowed the experience to be a more positive one. For Donna, on days when she did not feel things had gone well, she reflected on how she could do things differently and felt able to discuss her feelings with her colleagues. Although Donna had not initially found her change in role easy to adjust to, her extensive experience as a care worker had provided her with sufficient confidence to approach her colleagues for support. She had waited a long time to become a qualified nurse, completed an access to higher education programme to enter her studies, and been the first in her family to attend university. Because of this, she had developed a level of determination and resilience that she was now able to use to help her to succeed in her qualified role.

The life skills she had gained before commencing her nursing studies had helped her to realise that she would not always feel that she was coping, but that with support she could continue and would succeed. These are valuable skills that NQNs are not always aware they possess. It is important that the journey taken to reach qualified practice is explored as part of the pre-registration programme and through preceptorship, so that areas of skill

and resilience can be reinforced and used to support the student throughout their studies, and the NQN in their transition.

For the participants who did not feel they were coping with their new role (n=5), it appeared that they were both angry and disappointed. Although they perceived they were prepared on entry to their workplace, for them the realities of practice could not be aligned to their ideals of what qualified practice should be. For these participants, their personal habitus had not been sufficiently adjusted to fit into their new environment (Johansson, 2014) and they struggled to fit into the collective habitus of their workplace (Wacquant, 2004). This may not have been the case, had they entered qualified practice in a different workplace as each environment will be different. However, this finding provides evidence that there needs to be recognition of the differences between workplaces and in the way that individuals' respond to those environments. By providing bespoke support opportunities to NQNs, individual needs and differences can be acknowledged, their areas of concern or difficulty can be identified and transition support through individual preceptorship arrangements can be introduced.

A common thread amongst this group of participants was the need for more support and a more gradual introduction to their qualified role and their new responsibility. Whilst they acknowledged the expectations that came with their new role and new professional identity, they had not felt able to adjust to those expectations whilst managing the demands on them in the workplace. For Nora and Rachel, the feelings of stress and anxiety had led them to decide to leave their current qualified roles and consider whether to remain in the profession. The lack of individualised support and preceptorship in their workplace, and a lack of recognition of their needs had been a shock after their experiences as a student. They had perceived that they would receive preceptorship like the mentorship they had received as a student. Despite their difference in age and previous experience, both Nora

and Rachel felt that they needed a more gradual transition to their qualified role with a level of support that was not available in their work areas.

As part of preparation for qualified practice it is important that discussions take place with student nurses in their final year to explore the purpose and process of preceptorship. Through liaison between preceptorship organisers and the HEI, students can then be given opportunities to explore what they can expect from preceptorship and how they can seek extra support if they feel they are struggling. This type of exercise may also help preceptorship organisers to explore ways to develop more bespoke approaches to transition programmes that are tailored not only to specific areas of the organisation, but also to the needs of the NQN. Individual meetings with workplace area preceptorship leads and HEI tutors, prior to the commencement of qualified practice could help the NQN explore their expectations of preceptorship. Specific needs and areas for further support could be identified, to inform the preceptorship programme if needed.

HEIs work closely with clinical partners to ensure that placement experiences are high quality, and they share the responsibility for the monitoring of placements with Health Education England, reporting to the NMC. However, the quality of placement experiences, support available to student nurses and positive role modelling of qualified nurses can be variable. West et al (2020) argued that there is a lack of agreement between educational institutions and clinical practice areas about what constitutes practice readiness and realistic expectations of NQNs on entry to the workplace. Consequently, student nurses receive mixed messages about what they need to be prepared for and the expectations of them within the workplace, once qualified (Wolff et al, 2010).

Within this study there was an excitement from participants, that they were now practicing as qualified nurses – ‘doing it’, and had the symbolic and cultural capital (Bourdieu, 2000) associated with being a qualified nurse. Kramer (1974) identified this as part of the

honeymoon phase of transition, but, within the current study, even when participants were feeling stressed and anxious about their new role, they all still felt excited about the opportunity to put into practice their skills and knowledge as an NQN. This suggests that the first two phases of Kramer's (1974) transition theory are closely interlinked and supports Duchscher's (2008) view that the process of transition is not linear. Overall, all participants felt that the pre-registration programme had provided them with the knowledge and technical skills for entry to qualified practice, even if there were specific areas for each individual where they felt less prepared. However, they acknowledged that their learning would continue now they had entered qualified practice with greater exposure to a range of different situations and challenges; with Gaynor acknowledging that this was only the start of the learning journey.

For 25% (n=5) of participants, while they felt that their pre-registration studies had provided them with knowledge and skills to enter qualified practice, they reported difficulties adjusting to some aspects of their role. Although they felt they had received sufficient placement experience and theoretical learning, they suggested that a more gradual introduction to a greater workload as a qualified nurse, and more supportive approach from their colleagues in the workplace would have improved their transition.

A greater emphasis on problem-solving scenarios and solution focused activities during the pre-registration programme, requiring students to apply their skills of negotiation, problem solving, team working, and delegation could assist students to see how their newfound knowledge and skill can be applied to different situations and help with their transition to qualified practice. For students who find this type of activity difficult, individualised support should be available from tutors and Practice Supervisors, to enable them to practice and develop confidence in recognising their abilities and using their different skills to negotiate the types of problems seen in contemporary nursing. Reflexive practice should be developed further, to encourage students to consider areas of

challenge and difficulty and explore coping mechanisms and support to help them to deal with those challenges and overcome their difficulties.

Practical placements were seen as very beneficial to participants, providing exposure to positive role models to emulate and poor role models whose practice should be avoided. Bourdieu (2006) suggested that through such exposure the characteristics and expectations associated with nursing habitus can develop and integrate into the individual's practice. Despite the recognition of the preparation provided during the pre-registration period, there was an acceptance by five of the participants that a full appreciation and understanding of the qualified role and the professional identity of the qualified nurse could only occur once immersed in qualified practice. The realities of working in an area with heavy workloads and staffing difficulties was not something that Donna, Linda or Vivian felt they could have been prepared for prior to their entry to qualified practice. They felt that they had learnt how to practice as a qualified nurse but applying that learning within the unique context of the challenges of their workplace could only come with experience. For Gaynor, her pre-registration preparation had prepared her for nursing within the community. However, the sense of isolation she felt when she was working alone on the district on a daily basis was something that she felt she had to learn to adapt to over time.

For Rachel and Donna, the changes to their personal and professional habitus through their increased capital was not something they felt could be prepared for in advance. As first-generation graduates with non-traditional entry to their degree programme, they had concentrated on acquiring the knowledge and skill to achieve their degree and professional qualification as a nurse. However, they had not been able to align those achievements with the responses to their changed status they then received both in the workplace from colleagues and from society. For Donna, reassurance from colleagues that her newfound respect from the multidisciplinary team and senior colleagues was deserved and

appropriate, helped her to adjust and align her personal habitus with her new professional habitus. But, for Rachel the change to so many areas of her capital and the lack of support and reassurance from workplace colleagues was too overwhelming.

Whilst the student nurse may develop the more general characteristics expected of the nurse, Bourdieu (1992) argued adapting those characteristics to the explicit and implicit rules of the workplace (the doxa) can only occur when the individual is involved in the shared beliefs and powerbase of that workplace. For the NQN, exposure to the workplace demands, culture and unwritten rules is therefore arguably necessary for them to align their new professional attributes to the reality of qualified practice. As Vivian stated:

"I don't think anything can prepare you. You'll learn the job, on the job" [line 326].

This echoes the findings from Dearmun (2000) and Feng and Tsai (2012) who suggested that NQNs can only feel that they are performing as a qualified nurse, with the associated professional identity, once they have learnt the culture of the workplace and adapted to working within it. For Vivian, the only way that she could ultimately be ready for qualified practice, was to be immersed within it.

These findings suggest that workplaces need to consider the unique challenges within their areas and how preceptorship programmes can help the NQN adapt to those changes. Some of those challenges may appear obvious, for example, solo working in the community. But, if the NQN has never been able to experience solo working during their pre-registration programme and has no previous solo working experience to draw on, this may be something that needs to be identified as part of their preceptorship support; helping them to adapt and develop coping mechanisms when calling for assistance and managing situations alone. Inclusion of workshops within the pre-registration curriculum where students can explore 'a day in the life of', with different nurses, could be opportunities for

this type of challenge to be raised to encourage students to start to consider how they can be prepared for their chosen specialism. Similar opportunities with recently qualified nurses may provide opportunities for discussions around the change that can occur to the different types of capital and how those changes might be managed.

There also needs to be discussions between ward managers, senior managers and HEIs around staffing shortages in areas where students may be taking up qualified positions. Through these discussions there can be identification of additional challenges that await the NQN and the pressures on staff in the workplace who will be expected to support the NQN. Senior managers should then ensure that as part of the preceptorship arrangements for the NQN, additional support is made available to both the NQN and staff in the workplace. Regular well-being checks should be made to ensure that the NQN's addition to the workplace has not increased the stress on staff and that the challenges of the workplace are manageable for the NQN.

One way that NQNs evaluated their readiness for practice was through their ability to work autonomously and make independent decisions for their patients. For 90% of participants, they had embraced the autonomy gained from their independent decision making. Kelly and Ahern (2009) argued that it is difficult for NQNs to make critical decisions as they have not been exposed to that level of responsibility as a student. However, for many student nurses they bring life experiences and experiences from previous careers to their nursing roles. It is not unusual for student nurses to leave highly responsible careers to enter the nursing profession.

Within the current study one student had previously had an international career, one had run her own business, two had previously had positions of responsibility in the local authority, and five had more than five years of healthcare experience. In addition, half of the participants were parents and had been rearing their families alongside studying for

their nursing degree. It is important that during the pre-registration programme these types of experiences are drawn upon to remind students of the critical decision-making skills they have, and their capacity for managing responsibility and accountability. If this is not explored and reinforced during the pre-registration period, some students may not see the importance and relevant of those transferable skills in their transition to qualified practice. Where students do not have these life skills, extra support should be given during the pre-registration programme and they should be encouraged to take positions of responsibility, for example, as a student representative, to help them to develop those skills. For Olivia, she had not entered the programme with many life skills and had found this area of her development during her pre-registration programme more difficult. As a result, on qualification there was an anxiety that although she was equipped with the knowledge and skills to make decisions, the lack of experience with autonomous working had created pressure which had in turn led to self-doubt. Duchscher (2012) identified within her theory of transition shock that this was a normal reaction for the NQN but acknowledged that it was nevertheless a difficult and stressful part of the transition process.

The findings from this study suggested that in the main, NQNs were able to take their confidence around decision making from the pre-registration programme and apply it to their qualified practice. From Bourdieu's (1992) concept of cultural capital, 90% of the NQNs entered their workplace with a new level of power, enabling them to be autonomous practitioners and make clinical decisions; however, for 10% (n=2) of NQNs, the responsibility that came with that decision making created an anxiety that led to self-doubt. Alongside this, their changing personal and nursing habitus (Bourdieu, 1992; 2006) created a disruption to the NQNs' familiar reference points, causing increased uncertainty and stress. For these NQNs, making critical decisions and developing their professional identity became more of a challenge.

When the NQNs were not able to align some of their expectations with the reality of their role, they expressed a lack of job satisfaction. This is not a new concept and has been documented in the literature as a key factor in the retention of nurses to the workforce, (Kuo, Lin and Li, 2014; Moloney, Gorman, Parsons and Cheung, 2018). Although Mackintosh (2006) argued that professional socialisation is significant for ensuring job satisfaction and retention within the profession, Dorcy (1992) suggested that for professional socialisation to occur, there must be learning and understanding of the values, attitudes and behaviours associated with that professional role, the nursing habitus (Bourdieu, 2006).

Within the study 70% (n=14) of participants said they were experiencing job satisfaction, but 30% (n=6) said they were frustrated with their qualified role. For 75% (n=9) of Generation Y participants there was satisfaction with their job and their new role. However, for Generation X participants the figure for job satisfaction dropped to 37.5% (n=3). All Generation X participants had returned to study to enable them to enter University and they had entered nursing at an older age. For them, following a long-held desire to become a nurse and having a career that gave them the satisfaction they had been longing for, was important. They discussed the challenges of returning to formal education whilst holding down jobs and managing family commitments and how this had given them a determination they had not had previously. For them, becoming a qualified nurse was more than just a qualification, it was the achievement of an ambition they had once thought they would never fulfil. They had expectations about what being a qualified nurse would be, and for some like Donna, with support through her pre-registration programme and from her workplace, she was able to adjust her expectations to identify the difference she was making, bringing her job satisfaction. However, for Michael there had been disappointment that he no longer had as much time to spend with clients, as he had before qualification. He was adjusting to his new role with support of his workplace, but he had needed to continue to work to align his expectations with the reality of his role.

Across both generations, for participants who felt they were doing a good job, socialisation was occurring and there was an increasing confidence and job satisfaction with feelings of accomplishment within their new role. When participants expressed dissatisfaction in their new role, there was evidence that they had not been able to align an element of their ideology with the realities of practice. Opportunities need to be provided throughout the pre-registration programme to evaluate the journey towards qualified practice. Skills and experiences brought to the programme should be developed to support transition to the qualified role. Reflexive practice focused on individual development throughout the pre-registration programme should be linked to bespoke preceptorship support arrangements. This would enable greater discussion around the strengths and needs of the student, their expectations of qualified practice and the realities of the challenges they face as they move towards their transition period and qualified role.

For Julie, Michael and Rachel, they felt that they had developed the knowledge and skills to provide hands on care to patients, but now their role was more administrative and managerial. They explained that they were frustrated because they could not provide a level of basic care, they felt should be part of their role. By comparison participants who discussed satisfaction with their qualified role, were more focused on the ways they had contributed to making a difference to their patients' wellbeing. For these NQNs, a level of satisfaction came from making a positive impact, despite the challenges of contemporary nursing practice. Hunter and Cook (2018) contended that NQNs need to be able to develop a positive identity if they are to gain job satisfaction and remain within the profession. This would appear to be something that the NQNs in the current study who were more satisfied with their role, had been able to achieve.

6.5.1 Summary of theme three

Entry to qualified practice was an exciting time for 15 (75%) of the NQNs and they were pleased to finally be 'doing it'. The practice element of the pre-registration programme was perceived to be a key influence in preparing them for their qualified role; however, 25% (n=5) of NQNs felt they could only really develop their professional identity and understand their qualified role once they were fully immersed in qualified practice. Bourdieu (Johansson, 2014) suggested that changing the personal habitus to fit within their new environment was an important development for the NQNs if they were to have a positive transition experience. 75% of participants felt they were adjusting to their new role and felt their pre-registration preparation had helped them cope with the more difficult days in their transition. For the NQNs whose transition was more problematic, there was a recognition that their ideals were not aligning with the realities of practice. These NQNs expected greater support and nurturing to help with the transition and were disappointed that this was not available in their workplace. They had not developed sufficient capital (Bourdieu, 2000) to align their expectations with the habitus of the workplace (Bourdieu, 1993) and required greater levels of support to make an effective transition (Meleis et al, 2000).

To support all NQNs to develop the capital to align their expectations with the habitus of the workplace, more needs to be done within the pre-registration programme to recognise the skills and experience they bring to the programme. They should be encouraged to understand the value those skills and experiences have to enhancing their confidence, self-belief, problem solving time management and resilience. Through networking opportunities with nurses from qualified practice, students can discuss the challenges of being a nurse in contemporary healthcare, identify life skills they possess and how those skills could be used to help them manage the challenges they will face when qualified.

By introducing this type of experience early in the curriculum, alongside solution focused activities, early challenges to personal habitus can occur and students can be supported to become more flexible in their expectations. By increasing these types of activities through years two and three of the pre-registration programme, students can build up their confidence and recognise their increasing cultural and symbolic capital. These activities should be supported through close liaison with Practice Supervisors and Assessors to identify areas of support for each student and to ensure regular constructive feedback is given. Where students have less life experience before entering their pre-registration programme, they should be encouraged to engage in initiatives to develop greater skills of responsibility and time management, and should be assisted to see the value these skills will have to increase their capital and prepare them for qualified practice. Alongside final placements in identified workplace areas, bespoke preceptorship support should link to the final part of the pre-registration studies. These activities can help to build the capital of the student and assist them to challenge their assumptions and adjust their habitus in readiness for qualified practice.

It was reassuring that 90% of NQNs felt well prepared for decision making but it remains a concern that 30% expressed some level of frustration or dissatisfaction. This was particularly significant to Generation X NQNs who had entered the profession later in life and all but one of whom had at least two years previous care experience. Although greater levels of satisfaction may occur as NQNs are more able to align their expectations to the realities of the role, the risk of some leaving the profession remains. The nursing habitus (Bourdieu, 2006) that the pre-registration programme had prepared them for, had not translated to the realities of qualified practice. For these NQNs, further adjustments to their expectations and prioritising of their increased workload were required, through support of their preceptor and colleagues during the transition period.

New findings relating to this theme were:

- The quality of the practice learning experiences at any point in the pre-registration programme can influence where NQNs choose to start their qualified career.
- Taking up a first qualified post in an area of interest is more important to Generation X NQNs than the continuity of staying in the sign-off placement for their employment.
- Generation Y NQNs who are first generation graduates prefer to remain in the sign-off placement for their first job, as they require an element of consistency as they adapt to the multiple changes to their capital on qualification.
- If the student remains in the sign-off placement as an NQN there can be conflict between the workplace assumptions of reduced preceptorship needs and the support expectations of the NQN.
- Greater consideration needs to be given to the impact the increased capital and status of qualified role can bring to the NQN, outside of, as well as inside the workplace. The NQN needs support through the preceptorship programme as they adapt to these changes.
- Previous life experiences can support the development of resilience through the pre-registration programme to help the NQN cope with the changes, increased responsibility and challenges they experience during their transition to qualified practice.
- Greater exploration of changing personal and professional identity, particularly in relation to changes in capital, during the pre-registration programme could help to prepare NQNs for the adjustment to their habitus on qualification.
- There should be greater liaison between healthcare providers and HEIs, for areas under workload or staffing pressures, to ensure that NQNs entering those

areas, and staff working in those areas, receive additional support during the preceptorship period, including well-being checks.

- Generation Y NQNs report greater job satisfaction than Generation X NQNs at the beginning of their qualified career.

6.6 Theme four - Perceived effects of evolving identity

The final theme focused on how the evolving role and professional identity of the NQN was influencing them in a wider personal and social context. In discussion of his concept of habitus, Bourdieu (1992) argued that as individuals gain power (capital) in one area (for example, professional status), their power in another area (for example, social status) can increase. For the participants, although their capital (their power) within their new workplace was not great in the hierarchical structure, their new professional role as a qualified nurse had brought increased capital. The new status as a registered practitioner had impacted on three distinct areas for the participants, and this was acknowledged by them in their discussions. They were able to describe the perceived changes to their capital across the three sub-themes of personal achievement, value in society, and influence in clinical practice.

80% (n=16) of participants discussed their pride in successfully completing their pre-registration programme and gaining the title of nurse. This pride in their achievement was identified by two thirds (n=8) of Generation Y and all Generation X (n=8) NQNs. All the Generation X participants discussed the achievement it was for them to gain a degree and a professional qualification, and how it was not something they had thought they would ever have an opportunity to do as they had not pursued their nursing career earlier in their lives. For twelve of the participants who expressed their pride, they were the first generation in their family to go to university and they felt an additional achievement as this

was a new phenomenon within their family; participants explained that this was something that most of their families felt was beyond their social standing. This was particularly so for Rachel and Vivian when they discussed how their sense of pride was reinforced by family and friends who were keen to let others know about their new status. Donna and Vivian discussed how their success had been met by surprise and awe from family and friends. The new professional status and degree provided greater social power to Donna and Vivian with family and friends, increasing their social standing with a level of respect and influence they had not had before. Bourdieu (1992) argued that these changes occurred because the NQNs were now operating in a different context (the qualified workplace) and were adapting their personal habitus to fit with the habitus of that area. As a result, as qualified nurses, the NQNs had increased their professional status and social power (their cultural and symbolic capital).

This finding identifies that the attainment of the degree and professional status has an impact that expands beyond the NQN's workplace and influences how they are seen and treated by family and society. When preparing students for their qualified role, it is important to consider how their capital will change and the impact this will have on their relationships and status in society. By providing students with opportunities throughout their pre-registration programme to explore and discuss any changes they feel are occurring in the way they are perceived by family and society, students can start to identify changes to their different capitals and their personal habitus. This can allow them to consider any challenges they find in adapting to these changes and allow support to be offered from peers, the HEI and staff within clinical placements. As they move towards qualified practice this will provide students with an awareness of their changing status in society so that they are less surprised at the changes on qualification. This is particularly important for NQNs who have difficulty adapting to their new capital and position in both the workplace and society. For NQNs like Donna, who felt that her increased status had brought extra pressure from society, having opportunities to prepare for this during the

pre-registration period would enable coping mechanisms to be developed. This should also be considered during the transition period when greater recognition needs to be given to helping NQNs to adjust to their new position within the workplace and within society. If individual preceptorship programmes are developed and opportunities are given for NQNs to meet in discussion groups and engage in one-to-one clinical supervision activities, this can assist in the adaptation to their levels of capital.

A change in capital is associated with a change in identity, and Duchscher (2008) argued that qualified practice brings a significant change to personal identity. At the beginning of the qualified journey the NQN needs to have an awareness of this changing identity to enable them to adjust to their socialisation in qualified practice (McKinney, Saxe and Cobb, 1998). Within this study participants identified that they were treated differently now, both in the workplace and within the wider community. The Generation X NQNs felt that doctors and more senior nursing staff now acknowledged their presence in the workplace; when patients' conditions were being discussed there was a perception that they had something of value to add to the conversation.

Using the generational traits identified in the Mind the Gap project (HEE, 2015), these experiences enabled the Generation X NQNs to enjoy the increased independence they now had within the workplace. By comparison however, Generation Y NQNs had more negative perceptions of how they were treated in the workplace and felt that they were seen as a nuisance when they asked questions or asked for reassurance. Their generational traits (HEE, 2015) suggest that it is common for Generation Y NQNs to require regular feedback and reassurance, and they can become anxious and disillusioned if these needs are not met.

This finding highlights the importance of recognising the impact of generational differences and ensuring there is understanding of those differences so that NQNs can receive the

support they need, and workplace colleagues can develop the different skills needed to provide that support. CPD opportunities to educate staff in the workplace about different generational needs with opportunities to explore how their own needs and approaches may differ to colleagues from a different generation would be beneficial. This type of activity could identify areas of possible conflict so that support from the HEI and senior management can be introduced to help to align and develop team working between the different generations.

There also needs to be more education in the pre-registration programme around generational differences, so that students can start to develop an understanding of the differing needs of individuals within both the HEI and the practice areas. Preparation of Practice Supervisors, Practice Assessors and Academic Assessors should include the exploration of different generational needs, the different types of support that students might need, and ways to manage that support if it does not fit with their own perceptions.

Thirteen of the NQNs discussed how they were now perceived to be more valuable to society and how that had helped them to develop their confidence and embrace their new social capital. However, for Donna, her new status had led her to perceive that as a nurse she was judged more frequently and more harshly than she had been previously, and she was still trying to adjust to what she considered to be her new place in society. For Donna the frequent recognition she received in the workplace did not extend to how she perceived the public viewed her and this had proved to be anxiety provoking. Providing increased support through reflexive activities and informal peer support groups during the pre-registration programme and during the transition period can help NQNs to manage any negative perceptions they associate with their changing status and may help NQNs like Donna to adjust more easily.

As part of their changing identity NQNs in the current study perceived that they were more effective in instigating change in clinical practice. 70% (n=14) of participants felt that as a qualified nurse they were more able to make a difference to the care their patients received. Bourdieu (1993) suggested that within his concepts of habitus and capital, the relationships people have within each setting (what Bourdieu referred to as 'field') are not static and are influenced by the social structure and dominance within that field. Through their increased capital as a qualified professional, Bourdieu (1993) argued, the NQN had changed position within the social structure of the workplace and was more able to impact on decisions around patient care.

Of the fourteen participants who felt they were now able to influence the care patients received, seven of them had more than 3 years previous experience working in health care and ten of them were the first in their family to gain a degree. For these fourteen participants, being influential and making a difference to the patient experience was considered a significant achievement to them as individuals. They had increased capital in the workplace, giving them more influence over making change, but they had also increased their personal capital. Either through their change of role to qualified status or as the first in their family to gain a degree, they had changed their position in society and were now seen with greater capital and therefore greater influence. This is an important finding as it illustrates the influence the qualified status can bring to NQNs' social status and opportunities. The change in capital and status had made participants role models for their children or other family members who now felt that a university education could be available to them, and had allowed them to organise foreign holidays, buy a car or buy a house for the first time in their life and this was seen as a reward for their hard work and determination.

6.6.1 Summary of theme four

The concepts of capital (Bourdieu, 2000) and their effects on habitus (Bourdieu, 1992) were clearly seen in the current study. Changes to existing capital, social systems, and relationships with family and colleagues can be anxiety provoking for the individual. The findings from this study bring new understanding to the transition experiences of NQNs, how the pre-registration curriculum can support students as capital and habitus change, and how NQNs can be supported into their qualified role. Although fitting into the team and understanding their place within the team was clearly a priority for the participants within this study, fourteen of the NQNs were able to identify how they were having a positive impact on patient care and making a difference to the patients. This was an important achievement for them and something they felt proud of. The recognition and prestige that their actions as a qualified nurse brought to them, had increased their symbolic capital (Bourdieu, 2000) and provided them with a sense of achievement.

The perceived change in personal and professional status was seen as a positive development by 80% (n=16) of NQNs. Their social standing and usefulness to society, their social capital (Bourdieu, 2000), had increased; and there was personal and family acknowledgement of their achievement and an increased feeling of value within the workplace. However, the effects on personal identity (Duchscher, 2008) came as a surprise to six of the NQNs and there was an element of difficulty adapting to the expectations and perceptions of the wider public. For Gaynor and Donna, the expectations of them as qualified nurses brought new social pressures that were different to adjust to.

Overall, the changes that had occurred in participants' capital had affected their position within the workplace and brought them more power within that habitus (Bourdieu, 1993), to influence the workplace culture and the delivery of patient care. A positive finding was

that participants perceived that they were able to make a positive impact within the workplace and continue their development as a qualified nurse.

New findings relating to this theme were:

- For some NQNs the achievement of the nursing degree brings a change of status that they had not thought was achievable.
- Where NQNs are first generation graduates, they can become role models for their families to continue their education to degree level.
- For first generation graduates there is an additional feeling of achievement and pride in achieving beyond their perceived social norm.
- Becoming a graduate and achieving professional status impacts the NQNs personal capital and how they are seen and treated by family and the wider society.
- Students need to be prepared for the changes to their personal and social capital that occur on qualification to help them to adjust to their changed social status
- NQNs can find their increased social status difficult to adapt to and need additional support to adjust to what they perceive to be increased social pressures on them.
- The increased capital that NQNs possess on qualification can make them greater change agents in their workplace and bring significant change to their personal habitus.

6.7 **Generational differences**

Latest statistics from the NMC register (NMC, 2021) identified that 63.5% of registrants are over the age of 40 years, indicating a high proportion of the UK workforce moving towards retirement (RCN, 2017). This creates an unusual mix of generations within the workforce with different traits and needs. Sherman (2006), HEE (2015) and Jones et al (2017) suggested that members of Generation X are very self-reliant, independent, and keen to have a good work-life balance. They work to make a living and have saved to have a comfortable lifestyle as they have got older. They enjoy structure and direction in their work but enjoy problem-solving and independent working. Whilst a career in nursing was not initially seen as appealing to a lot of this generation, many of them are entering nursing later in life as they desire jobs that they feel are more meaningful (HEE, 2015; Sherman, 2006).

By comparison, Sherman (2006) and HEE, (2015) suggested that Generation Y nurses are more ambitious and keener to gain recognition. For this generation, the work-life balance is key; they earn money to spend on their chosen lifestyle and want a better balance between home and work. Their work needs to have a purpose and a good teamworking environment is important to them. They have high career expectations, but not at the expense of their life outside of work, and they are willing to move between jobs and careers to achieve their ambitions. This is a generation that grew up in a more nurturing environment and as such expect a greater degree of support and encouragement to succeed (Sherman, 2006; HEE, 2015).

Although there were no Generation Z participants in the current study, they are now entering the workplace and bring another dimension to the generational challenges, as they are often referred to as “Digital Natives” (HEE, 2015). Generation Z are considered to have greater expectations of digital connectivity between the systems and

communication channels they are working with, becoming frustrated when technology is not streamlined. This generation is more resistant to traditional ways of working and is proactive in championing new ways and initiatives. With the range of generational differences and expectations now within the healthcare workforce, providing individualised support and development opportunities is particularly important, both to NQNs and to more experienced staff.

Between the two generations in this study there were some clear differences in perceptions, particularly in relation to responsibility and accountability, support, job satisfaction, and perception of others. Only 41.5% (n=5) of Generation Y participants felt they were sufficiently prepared to manage the changes in responsibility and accountability on entry to the workplace. By comparison 62.5% of Generation X (n=5) felt positive about the change and perceived that they had dealt with it well. One reason for this may be the additional life skills and work experience that all the Generation X participants brought to their new careers. Generation X students usually enter their studies after a significant period in the workplace, sometimes in roles of great responsibility. In addition, they often complete the programme whilst juggling family and managing household budgets. As a result, they have experience of managing responsibility and can use their life skills to support them in this aspect of their new role.

Within the current study all Generation X participants brought a range of life experiences had provided them with significant responsibility. They had all taken a non-traditional education route into their pre-registration programme whilst managing multiple demands and responsibilities. The Generation Y participants were divided between older members who had some previous work experience and were starting to raise a family alongside their studies. The remainder having either entered the programme straight from the completion of their A-level study, or shortly afterwards, had discussed having minimal responsibility outside of their own well-being.

Montenery et al (2013) suggested that Generation Y nurses are a more confident generation who value being part of the team. However, within this study there was an almost even split across both generations, of participants who felt they were confident and those who were struggling. There was a difference in the generational perceptions of how supported participants felt with a clear link in the literature between perceived support and the effects on self-confidence (Delaney, 2003; Duchscher, 2001). However, in this study 75% of Generation Y participants (n=9) felt well supported by their workplace compared to only 50% (n=4) of Generation X participants. Price et al (2018) suggested that this is important for the Generation Y NQNs in their negotiation of the challenges they face in the transition to the qualified role. They have a greater need for acceptance into the workplace compared to other Generations and require greater support in transitioning to the realities of qualified practice (Duchscher and Cowin, 2004).

It is concerning that only 50% of Generation X participants felt they received sufficient support from their workplace, and this may be linked to workplace expectations. NQNs discussed how they were frequently perceived to have been qualified for much longer by colleagues, patients, and families because they were wearing the staff nurse uniform. It may be that because they were older on entry to the workplace, the perceptions of their level of experience were exacerbated, leading to less support being offered and greater expectations of them compared to younger NQNs. Generation X NQNs are also less likely to seek frequent reassurance and feedback (HEE, 2015), which may be misinterpreted as needing less support. This indicates the importance of ensuring that NQNs are easily identifiable to the workplace team, and that individual support should be provided without assumptions based on generational traits.

Job satisfaction was an area that saw a clear difference in generational perceptions. For Generation X participants, 62.5% (n=5) did not feel they were gaining sufficient job

satisfaction, and this is concerning as job satisfaction has repeatedly been linked to nursing attrition (Moloney et al, 2018). The demographics of this study identified that 87.5% (n=7) of Generation X NQNs had previous healthcare experience. They had completed their nursing degree to extend the level of care they could give to their patients and be more influential in the decision-making processes. Now, as qualified nurses, their role had changed as they could no longer provide the level of basic care they had been used to providing and they were frustrated that this was due to workload demands and the need to delegate aspects of care. However, there was an appreciation that they could now enhance the patient experience and there was an acknowledgement that they needed to adjust their expectations to the realities of qualified practice.

By comparison 25% (n=3) of Generation Y participants were not satisfied with their role. Whilst this is a lower level of job dissatisfaction, Jamieson, Kirk, Wright, Andrew (2015) cautioned that the Y generation will choose to have multiple careers, unlike the generations before them, and there needs to be a greater focus on job satisfaction to retain this generation of nurses within the profession. For the 25% of Generation Y participants who were not satisfied with their role, they all had more than three years of experience in healthcare before commencing their nursing degree. They expressed similar frustrations to their Generation X colleagues in their increased administrative responsibilities and reduced hands-on caring role. For two of these NQNs they were adjusting to the differences the qualified role had brought, but for Rachel, this was another contributor to her difficulty in transitioning.

Research into Generation Y suggested that within the workplace, this generation particularly values positive socialisation, good team working support and mentorship to extend their learning and development (Hershatter and Epstein, 2010; HEE, 2015). Jamieson et al (2015) supported this view and argued that these can be key factors in job satisfaction for Generation Y nurses. Although 75% of this study's Generation Y

participants experienced job satisfaction, it is an area of concern that 42% (n=5) of them did not feel that they were perceived positively by work colleagues. This is disappointing given that 75% of them had felt well supported and 83% of them felt they had a positive impact on clinical practice. When they discussed how they felt they were perceived by others in the workplace, the 42% who did not feel they were perceived positively talked about the reactions they had from some staff in the workplace when they asked questions or wanted feedback or reassurance. They felt that they were seen as an extra workload by staff in the workplace and that as a result they were a burden rather than an effective team member, increasing their stress and anxiety. Even if they received support to develop and could see a positive difference from their practice, unless they felt welcomed into the workplace and integrated into the team, with frequent reassurance, this impacted negatively on their transition and development in the qualified role.

This finding provides greater understanding of the needs of this generation and the impact on the NQN's transition if the differing generational needs are not understood. There needs to be greater support for staff in the workplace to understand how generational differences may impact on the preceptorship needs of each NQN and how the NQN's generational traits may not align with their own. Through greater CPD opportunities for education around generational differences, and opportunities to explore assumptions and areas of conflict, a greater understanding of how different generations in the workplace can work effectively together can be developed.

The choice of workplace for Generation X NQNs was driven by their interest in a specialism. This interest had been present prior to the commencement of the pre-registration programme and enhanced by a placement in that area; or occurred because of an experience during the pre-registration programme. Findings from this study indicate that for this generation of nurses, starting their career in an area of choice that aligns with their career interests is more important than having continuity of workplace from sign-off

placement to qualified practice. By comparison, students from Generation Y are more likely to continue their qualified practice in the area of their sign-off placement where there is a familiar workplace environment, particularly if they are also adapting to significant changes in their capital and habitus. An example of this is when they are first generation graduates, and they are adapting to the changes in their culture and social capital which are influencing their personal habitus.

This insight can help tutors and employers to support NQNs when they are making career decisions about first workplace. By encouraging the NQN in their final pre-registration year to consider factors influencing them, and which of those factors is most important, they can be involved in choosing their final placement in an area that is likely to meet their needs and enable them to start their preparation for transition to qualified practice.

It is important that awareness and understanding of generational differences is increased in workplaces and the HEI. There needs to be more focus during the pre-registration programme on these differences and their potential impact on teamworking and support mechanisms. If students develop an awareness of the differing generational traits from the beginning of their programme, they can identify their individual needs whilst developing an appreciation of the needs of their peers and staff within the placement areas. Nurses in both the clinical and educational environments should be given opportunities to develop a greater understanding of different generational traits and how these can impact on the support that individual students and NQNs may need. Senior managers need to ensure that career opportunities are available to all staff and that support and well-being are priority areas within the work environment. Within the workplace, preceptorship programmes and CPD opportunities should be available that support the different generational needs.

For Generation X NQNs who have extensive previous experience in healthcare, they may need support to adapt to the delegation aspect of their role and opportunities to explore how their new knowledge and skills are making a difference to the patient experience. This Generation should have opportunities to reflect on their reasons for coming into nursing and how their ambitions can be met as they develop and start to influence patient care. Greater awareness needs to be given to assumptions made about this generation in relation to their length of qualified experience and need for support. Greater identification of all NQNs can occur using different coloured lanyards or badges that make them distinct to colleagues and the multidisciplinary team. For Generation X NQNs this will help to remove the assumptions made by some colleagues that they have been qualified for much longer and have greater experience as a qualified nurse.

For Generation Y NQNs, there needs to be greater recognition of their need for reassurance. Individual preceptorship programmes should provide regular feedback with discussions around career progression and career structures available to them as they develop. There should be opportunities within the organisation for them to contribute to innovative ideas around different ways of working, and how a better balance of life and work might be met.

Supporting the findings from the four themes discussed above, new findings from this study relating to Generational Differences were:

- Adapting to the increased responsibility of the qualified role is easier for Generation X NQNs, which may be due to their increased life and work experiences prior to undertaking their nursing studies.
- For Generation X NQNs with extensive healthcare experience, adapting to their qualified role and adjusting their habitus can be more difficult and lead to greater job dissatisfaction. These NQNs are more likely to see the qualified role as an

addition to their previous healthcare one, rather than separate and complementary, and need greater support to adjust their expectations.

- Generation Y NQNs perceive that they are a burden or nuisance to staff in the qualified workplace when they request regular feedback or reassurance, and this causes them additional stress and anxiety.
- Different generations of NQNs make different impacts on the workplace team and dynamics. Greater understanding of different generational traits and generational needs of individual NQNs is required by staff in the workplace, to ensure that individual support needs are provided.
- Familiarity and continuity are more important for Generation Y NQNs when they enter the workplace, and they are more likely to choose to remain in their sign-off placement for their qualified employment. This likelihood is increased if they are also going through significant changes to their social capital and personal habitus, as first-generation graduates in their family and social circle.
- Preceptorship support is more likely to occur for Generation Y than for Generation X NQNs. There is often an assumption in the workplace, that the lack of need for frequent feedback and reassurance by Generation X NQNs, means that they have less need for support.
- Generation X NQNs are more likely to be mistaken by staff in the workplace for experienced nurses. As a result, less support opportunities may be made available to them, with greater expectations of them compared to Generation Y NQNs.

6.8 **Application to practice**

Developing students for their qualified role and supporting a smooth transition for NQNs are multifaceted processes influenced by the individual's unique perceptions and experiences. Opportunities throughout the pre-registration programme alongside strong liaisons between HEIs and future employers, can support students to adapt and develop their habitus for positive transition to qualified practice.

Placement preparations sessions throughout the pre-registration programme, before each placement experience with debriefing sessions at the end of the experience, can prepare students for the placements ahead of them, and support mechanisms can be explored. Students can be encouraged to consider the skills and knowledge they have and how that learning can be transferred to their next practice learning experience. Reflexive activities and discussion of previous experiences and concerns around their next placement, can develop students' awareness and understanding that each practice area is unique, with its own culture and doxa. They can then be supported to explore how their personal habitus may need to adapt to the new practice context they will be working and learning within.

Greater discussions between the HEI and placement areas in the development of curricula activities can provide innovative opportunities to consider the less tangible and tacit skills required in clinical practice, and how the curriculum can support the student to develop them. Through regular exposure to these activities before and after each placement experience, students can start to develop their skills of resilience and perseverance. Developing resilience should be a key and on-going part of the student journey, through the pre-registration curriculum, and students should be educated about what resilience is, and its relevance to them in the nursing profession. Resilience development can be achieved through several approaches, including regular positive and constructive feedback and encouragement, to develop their confidence and belief that they are able to

achieve the requirements of their programme and qualified practice. Ensuring individual and peer group reflexive practice is integral to the pre-registration programme, as a support mechanism and an approach to assessment, can encourage the students to learn from their experiences and provide opportunities for shared learning to occur. Structured peer group support opportunities, such as solution-focused activities and online student support communities can also contribute to their developing resilience. Providing extra curricula activities, for example a running club made up of academics, students and clinical partners or keep fit sessions, can be beneficial to students' health and well-being. Ensuring well-being is also promoted through events (such as yoga, and mindfulness sessions) and development of a wellbeing committee made up of HEI staff and students, will all be positive messages to help students feel valued as part of their learning community and develop their resilience.

Developing confidence and competence within the workplace remain key indicators of success to NQNs; entering qualified practice with additional complex clinical skills provides additional capital which aids confidence and socialisation. However, under the NMC Standards to support Learning and Assessment in Practice (NMC, 2008) some NQNs felt that the close relationship they developed as students with their mentor during their clinical placements, at times provided too much protection and they needed greater exposure to the realities of the qualified role. In recognition of the changing landscape of clinical practice, the new professional standards are designed to enable greater working between HEIs and clinical practice (NMC, 2018b). Removal of the mentor role and introduction of the Practice Supervisor, Practice Assessor and Academic Assessor roles brings a greater distinction between the supervisory role of practitioners and the assessment role of both practitioners and academics. These new standards require greater liaison between nurses educating students in the practice area and those educating students in the HEI. Through this closer working there will be greater dialogue about each student's experiences, development, and progress, allowing for a more individualised approach and opportunity

for further alignment of theory and practice within the curriculum. Greater flexibility in the approach to student supervision and support allows for different practice learning experiences (NMC, 2018b) to contribute to the ongoing development of the pre-registration curriculum and increased alignment to contemporary practice experiences.

Realistic workloads and associated administrative tasks during the final year of the programme will support development of students' time management and delegation skills, encouraging implementation of resilience skills and perseverance, to cope with the multiple demands on them. Clinical supervision opportunities and peer group sessions in clinical practice, supported by the HEI, will assist development of their confidence to adjust to their new role on entry to qualified practice. Simulation can be a valuable teaching tool as identified by Peter in the current study. Providing simulation activities to develop time management skills and approaches to manage stress when under pressure, can enhance student readiness for practice. These activities can make use of simulated wards, interprofessional learning opportunities and timed role play activities. They can be followed by debriefing sessions that encourage students to reflect on their experience, their learning from the experience and how their practice can develop because of that learning. Where this type of activity highlights a particular concern for a student, individual support plans can be developed through liaison between the personal tutor, Academic Assessor, Practice Supervisor and Practice Assessor, to ensure greater supported exposure to this type of activity is provided in the clinical setting. This development can then contribute through an individual transition programme for the NQN as part of their preceptorship.

Whilst NQNs in this study appeared to be well prepared for the professional expectations of their role, they were less ready for the impact on their personal identity. Greater challenging of assumptions through reflexive practice opportunities, solution-focused activities and clinician led workshops and seminars will enable students to consider their

personal habitus, identifying areas where adjustment and alignment to qualified practice is problematic. Providing increased opportunities for students to engage with clinicians through networking and seminar opportunities during the final year of the pre-registration programme will allow them to explore their expectations of their transition to qualified practice and the qualified role of the nurse. This can help to develop their awareness and understanding of the important contribution qualified nurses play in the patient experience.

Through individual personal tutor and peer group sessions, a more individualised approach to student support that encompasses their adjustment in their personal habitus can occur, in liaison between the personal tutor, Academic Assessors, Practice Supervisors and Practice Assessors. This ongoing individual support should then feed into and inform individual preceptorship arrangements for each NQN as part of their transition to qualified practice.

This study found that NQNs appreciate the need to provide individualised holistic care but need a greater understanding of skills from other fields of nursing to be able to do this effectively. The latest professional standards (NMC, 2018) address this issue and aim to develop more highly skilled generic nurses of the future. Through more innovation in the identification of placement opportunities reflecting the different needs and experiences of contemporary society, greater exposure to more holistic approaches to care can be facilitated. However, there needs to be greater understanding of different nursing fields amongst qualified nurses and continual development for the qualified workforce will be vital if these new professional standards are to be achieved (The National Improvement and Leadership Development Board, 2016).

Socialisation and support for NQNs as they transition to their new role continue to be key. Within the current study, whilst 75% of participants felt a readiness for qualified practice, and 65% felt supported by their workplace, where a lack of support or socialisation

continued to exist, these remain influencing factors in the attrition of NQNs. The value of preceptorship programmes needs to be increased within some workplaces with greater support and monitoring of preceptorship arrangement by senior managers and HEIs.

For NQNs in this study the lack of an identified preceptor for 45% of them is very concerning and does not align with the Department of Health or NMC guidance around transition support (DH, 2010; NMC, 2020). Additionally, of the remaining 55% (n=11) of participants, nine of them identified their preceptorship programme as a standard structure and document used for every NQN within their organisation or organisational division, or as a programme that was tailored and focused to the specific needs and skills of their area, but not to them. Only two NQNs discussed how their preceptorship programme had been developed in discussion with them, to meet their individual needs as well as the needs of the organisation. In both these cases, their perceptions of preceptorship were much more positive, and this transition support was seen as very beneficial alongside the wider support of their workplace team and managers. These two NQNs worked in very differing specialities in the same trust, and NQNs from similar specialisms within the same trust reported more negative experiences. This suggests that there was a greater understanding of and support for the value of individualised preceptorship within these two workplaces and there needs to be greater support from senior managers, supported by the HEI, to ensure wider dissemination of this good practice across all workplace areas.

Learning from this study identified that previous care experience prior to commencing the pre-registration programme can be valuable for some students and NQNs but can bring challenges for others. The confidence and experience gained from time spent working in health and social care can help students to recognise and adapt to the different doxa of clinical placements. The confidence further developed through the pre-registration programme can then assist them to seek support and persevere during their transition to qualified practice.

However, for some NQNs, adjusting their habitus during the pre-registration programme can be more difficult and they find it challenging to move to a more leadership and management of care role. Greater exploration of their changing identity needs to occur through one to one and peer group discussions during the pre-registration period, and more reflection on their developing role in clinical practice. Through this, greater support can be provided from both the HEI and practice colleagues, to encourage the student to examine the role of the qualified nurse, and how they may have to adjust their professional and personal habitus to meet the requirements of that role. This can continue during the preceptorship period if bespoke programmes are developed for each NQN through liaisons between the HEI and the employer. For NQNs the change of capital that the qualified role brings, and their change of position within the workplace can be difficult to adjust to, and regular one to one discussions need to take place with an identified preceptor to identify when this is occurring. Greater understanding by workplaces and managers, that changes in capital and habitus can add to the uncertainty for NQNs, would support the NQN's adjustment to their new professional and personal habitus.

Findings from this study identify students choose their place of employment based on their areas of interest and positive placement experiences from any point of their pre-registration programme. HEIs, senior managers and workplaces need to acknowledge the unique challenges of individual work areas, the importance of increasing student awareness of the unique nature of all placements, with placement preparation and opportunities to engage in workshops and seminars with qualified staff. There should be greater recognition by senior managers, of workplaces under excessive pressures or staff shortages. When NQNs are employed to work in these areas, staff supporting the NQN should receive additional managerial support and opportunities to discuss their expectations of the NQN to ensure those expectations are appropriate and realistic; with additional organisational support to assist with the NQN's transition.

Recognising the impact the NQN has on the workplace dynamic should be a key part of the development of preceptorship programmes. Alongside individual transition support programmes for the NQN, support should be in place from managers to help staff in the workplace prepare for and adjust to the addition of the new staff member. By engaging the workplace team in the arrangements to support the NQN and identifying their concerns, a more inclusive approach to the induction and welcoming of the NQN can be achieved.

Staff within the workplace need to see the introduction of the NQN as an opportunity to support their own staff development, and training sessions for NQNs or development opportunities, should also be made available to staff in the workplace, to update and develop their own knowledge and skills. This will then promote a more shared learning approach to the socialisation of the NQN and help to remove any perceptions that the NQN is a threat to other staff's development opportunities. Senior managers need to play a more active role in ensuring that staff in the workplace are prepared for the change that will occur when the NQN joins the team, providing opportunities for team and one to one discussions of expectations and needs of the NQN. Through greater commitment to staff CPD, senior managers can ensure that the workforce have opportunities to develop and progress, which can provide a more positive environment for the NQN to join.

This study identified the impact that generational or demographic differences can make to preparation for practice readiness and transition to qualified practice. Greater education is needed during the pre-registration programme and through CPD opportunities around the different generational traits. Through this, greater understanding and appreciation of individual staff needs can enhance team working and differing generational preceptorship support needs.

As Generation Y NQNs are more likely to remain in their sign-off area for their qualified role; the pre-registration programme needs to explore the changes to their support when they re-enter the workplace, and how relationships with staff will alter due to their changed habitus and position within the team as a qualified nurse. Additionally, clear career structures and career support starting during the preceptorship period can help these NQNs to see how their contributions to the organisation are valued and encourage them to remain within the workplace.

From this study greater understanding of job satisfaction for Generation X NQNs can contribute to the body of knowledge on this subject. Generation X NQNs often have extensive life and job experience that they can use to develop their skills of resilience. They are keen to transfer their skills to their new role but become frustrated when they must delegate fundamental care to allow them to address the managerial and administrative aspects of their qualified role.

Within the pre-registration curriculum and practice placements, students should be encouraged to draw upon their previous life and job experiences to apply them to the nursing context. However, exploration of reasons for entering the profession and perceptions of the qualified role should continue throughout the pre-registration period. Support from reflexive activities can help them to adjust their expectations and their habitus to align more with the habitus they will need as a qualified nurse. Through increased opportunities to learn from experiences and reflections on their changing role, they can be better supported to understand how the effective management of patient care can positively impact on the patient experience.

Generation X NQNs are often mistaken as more experienced nurses and their needs for support can be overlooked by members of the workplace team. Greater identification of

all NQNs, and education of generational needs for all workplace teams, would be a positive intervention to encourage support for all NQNs entering the qualified environment.

Through the lens of Bourdieu's capital and habitus, the demographic differences within this study provided new understanding of how different social and educational backgrounds can influence students' perceptions during their pre-registration programme and their preparation for qualified practice. For students who had not come through the traditional education route to their degree, tenacity was developed before entry to university, during their return to study balanced alongside work and family commitments. This provided them with a determination to succeed and resilience that most were able to draw on through their pre-registration programme and their transition to qualified practice. There should be more focus on exploring this determination and resilience during the pre-registration programme, to encourage greater transference of those skills during times of adversity. Through the sharing and learning from those experiences, peer support can be offered to students with less life experiences to support them in their development of resilience and coping strategies. Where students have previous experience of time management or responsibility, these skills should be drawn upon and applied to the time management and responsibility aspects of their nursing role.

Personal and professional identity should have more focus within the pre-registration programme, and in the development of Practice Supervisors, Practice Assessors and Academic Assessors. NQNs within this study needed greater support to adapt to their changing role and to the way they perceived they were treated by colleagues and society. For some NQNs the achievement of a degree and a professional career were beyond their previous aspirations. The pride they had in their accomplishment came with a change in their personal and social status that was unexpected. Greater exploration of the changing capital from achievement of the degree and professional status would increase

understanding of their impact on the individual and the support needed through preceptorship, to manage the multiple changes.

Whilst the changes to status are perceived positively by some NQNs and they become role models for family and friends, the added social pressure this can bring can make adaptation to their new identity and alignment to their new habitus difficult. There needs to be more recognition of this with opportunities for students in their final year to meet with recently qualified nurses to hear about their different experiences. The establishment of support networks and peer group sessions for the NQN would then allow for exploration of changes they are experiencing and ways to adapt to those changes.

This study has brought new knowledge and understanding of how demographic and generational traits can influence and enhance the pre-registration and the individual preceptorship programmes of NQNs. However, further research is needed to bring greater insight into the complexities of these factors and their influence on the transition experience of the NQN.

From the findings of this study and their application to practice, recommendations were developed. These are discussed in Chapter 8 – Recommendations and Conclusions.

6.9 **Strengths and limitations of the study**

Strengths

This study explored NQNs' perceptions of practice readiness through the lens of Bourdieu's capital and habitus. From this, new knowledge and understanding was gained around how NQNs' make sense of their transition experiences and the impact of

demographic and generational differences on perceptions and habitus. The knowledge contributed by this study responds to the recommendations of Aldosari et al (2021), HEE (2018) and Watson (2020) to provide greater understanding of factors influencing the transition of NQNs and their retention to the workplace. It also provides greater understanding of generational differences in response to the recommendations by Beech et al (2019) and HEE (2015). This contribution to the knowledge base will aid understanding of individual needs of NQNs during the "flaky bridge" period of their career (HEE, 2018), the different generational needs of nurses working in clinical practice, and areas for further research.

The recruitment of sufficient participants to achieve data saturation provided evidence to support a robust and systematic method of data collection in a research process that was supported by an experienced supervisory team. Through supervision activities, my reflexive activities, and member checking of transcripts, trustworthiness was strengthened (Lincoln and Guba, 1985) to aid credibility to the emerging concepts and themes identified. Contributions to the knowledge base from this study relate to the pre-registration programme, preceptorship, demographic and generational differences between NQNs, and the importance of ongoing CPD for staff in the workplace.

Findings identify how the pre-registration curriculum can be enhanced through greater exploration of students' perceptions and assumptions of qualified practice, to support adjustment to changes in capital and habitus. The study provides new evidence around the importance of previous life skills for student nurses and the benefit of those skills to the qualified role. Evidence from the study concludes that simulation can be valuable within the pre-registration period, not only for the development of technical skills but in preparation for the time management demands of qualified practice.

Recommendations from the study emphasise the importance of preparing students for each placement experience within the pre-registration curriculum. Students should be reminded of the unique nature of each placement area's culture and doxa, and how the skills and knowledge from the programme and life experiences can be used to help them to adapt to their next placement area. These sessions should develop throughout the three-year programme to assist each student to reflect on and adjust their personal habitus; developing coping and resilience skills to help them to manage their transition to qualified practice. The need for greater innovation in identification of placement provision emerged from this study, to provide students with more experience of the different needs of individuals in contemporary society and more opportunities to develop their cross-field skills to provide holistic care.

The study has identified the need for liaisons between the HEI and employers to provide opportunities for qualified staff to input into the pre-registration curriculum and contribute to the development of realistic expectations of qualified practice. This liaison should also extend to the development of individual student support plans that feed into individualised preceptorship programmes, through the relationships developed between Personal Tutors, Practice Supervisors, Practice Assessors and Academic Assessors.

A lack of formal, individualised preceptorship support was a key finding in this study, suggesting that senior managers need to play a more active role in ensuring that preceptorship programmes are made available to all NQNs in their organisation. Senior managers need to work more closely with individual practice areas and the HEI to develop bespoke preceptorship programmes that meet the individual needs of the NQN and not just the needs of the organisation and work area. Greater support and recognition from senior managers in the organisation need to be provided for staff in the workplace who are

supporting the NQN's transition and preceptorship, with acknowledgement of the additional workload this brings and the need to ensure the well-being of all staff members.

Where students decide to remain in their sign-off area for the qualified role, this study has identified that their expectations of support on qualification can misalign with the workplace perceptions. Assumptions are made by some workplace areas that familiarity gained during the pre-registration programme means that less support is needed during the transition period. Bespoke preceptorship programmes should be developed prior to entry to the workplace, with support from the HEI, to explore the expectations of the NQN and the employer, and ensure expectations are realistic and transition support is appropriate.

A key finding from this study relates to assumptions linked to generational differences. Assumptions are made by managers and work colleagues about the level of support NQNs need on entry to the workplace, often related to the NQN's previous life experiences and age. NQNs with extensive previous life or care experience may use the confidence and resilience from those experiences to help them to navigate their transition to qualified practice. However, this is not always the case, and the move to the qualified role, with its change of cultural and social status, can be anxiety provoking for some NQNs. In addition, generational differences can lead workplaces to make assumptions about the level of support and preceptorship needed by individual NQNs. As a result, Generation X NQNs can receive less preceptorship support and can be mistaken as experienced nurses, leading to less support from the wider workplace. Greater understanding is needed by students, HEIs and employers, of the different generational needs of the NQN and staff in the workplace, to promote cohesive and supportive team working environments. This needs to include education about how different generations perceive they are identified and treated on entry to the workplace, and their needs to adapt to their new role, as part of their transition process.

Another area from this study where new knowledge has contributed is around the impact of changing capital and habitus for the NQN. The findings bring greater understanding of how the pre-registration curriculum can better recognise and explore student's life experiences and demographics to develop their resilience and support their well-being through the student and transition journeys. For first generation university students, there needs to be greater recognition of the impact their university education and professional status may have on their personal lives, on their relationships with family and friends and the reactions they receive from the public on qualification. There should be greater focus on this during the pre-registration programme to prepare students for the changing perceptions of others. Whilst some NQNs will embrace these changes, others may find what they perceive to be the increased social pressure and expectations on them difficult to adjust to, and this should be identified and supported as part of the preceptorship period. Greater understanding is required by employers of the significance of becoming a professional and graduate for NQNs who have not followed a traditional pathway to university, or whose background did not provide opportunities for the personal and professional life and career opportunities now available to them.

Findings from this study support the call from Beech et al (2019) that greater support should be available for workplaces, with more CPD opportunities to develop a positive workplace culture and recognition of the needs of individuals working in the area. More acknowledgement of the impact the NQN will have on the workplace dynamic, with manager support to prepare for the change, will assist the workplace to prepare for their role in welcoming and supporting the NQN. Alongside this, staff should have access to development opportunities to further their own career, and managers should align the initial training needs of the NQN with any updating needs of experienced staff, to foster a culture of shared learning and development in the workplace.

Limitations

Whilst qualitative research can be beneficial for capturing the views and perceptions of individuals, the findings are specific to the participants in the sample group and cannot be generalised. Furthermore, the researcher is often close to the research being undertaken with the potential risk of researcher bias in the data collection and interpretation of results (Taylor, Bogdan, DeVault, 2016), and the role of the researcher is acknowledged within this study. The results from this study provide an in-depth view of the perceptions of participants but acknowledge that the perceptions of the rest of the cohort may be different.

Due to the very small number of participants from the nursing fields of child, learning disabilities and mental health, comparisons could not be drawn between or across fields. The purposive sample used came from one study site and one HEI within the UK and it is recognised that the pre-registration curriculum experience will have been different for NQNs in other UK HEIs. In addition, whilst the results of this study can be compared to findings from other UK and international studies, internationally there are considerable differences in nurse education and transition, therefore, consideration must be given to those different processes and systems.

6.10 **Chapter summary**

Findings from this study suggest an increase in some areas of practice readiness for NQNs and a lack of bullying culture reported in some previous studies; however, there needs to be greater focus on developing students' understanding of the different fields of nursing. The NMC Future Nurse Standards (NMC, 2018d) recognise the need to develop nurses with the skills to manage contemporary care needs. Their aim is to develop nurses of the future who have generic skills to provide compassionate, evidence based, person centred care for people across the whole age spectrum and in all care settings. To support this, a greater range of innovative placement areas will need to be available, which reflect the challenges of modern-day society. Additionally, the qualified workforce will require continual development opportunities, to develop their own generic skills and gain greater understanding of other fields of nursing.

Greater discourse around the realities of qualified practice and preparation of senior student nurses with more realistic workloads and resilience techniques may provide increased skills on entry to the workplace. Under the NMC emergency standards (NMC, 2020), some students opted to spend their final six-months of pre-registration study in the clinical area, which may have helped to develop greater understanding of the qualified role. However, findings from the updated RePAIR project (HEE, 2020) suggested that these students felt disjointed from their academic studies and had concerns about meeting the graduate requirements of their role, alongside the skills and competence developed in clinical practice. To support the development of practice readiness, greater liaison between the HEI and employers could instead provide opportunities for qualified nurses to contribute to the taught element of the pre-registration programme through workshops and seminars. Students in their final year could then discuss their perceptions and concerns around the qualified role and explore the experiences of the qualified nurses whilst developing support networks. Greater use of simulated wards and role play,

alongside debriefing exercises and increased reflexive practice would provide opportunities to develop greater time management skills and encourage students to transfer their life skills to the nursing context.

To address the oppressive practices that continue in some workplaces, exploration of academics and clinical nurses' expectations of the NQN may promote greater discourse around reasons for those oppressive practices. Supporting qualified nurses will be key to this and continuing professional development in the workplace is important to raise awareness of the needs of NQNs and their generational differences.

Job satisfaction remains a key issue in nursing, and there needs to be greater consideration of NQNs alongside the wider exploration of this and retention of nurses to the profession. Overall findings from this study suggest that Generation Y NQNs gain greater initial job satisfaction, but the resilience and perseverance skills developed by Generation X NQNs can help them to recognise the contribution they are making to the patient experience, if they are supported through the preceptorship programme or by workplace colleagues. Support from the workplace is valued by NQNs but senior managers need to have greater oversight to ensure that preceptorship programmes are provided to all NQNs and individualised, with support for those acting as preceptors.

The changing personal and professional identity of the NQN is not always easy for them to adjust to, and greater exploration of this should be provided within the pre-registration programme. For first generation graduates, their change in status in both the workplace and wider society can cause uncertainty and anxiety, and support with this adjustment should form part of bespoke preceptorship arrangements.

Across the four themes that emerged from this study, new knowledge and understanding of NQNs experiences was gained. The identification of recommendations and areas

where further research would enhance understanding, are discussed in the final chapter of the thesis following my critical reflections of the research journey.

CHAPTER SEVEN REFLECTIONS ON THE RESEARCH JOURNEY

7.1 Introduction

This chapter reflects on my doctoral journey, my contribution to new knowledge, and my personal learning. Reflection was important as it enabled me to review my experiences and actions, considering my development and learning as a result (Bolton, 2014). Through this journey my personal habitus has changed, and I have needed to adjust to changes in both my cultural and social capital.

At the beginning of my doctoral journey, my interests in developing practice readiness were influenced by an awareness of feminist discourse. Initially I was not sure where this influence had come from, but reflection on my experience and findings from a pilot study conducted as part of my doctoral journey provided insights into the development of my personal habitus and its potential to introduce bias into my research. When reflecting on previous personal life and career choices it became apparent that a great appeal of nursing was the hierarchical structure and patriarchal approach that existed at the beginning of the 1980s. Following an education throughout the 1970s and early 1980s, and an older widowed parent with clear patriarchal views, nursing provided a safe and familiar environment in which to develop a purposeful career for my altruistic values.

However, I now realise that my interest in feminist discourse came from a realisation that the safe and familiar environment had quickly become stifling and frustrating. My experience of the subordinate role of the nurse during the 1980s had led me to a desire for greater autonomy and professional recognition. The work of Celia Davies around the idea of feminine and masculine attributes linked to work skills (Davies, 1995; 1995a) had interested me. I felt this would be a significant factor in student nurses' development and a relevant focus for my forthcoming research study. However, the findings from my pilot

study did not support my assumptions. My reflections and learning from that experience were my first insights into my own assumptions around nursing curricula and development of the nursing profession. I was shocked to realise how my personal habitus had been developed and led me to assumptions that I had never previously questioned. This was the start of my journey exploring and challenging my habitus and assumptions, and their influence on my role as both an educator and a novice researcher.

My reflections on my pilot study experience enabled me to identify that my interest in feminist discourse in nursing was a personal one rather than a focus of participants. From the feedback of participants in the pilot study and engagement with the literature, I was able to identify that students were more concerned about their preparation for the transition to qualified practice. Consequently, the focus for my doctoral research became the perceptions of NQN readiness for qualified practice, and how the pre-registration curriculum could be enhanced to further develop that readiness.

7.2 **Reflections on the theoretical concepts underpinning the thesis**

Throughout my career my early research experiences and professional practice had been based within the positivist paradigm. Quantitative research with a clear focus on one truth was a dominating influence in my beliefs and practice, reinforced through my early nursing experience. My beliefs and habitus were built on the view that ultimately there was one truth, that could be proven and generalised. However, my experience as an educationalist raised doubts in my beliefs and challenged my habitus. This was often confusing and unnerving as I was unsure where those doubts had emerged from. Reflecting on my doctoral journey, I realise that my teaching experiences suggested to me that individuals receive and process information in a variety of ways and bring different perceptions and understandings to that information.

When embarking on educational research, and later my doctoral studies, qualitative research became more attractive and meaningful to me. I realise as I reflect on my education and career, experiences that have resonated with me are those where different perceptions and 'truths' must be considered. By becoming more aware of the influences on individuals and less judgemental of the views they hold, I have recognised a desire within me to explore why individuals see things from different perspectives. On a personal level, I feel that this has made me challenge my own perceptions and assumptions more and has enhanced my practice. I strive to understand issues from the perspectives of others, to support the development of my own knowledge and understanding. Qualitative research has taught me to accept that there is not always one truth. Instead, exploration and consideration of the truths of others can enhance knowledge and understanding to develop new ideas and foci.

The use of Bourdieu's concepts of capital and habitus (Bourdieu, 1992) in this study, led me to give greater consideration to influences not often considered in the literature. I was surprised when, during analysis of the data, I started to view the voices of the participants through different perspectives. Despite over 25 years of experience as an educationalist, I never previously considered the demographic differences of my students in any detail. I had experience of supporting personal students finding the transitions from healthcare worker to student nurse and qualified nurse difficult, but I had not given any great thought to how their previous experiences could be used as a positive tool. I had not considered the potential impact of being the first in the family to attend university, or the support that might be needed to adjust to a new social status outside of the workplace. On reflection I realise that these were not concepts that I had considered when planning new curricula. With greater understanding of capital and habitus, I can now look at students more holistically and make greater sense of their concerns or perceptions, with greater recognition of the importance of life experiences within the curriculum.

I had initial reservations about my choice of Bourdieu's work and whether his concepts would be an appropriate lens to view my findings through. However, the learning I have gained from this perspective and the new knowledge my findings can contribute to the discussion of practice readiness has proved that this was not only an appropriate, but a valuable lens for increasing understanding of the student and NQN journey. This has raised questions for me around how much emphasis we place on students' life experiences and changing habitus, how much we support practice colleagues understanding of this, and where this is visible in the pre-registration curriculum? Consequently, when I now engage in activities relating to curriculum development or student support, I am more focused on ensuring that consideration of individual student experiences and changing habitus is included as part of the pedagogic discourse, curriculum development, and preparation of academic and clinical colleagues.

7.3 **Reflections on the study design and data collection**

My interest in curriculum development and my key role in developing new curricula in the HEI influenced my focus for this study. My experience as a nurse educator and personal tutor raised questions for me around preparation of students for qualified practice and formed the basis of my thesis research interest. I was able to recognise that as an experienced member of the teaching team, my perceptions and assumptions had developed over a number of years and would be influential in the decisions I would make throughout the research process. Reflexive practice was therefore an essential component of my research from the planning stage through to completion of the thesis.

A recognised challenge in qualitative methodology is the time required to transcribe data collected (Polit and Beck, 2012; Saks and Allsop, 2013). As a novice, part time researcher, this was an area of concern for me, as I needed to collect and transcribe my data around my full-time work commitments. As qualitative research was a new learning opportunity

for me, I undertook a pilot study as part of my doctoral programme to develop my skills in this paradigm. I used a focus group to gather data for my pilot study and to explore if this approach could be used for my thesis research. Focus groups can be an effective way to capture a reasonable amount of qualitative data in a short period (Lloyd-Evans, 2006) and they can be useful for gaining insight into a range of perceptions of a group (Liamputtong, 2011). However, Cohen et al (2011) argued that data collection from a focus group tends to be more generalised than data collected during individual interviews. When I reflected on the process and analysed the data, I identified the discussion had been driven by two or three key participants, reflecting the perceptions of the more prominent group members, a point noted by Smithson (2008). From this I concluded that a better approach for me to capture individuals' perceptions would be using semi-structured interviews. I was aware that semi-structured interviews would be more time consuming and generate more data than using focus groups; however, I recognised the value of this data collection method to capture the perceptions of each participant (Barriball and While, 1994).

Reflecting on the pilot study provided a greater awareness of how individuals can be influenced and my personal assumptions and biases. This increased awareness enabled me to see the potential influence I could have over the research, and I became more mindful and critical of assumptions I was making. Using a reflexive approach (Polit and Beck 2012), review of the pilot study experience identified that I had made assumptions and had approached the focus group with an expectation of the results, and how those results could inform the focus of my research. I was quite shocked to have such a revelation and it enabled me to develop a more inductive approach to the research process.

Taking on the role of researcher within my own organisation presented a risk of introducing bias to my interactions with participants and the data collected. To minimise any perceptions of coercion, I did not introduce the study to the participants until the last week of their programme and did not contact them individually until they had entered qualified practice. Whilst this delay in individual contact allowed for a clear demarcation of them no longer having an HEI relationship with me, it added time pressures and delays for me to recruit and interview all interested participants. On reflection, during the final week of their pre-registration programme I could have organised focus group interviews to take place at the end of their first week of qualified practice, with follow-up one to one interviews arranged over subsequent weeks. This would have provided additional data and helped with time pressures in arranging and collecting the data. This was a key learning experience for me, that I will consider when engaging with future research.

I had very little contact with the participants who engaged in my research. They were not my personal tutees and I had only taught them for occasional sessions over their three-year programme, with only one session during their final year. However, I was known to them and therefore had the potential to influence the interview process as an insider. Moore (2012) suggested that as an insider in the research there is a danger that the interviewer may make assumptions about a participant's behaviour and actions, due to their familiarity. I was conscious of my assumptions of them and used my reflective journal after every interview, and my supervisory discussions to challenge observations I had made and the influence of any assumptions on my perceptions and analysis of the data.

Miller and Glassner (2016) argued that insider status within the research can bring an increased element of trust from participants. On reflection of the interview process, I was surprised by the willingness of all participants to discuss their backgrounds, and some life

experiences and challenges they had faced. I feel that the enthusiasm and honesty participants brought to the interviews came with a level of trust they had from their knowledge of me and my role within the HEI. Where I had expected a level of reluctance or reservation from them, I encountered a keenness to have their voice heard. All participants thanked me for providing them with an opportunity to discuss their experiences and said that they felt an increased value because their opinions and perceptions had been sought. This was an unexpected and positive learning experience for me, as I had not expected participants to feel that the activity had been valuable to them. The opportunities for them to reflect on their experiences and draw conclusions about themselves had provided learning for them, as well as data collection for my study.

The interview process was both challenging and rewarding for me. During the data collection process, I constantly reminded myself of my role in the research and the need to limit the influence of my researcher voice on the data. I ensured that I was constantly aware of my presence in the interviews and completed my reflexive journal following each one. Through these reflexive processes and regular discussions with my supervisors, I acknowledged the subjective element I brought to the research (Lichtman, 2014) whilst using reflexivity to reduce the impact of that subjectivity. All participants had responded enthusiastically to questions being asked and were keen to explore the points that they raised in the discussion. I became more confident as the interview process progressed, and I was able to see how the interview schedule was developing and the research was being led by the participants and their experiences. The reflective journal provided a clear account of challenges to my assumptions and moments of learning. At times I was surprised by some of the data being captured; serving to reassure me that I was being mindful of my own preconceptions.

I was shocked at the amount of time the transcription process took, but this enabled me to immerse myself within the data (Morse and Field, 2002). I found it difficult to keep pace with the transcription and analysis of the data but made sure that an inductive approach continued throughout the data collection cycle by undertaking initial analysis of each interview recording, to inform the interview schedule. This ongoing initial analysis of the data served to constantly remind me that each participant brought their own individual experiences and perceptions to their interview, from which they developed their truth.

One criticism of qualitative research is its subjectivity. However, Miller and Glassner (2016) suggested that this methodology allows researchers to understand how individuals make sense of their worlds and the subjectivity that exists is part of that understanding. Through the identification of the researcher and their role within the research, understanding can be gained about the way different participants engage with and share information with different researchers, depending on the rapport and relationship they have with that researcher. For me as a lecturer and researcher, I was mindful of the need to accept the perceptions of each participant, as they were told to me, with constant challenges to my assumptions and interpretations of the data. To increase the trustworthiness and credibility of my research I used a structured approach to my data analysis (Braun and Clarke, 2006), employing both manual and electronic processes to cross check the development of my codes and themes. Whilst this was a very time-consuming activity, it brought an extra level of scrutiny and confidence to my analysis to ensure that I was not looking for pre-determined codes or overlooking codes that I assumed would not be relevant.

My reflective journal detailed my lack of confidence in analysing the data and my constant focus on reducing my own subjectivity in my interpretations. It identified moments of unexpected challenge to my assumptions, but also moments of surprise and realisation.

Regular supervisory meetings were vital to challenge my decision making; and critical friend discussions added an additional element to the scrutiny process; regularly challenging me to provide evidence for the findings and decisions I was making.

One such occasion was in relation to clinical skills. Without realising it, I had expected clinical skills to be a large influencing factor in NQNs' perceptions of practice readiness. I had therefore looked specifically for this in transcripts and initially highlighted it as a potential theme. A reason for this was from my involvement in enhancing clinical skills provision and simulation activities in the development of curricula over a 10-year period. I had subconsciously started to look for participant comments linking to clinical skills and was making associations to identify a developing theme. Only through reflection and discussions with my supervisor and critical friend was I able to identify that clinical skills was a small element of a much wider theme. Through my reflexive practice I was able to reflect on my bias in this area and look afresh at the transcripts with a less subjective focus. Through my discussions with my supervisors and critical friend, I was able to identify how my "insider" role and knowledge of the increased levels of clinical skills in the curriculum had led me to an assumption, that was not supported by the participant voice. Whilst skills were an area mentioned by participants, it did not have the significance I had assumed. This realisation helped me to understand that personal assumptions and biases are not always easily recognised or acknowledged and using different forms of reflexive practice can help to reduce bias within the research.

As an additional check for accuracy in the data, the member checking of transcripts by participants provided confirmation and reassurance, that their perceptions had been captured as they intended and the data was an accurate portrayal of their understanding of their situation (Polit and Beck, 2012). Checking of the transcription process and the

data analysis by my supervisors gave a quality control and trustworthy element to the research process, which was important, ensuring participants' voices were being represented accurately, and whilst present, my impact as a researcher was minimalised.

7.4 **Reflections on the findings**

On reflection of the findings from my research study and subsequent discussions, I am pleased that NQNs felt positively about a number of their experiences during their three-year pre-registration programme; realising that each individual was able to identify areas where they felt less prepared. Whilst there were clear themes and areas of commonality from the findings, I understand that the individual habitus of each NQN means there will always be differences in how they perceive their experiences. This realisation has confirmed for me, the importance of ensuring that during both the pre-registration journey and the transition to qualified practice, each student and NQN is viewed and supported as an individual. By acknowledging the influences of personal habitus, life skills, and experiences on each individual, a greater understanding of their needs and identification of effective approaches can be implemented to support their development of practice readiness and transition to their qualified role.

I was particularly surprised with the findings from my study around mature students' difficulty with adjusting to their changing personal and social capital, and reactions to generational support needs in the workplace. Reflecting on this, I realise that pedagogic discourse around the preparation of students for their changing capital has not been part of curriculum development discussions in the HEI to this point, and this has been missing from the curriculum. I am now more aware of the impact of demographics on some students' development and the influence this can have on their transition experience to qualified practice. As a result, I am more vocal about this in curriculum meetings and proactive in ensuring this is included in the curriculum. Similarly, reactions from clinical

workplace colleagues to generational needs for support, and the lack of preceptorship provision for Generation X NQNs has helped me to realise that greater understanding of generational differences is needed by nurses in both the HEI and the qualified workplace. From this, I have ensured that education and updating for Practice Supervisors, Practice Assessors and Academic Assessors now includes exploration of different generational traits and how they can be supported in both the pre-registration curriculum and on entry to the work environment. I am also more mindful that liaisons with healthcare providers and managers need to include discussions around the importance of CPD opportunities for all staff in the workplace and the need to ensure their understanding of the different generational traits and needs of the workforce.

My reflections on the thesis process and findings from the study have influenced my contributions to curriculum development (discussed below) and informed the recommendations for enhancement of practice readiness, discussed in the final chapter of this thesis.

7.5 **Reflection on the researcher/practitioner role**

As an experienced nurse and nurse educator, I was keen to expand my thinking and practice with greater awareness of research. My passion and interests lie in curriculum development and assessment, and I was interested in evaluation of the pre-registration nursing curriculum once NQNs were exposed to the real world of nursing. Through completion of this research study, I have been able to develop my knowledge and skills of research within the interpretivist paradigm, whilst evaluating the effectiveness of a curriculum within my organisation. I have been able to identify preconceptions that I did not realise I had, and recognise that issues that interest me, are not universally relevant to those around me. This was a large and unexpected learning curve for me, near the beginning of the research process, and taught me that I have assumptions I was not aware

of. I also learnt that my interests do not necessarily reflect the interests of the participants I want to research, and this allowed me to refocus my thinking and challenge my perceptions and assumptions. From the experience of my pilot study, I learnt that assumptions occur when least expected and this became an important checking mechanism for me.

My identity as a nurse educator has changed and developed over my career, as I have gained a passion for education and the challenges and opportunities it offers. I find that I identify more easily now with my profession as an academic rather than a clinical nurse, appreciating that our individual professional identity is influenced by the habitus we adapt most effectively to (Bourdieu, 1992). I have a greater understanding and appreciation for nursing colleagues who are conflicted by their identity as an educationalist and can see how this links to my epistemological and ontological positioning around individual truths.

The doctoral journey has developed my new skills and knowledge, challenged my thinking and provided a deeper understanding of theories of research. As a result, my teaching and supervision of students has improved to provide more questioning and supportive supervision. I am more reflexive in my thinking and less quick to jump to conclusions or make judgements. I am more challenging of my assumptions and preconceived ideas and more questioning of where my judgements are coming from. Moving forward I feel this will continue to enhance my practice as a nurse educator, curriculum developer and researcher. I will continue to question my judgements and preconceived ideas, alongside those of my peers and students. By being more open to different ideas and perceptions, I hope I will appreciate the uniqueness of what others have to say, and the learning that can occur as a result.

Perhaps the greatest challenge I have experienced from this journey is the effect it has had on my self-confidence. Throughout the process my confidence has been repeatedly

challenged and I have continually doubted my ability. It has made me realise that the impostor syndrome within me (Chandra, Huebert, Crowley and Das, 2019), is greater than I thought. I am now able to acknowledge my reluctance to embrace opportunities and how this has thwarted my career over the years. Reviewing my reflective journal, I constantly doubted my ability to succeed; each stage of the process was a new trauma to be managed. As I prepared for my progression, I had written in the diary

"I feel totally lost and inadequate. Why am I putting myself through this?"

And yet, as the journey progressed, within the diary, there were moments of satisfaction as my focus became clearer and my understanding and confidence with the research process grew. I am now more resilient with a greater understanding of myself as a person, as a nurse academic and as a researcher; with an appreciation that I must control confidence issues if I am to continue to develop and progress with my career.

I realise now, that when developing curricula, we need to consider how that journey may be different for each individual, and the different experiences and support mechanisms that can be put into place. Idealistic expectations need to be challenged to prepare students for the realities of qualified practice; with more dialogue between HEIs and clinical partners around the expectations of the NQN. There needs to be greater challenging of our assumptions and ideals, to ensure that we have a clear, agreed focus of what the NQN should be on entry to the workplace, with expectations that meet service needs but are realistic for the individual. As nurses in clinical practice and education we need to be more realistic about what we are trying to do, and able to achieve, combating the challenges of contemporary nursing practice. There needs to be greater engagement with clinical nurses to review expectations of the NQN, on a micro level (in the workplace), alongside the meso level (institutional).

The findings from this study have led me to a number of recommendations that can inform the curriculum, the practice environment and the transition support provided by preceptorship programmes. I now appreciate that a greater understanding of individual habitus and life experiences needs to be built into the pre-registration curriculum. I recognise that greater support is needed for nurse lecturers and colleagues in the clinical areas if they are to provide individual support for students and NQNs. My learning from this study has given me a greater appreciation of continuing professional development for nurses, both in clinical practice and academia. All nurses need to have opportunities to develop and enhance their knowledge and skills if we want them to educate and support the nurses of the future. Through greater use of reflexive practice, demographic influences and generational traits should inform the discourse around the support needs of all nurses and development of future curricula. With greater education of the nursing workforce around generational traits and the value of individualised support for NQNs entering the workplace, a deeper understanding of the multi-generational team working in practice can be gained, and a supportive culture offered to all staff in the workplace, including NQNs. I am now more aware of the influence I can have in developing future curricula and supporting academic colleagues to consider the tacit skills that can be developed during the pre-registration programme, and how greater focus on them throughout the programme can support practice readiness.

During the completion of this doctoral research, I have been able to use my learning to support less experienced colleagues during curriculum development activities. I have provided advice around programme development, and approaches to support academic and clinical colleagues as educators, becoming more aware of my generational traits and their influence on my perceptions and educational philosophy. I now have a greater appreciation of the need for ensuring well-being and resilience building are integral to the pre-registration programme and have become more effective in developing curricula to enhance the student experience.

From my research journey, I have worked with colleagues to introduce solution-focused reflexive activities, threaded through each year of the pre-registration programme. From these activities students have been supported to develop greater reflexive and problem-solving skills, whilst Personal Tutors have developed a greater understanding of their tutees as individuals. Through my organisation of the Staff Student Voice Committee, I have worked with colleagues and student representatives to promote several well-being activities which have been integrated into the curriculum, and sports groups which take place at the end of the taught day. I have developed educational training for Practice Supervisors, Practice Assessors and Academic Assessors which includes consideration of influences on personal development and support needs, and the value of transferable skills. I introduced a buddy system where new student nurses have an informal support buddy from either Year 2 or Year 3 of their programme and have been liaising with colleagues in clinical practice to explore a similar system for NQNs in the workplace.

In recognition of the importance of CPD opportunities for all qualified nurses, I introduced a programme of mentor support for all new nurse academics to help them to adjust to their new role and changes to their habitus. I worked closely with practice colleagues to provide opportunities for clinicians to contribute to the pre-registration curriculum and supported their learning of educational theory and their educational role in both the HEI and clinical practice. I am engaged in on-going Faculty and wider University discussions with healthcare providers to explore opportunities for staff CPD and joint academic/clinical appointments across a range of health programmes. This will provide increased opportunities for practice colleagues to contribute to pre-registration curricula, whilst providing CPD opportunities and teaching experience for those with an interest in a career in education.

My development as a researcher has had a positive and demonstrable impact on my role as a nurse educator, and I am now more engaged in evaluative research of health care programmes, and wider pedagogic research in the HEI.

7.6 **Personal Learning**

My journey through the doctoral process has been an emotional rollercoaster, filled with doubt, anxiety, excitement, but ultimately a sense of achievement. Learning that occurred went much deeper than gaining a better understanding of research methodology and practice readiness. A greater appreciation of my personal strength and resilience was gained; doubts and demons were challenged and were, to some extent, defeated. To use Bourdieu's concept (Bourdieu, 1992), my habitus has changed forever. My levels of capital increased, and my confidence developed; I am now more aware of different perceptions and assumptions; acknowledging that there is often more than one truth, influenced by the individual's beliefs and experiences.

As a result, I have emerged as a more tolerant individual who is less judgemental, more reflexive, more appreciative of others and wiser to the things that cannot be controlled. I now have a greater confidence to accept success as well as failure, with a desire to explore where the newfound knowledge and resilience may lead. Throughout the thesis journey I have transitioned to a researcher. As I worked to reduce my influence on the research process, I recognised the changes to my cultural and social capital, and the uncertainties I experienced from my changing role and contexts. This has served to remind me that role transition can occur multiple times throughout our careers. The skills of resilience are as important for me, as they are for my students and the NQNs entering qualified practice, and provide key tools to support my development and enable me to support the development of others.

The final chapter of this thesis offers recommendations from the findings of my study and a conclusion to the thesis.

CHAPTER EIGHT RECOMMENDATIONS AND CONCLUSIONS

8.1 Introduction

The final chapter of this thesis acknowledges the originality of this research study and makes recommendations from the findings, recognising their implications for the curriculum, practice education, preceptorship, and future research. The research explored practice readiness from the perspective of the NQN through Bourdieu's lens of capital and habitus (Bourdieu, 1992). Through engagement with NQNs in the first few weeks of qualified practice, their expectations, assumptions, and perceptions were explored and discussed. The research came for the interpretivist perspective with the epistemological and ontological underpinning of truth being unique and individual.

8.2 Summary of the process

The literature review came from both a UK and international perspective, with UK literature around transition closely linked to preceptorship. Findings from the literature identified that despite research and initiatives to improve the transition period, on entry to the qualified workforce, NQNs were not prepared for the realities of contemporary practice, particularly around the multifaceted role and increased workload (Aldosari et al, 2021; Arrowsmith et al, 2016; Mawson, 2020; Monaghan, 2015; Watson et al, 2020). NQNs perceived that they were not supported by more experienced colleagues and not welcome in the workplace, leaving them shocked and dissatisfied (Aldosari et al, 2021; Duchscher, 2001; 2008; Kelly and Ahern, 2009). Recommendations from the literature reviewed were that NQNs needed to be more resilient, with more realistic expectations of the qualified role. There needs to be more preparation for the realities of qualified practice and an

individualised approach to preceptorship support during the transition to qualified practice. The literature review revealed a lack of information about the influence of generational traits and personal backgrounds on the development of practice readiness and the transition experience.

The qualitative methodological approach in this thesis enabled the capture of participants voices and thematic analysis allowed for the emergence of four themes. The findings offer new insights into NQNs' perceptions of their experiences and the impact of generational traits and demographic differences. This new knowledge provides an opportunity to inform future curriculum development, enhance practice readiness and preceptorship for NQNs on entry to the workplace, and suggest areas for future research.

8.3 **Recommendations from the study findings**

Recommendations from this study are split into four categories, Pre-registration Curriculum, Practice Environment, Preceptorship Period, Further Research (summarised in Table 8.1).

Table 8.1 Summary of thesis recommendations

	Summary of Recommendations
Pre-registration Curriculum	From Year 1 and throughout the pre-registration programme explore issues around habitus, promotion of well-being and the development of resilience. Greater liaison throughout the pre-registration programme between the Personal Tutor, Practice Supervisors, Practice Assessors and Academic Assessors to develop individual student development plans that then feed into individualised preceptorship programmes. Inclusion of preparation for practice sessions before each placement experience, and debrief sessions following each placement experience, to support development, reflexive practice, resilience building, and adjustment to personal habitus. Scheduled sessions through the final year of the pre-registration programme for students to experience simulated opportunities of the demands of qualified practice. Supported by opportunities in workshops to meet with qualified nurses to explore the qualified role and their concerns and assumptions linked to qualified practice. Greater liaison in the final months of the pre-registration programme (once employment is secured) between the student, Personal Tutor, Practice Assessor, Academic Assessor and an identified Preceptor, to explore the transition period and develop an individualised bespoke NQN preceptorship programme that leads on from a student development plan.
Practice Environment	There should be greater acknowledgement of the impact the arrival of the NQN has on staff already in the workplace, with staff preparation and support to manage the change. Greater provision of continuing professional development opportunities for all staff in the workplace, supported by senior management. Stronger liaison between HEIs, workplace areas and senior managers to recognise the importance of individual preceptorship plans for NQNs which are realistic and developmental. Greater opportunities for students in their final year of their pre-registration programme to experience the management of a workload and associated tasks more aligned to the realities of qualified practice. Liaison between HEIs and healthcare providers to develop a range of innovative placement experiences for students.
Preceptorship Period	Individualised preceptorship plans for each NQN, with identified preceptor, developed prior to entry to the qualified workplace with senior manager oversight and support. Greater understanding and consideration of the impact of generational differences, previous care experience and personal demographics on the transition experience for the NQN. Structured induction for all NQNs which includes workplace and peer support networks. Increased liaison between HEIs and senior managers to identify the unique challenges and support needs of individual work areas, to enable provision of a positive preceptorship experience for the NQN and staff in the area.
Further Research	Further exploration of demographics and generational differences linked to the transition experience of NQNs. Further study of the perceptions of generational differences in students, NQNs and clinical areas, and their impact on individual support and development needs of students and qualified nurses. Further research into the impact of NQNs on the workplace and the support needs of staff in the work area. Exploration of nurse academics, and clinical nurses' expectations of NQNs, and any association with oppressive practices in the workplace.

8.3.1 Recommendations for the Pre-registration Curriculum

Readiness for qualified practice is multifaceted and needs to be developed throughout the pre-registration programme. Each student enters their studies with personal habitus and expectations developed from their up-bringing, education and life experiences. From the first year of the programme, students should be encouraged to consider their assumptions and where their perceptions and expectations have come from. Reflection is a valuable tool to aid learning (Steven, Wilson, Turunen, Vizcaya-Moreno, Azimirad, Kakurel et al, 2020) and needs to be a key component of pre-registration nursing programmes (NMC, 2018a). Whilst reflection can be used to ensure learning from experiences during the student journey, it should also be used to encourage students to consider their habitus, and how that habitus is aligning to their nursing experiences.

To develop the pre-registration curricula, students should be introduced to the concepts of capital and habitus (Bourdieu, 1992), to enable them to reflect on their life journey and the learning and skills that have brought them into university. Using reflexive practice, students should explore what they expect to gain from their experience during their pre-registration programme, and ultimately who they will be on qualification. Students can be encouraged to recognise the life skills they have developed, and the value of those skills within nursing. Mature students, who have not entered university through the traditional route, may forget the tenacity that has brought them to this point; the multiple roles and responsibilities they have juggled, and the time management skills they have developed, to enable them to achieve the requirements to enter the programme. These accomplishments can be effective tools to help them to navigate their pre-registration studies and the transition to qualified practice. Reflective practice sessions throughout the curriculum and reflexive assessments should encourage students to revisit their habitus,

build on their transferable skills and examine how and if their perceptions and expectations are changing.

The nursing workplace now contains individuals from four generations (baby boomers, Generation X, Generation Y, and increasingly Generation Z). HEE (2015) suggested that each generation has its own traits which will impact on the dynamics of the working environment. Whilst the traits for each generation are generalised and will not be applicable to every individual, they provide an indication of the different needs of staff in the workplace, the diversity of those needs, and the challenges in ensuring those needs are met. Students continue to enter nurse education from Generations X and Y, alongside the younger students from Generation Z. Their generational traits can influence how they manage the demands of the pre-registration programme, as well as their expectations of and preparation for qualified practice. To support the different generational needs of both students and staff in the workplace, education on generational differences and techniques to promote effective teamworking between generations, should be included within the curriculum. These sessions should be revisited regularly as students have increased exposure to working in the practice environment, and students should be encouraged to reflect on how their individual traits have influenced their interpretation and response to their experiences. Alongside this, the HEI should liaise closely with healthcare providers to support the education of all staff in the practice environment about generational differences. If a greater understanding and appreciation of the different generational traits can be developed within practice settings, this can contribute to the development of a positive workplace culture and a supportive experience for students and NQNs entering the area (Beech et al, 2019; HEE, 2018).

To support students to understand the influences on their habitus, and their individual needs, one-to-one student meetings with Personal Tutors and with Practice Supervisors, Practice Assessors and Academic Assessors (NMC, 2018b) should include discussion of individual student life skills and experiences, and their value to nursing. Through this, consideration of changing capital and habitus can be explored and any areas of difficulty for the student identified. They can then be encouraged to consider why their habitus may not be adjusting to their developing capital and how they can be supported. A personal development plan may then help them to adapt their habitus and assumptions, to align more effectively with their developing nursing habitus.

Changing personal habitus can be a stressful occurrence (Morberg et al, 2012) and is one of the challenges students face throughout the curriculum. To support students to manage the challenges of their programme and to prepare them for their transition to qualified practice, there should be well-being activities and resilience development within the curriculum. Well-being activities can include sports teams and running clubs for students and lecturers. Regular well-being activities can be introduced, to include mindfulness sessions, yoga, and stress management, promoted through a student/staff well-being committee. Resilience should be taught from the beginning of the pre-registration programme to develop students' understanding of what it is and its importance in nursing. Skills of resilience should be strengthened across all years of the curriculum through reflective practice, small group solution-focused activities and peer support sessions, facilitated by the Personal Tutor.

During the final year of the programme, students should be supported to understand how their resilience, transferable life skills and adjusting personal habitus is preparing them for their transition to qualified practice, alongside their increased knowledge and skills

competence. Informal support can be valuable alongside more formal approaches during the transition period (Watson et al, 2020), and this can be extended across the pre-registration programme. Development of networking peer support systems through social media groups, and opportunities to engage in discussions and networking with qualified staff throughout the pre-registration period, will help students to adjust their habitus to align with the realities ahead of them.

Individual student development plans that focus on their development of practice readiness across the pre-registration journey should be created. Through regular liaison between HEIs and clinical partners, these can then be used to encourage students to explore their habitus and develop the skills to prepare and support them through the "flaky bridge" period at the end of their programme. Encouraging students to review their development and perceptions during the pre-registration programme and supporting them to identify areas where they are struggling to develop and adjust to their changing capital, as well as their knowledge and skills, can form the start of a personal transition support programme that can be continued through preceptorship. HEIs should work closely with employers to explore innovative approaches to the development of less tangible but important skills, such as perseverance, resilience, and ability to adapt to change and manage stressful situations, and these can then be individualised to the needs of each student and feed into their development plans.

Each practice area is unique, with its own doxa, culture and challenges. Students will experience a number of different placement areas during their pre-registration programme, and it is important that they are prepared for each unique experience. Timetabled placement preparation sessions should take place before each placement experience. Students' assumptions and concerns should be explored during these sessions, with consideration of the transferability of life skills and developing nursing knowledge and

skills. Placement preparation sessions should acknowledge the individual doxa and culture of each placement area and support students to develop the skills of transferring knowledge between different placement environments, through reflexive practice and solution focused activities. Students should be encouraged to consider how they may impact on the placement area, adaptation to the doxa of the environment, and how the experiences gained from the placement may impact on them and their habitus.

Small group debriefing sessions should take place with the Personal Tutor after each placement experience. Students should be encouraged to support each other to explore the learning from their practice experience and any challenges or changes to their habitus. Opportunities for self-assessment of needs should form part of the debriefing sessions and these should be followed up at individual personal tutor meetings. During the personal tutor meetings each student's development plan should be reviewed, informed by feedback from Practice Supervisors, Practice Assessors and Academic Assessors, alongside the student's self-assessment. Close liaison between the HEI and placement colleagues can then ensure that bespoke support is available for any areas where the student is having difficulty, including adjusting their habitus.

NQNs continue to report shock (Watson et al, 2020), and difficulty managing the multifaceted role of qualified practice. Throughout the final year of the programme, greater use should be made of simulation to provide more opportunities for students to experience the workloads of qualified nurses and the additional tasks that are associated with that workload. Simulated wards, interprofessional learning activities and timed role play can provide opportunities for students to explore challenges of time management and prioritising, with reflection and learning from those experiences. During these sessions greater focus should be given to students' previous life and work experiences, and they

should be encouraged to apply those skills to the decision making and time management challenges of the simulations. Encouraging greater student awareness and application of their tacit skills can then enhance their confidence and resilience for the realities of qualified practice.

These sessions should be supported by workshops around developing time management and managing multiple demands. Through liaison with employers, qualified nurses from practice should be enabled to engage in and facilitate these workshops. Providing more opportunities for clinical staff to contribute to the curriculum, particularly in the final year of the programme, would enable greater liaison between practice and the HEI, and provide students with opportunities to discuss their approaching transition and expectations of them as NQNs.

During the final year of the programme there needs to be greater focus on preparing for the transition to qualified practice and the purpose of preceptorship. Students should be provided with greater information of preceptorship processes and the difference between preceptorship and student support and supervision. Through liaison between the student, Personal Tutor, Practice Assessor and Academic Assessor, the individual student development plan should be reviewed, and key areas identified to inform the preceptorship support programme. Once the student has secured employment, HEIs and managers should liaise to facilitate development of a bespoke preceptorship plan through discussions with the student, so that this is in place in readiness for the student's transition to the qualified role. Individual preceptors and small workplace teams should be identified to act as a support network for both the student and the preceptor on entry to the qualified area. Where these are in place prior to completion of the pre-registration programme, greater discourse can occur between the HEI and the preceptor, to identify mechanisms that can be implemented to provide individual support for each NQN.

8.3.2 Recommendations for the Practice Environment

The practice environment provides 50% of the education and preparation for student nurses (NMC, 2018). The staff in those practice areas work in challenging and stressful circumstances where team working is essential (NMC, 2018d). When an NQN enters the workplace, their presence will change the dynamics of the team and for some staff this can be unsettling and anxiety provoking (Child, 2015). If the NQN is having difficulty understanding the doxa of the workplace and adjusting to the culture, this can cause added pressures for everyone in the working environment. There needs to be greater recognition of the impact the NQN addition can have to the workplace and the adverse and unforeseen effect it can have on some colleagues. Senior managers need to be more aware of the changes that can occur when new staff are introduced into the environment and provide greater support to help the workplace to adapt to the change.

Prior to the arrival of the NQN, managers need to provide opportunities for staff to meet and discuss their concerns or needs and their expectations of the NQN. Allowing staff the time to have these conversations with management support, offers reassurance about forthcoming change and opportunity to address any unrealistic expectations of the NQN prior to their arrival. Senior managers should be aware of areas in their organisation where NQNs have started to practice and should provide additional support to those areas during the preceptorship period to ensure that both staff and NQN are able to make a positive adjustment to the new team dynamics.

Continuing professional development is an essential part of any profession and is a requirement of NMC revalidation for nurses (NMC, 2021b). The challenges of contemporary nursing practice mean that opportunities for all nurses to engage in CPD

can be difficult but are essential to the well-being and updating of the workforce. Through liaison with the HEI, managers need to provide more CPD opportunities for experienced workplace staff, and these should include face to face and online learning activities to cater for the different needs of staff. When training sessions are provided for NQNs, managers should also consider, from staff appraisals, how such training needs may be beneficial for updating some more experienced staff. Where these resources can be aligned for NQNs and other staff in the workplace, a culture of shared learning can be fostered. This will help to remove the perception reported by some NQNs, that they are seen as a threat to other staff in the workplace and may hence reduce some of the power issues experienced by NQNs.

Staff in the workplace also need support to develop their understanding of the change that occurs to professional identity and status on qualification, and the different ways individuals react to this. They can be encouraged to explore their own perceptions and factors that influence their expectations of NQNs (such as previous experience or age), and why those expectations may not be realistic. From this, discussions around the individual needs of NQNs and the importance of team support for the NQN during their transition can be developed, and any additional needs of the team identified.

When there is greater understanding of the differing needs of NQNs and the value of support from the workplace, a better understanding of the transition period and preceptorship can be developed. Through strong liaisons between the HEI and workplaces, and clear effective oversight and management from senior managers, more individualised and effective preceptorship programmes should be developed, that link more closely to the pre-registration programme, to form a more individualised and smooth transition of support to qualified practice.

To increase the effectiveness of practice readiness, students during their final clinical placements should be given greater exposure to the realities of qualified practice (HEE, 2018), through opportunities to manage a full workload under supervision. Practice Supervisors should be supported by the HEI and their managers to recognise the value that providing a more authentic experience can contribute to the NQN's development. Through opportunities to practice their skills of time management, clinical decision making, stress management and personal well-being, NQNs will gain confidence and insight to help to provide them with greater practice readiness.

Additionally, placement providers should work closely with HEIs to identify more innovative placement areas that reflect contemporary society (for example, support for refugees, asylum seekers, victims of domestic abuse). By providing experiences where students can develop generic skills that cross different fields of nursing practice, NQNs will gain a more holistic approach to their role which will be beneficial to patient experiences. CPD opportunities should also be available to support the development of these generic skills for experienced nurses in the workplace, to increase their skills and understanding and enable them to provide support and learning for students whilst meeting more holistic needs of patients.

8.3.3 Recommendations for the Preceptorship Period

There should be greater senior manager oversight within organisations to ensure that individualised preceptorship programmes and identified preceptors are in place for all NQNs entering the qualified workplace. Through greater liaison with the HEI towards the end of the pre-registration period, preceptorship support plans should be developed which build from individual student development plans, through discussions with the student and

their Personal Tutor. When workplaces are under increased pressures, greater managerial and educational support should be available to the NQN, the preceptor and the wider workplace team. Through this there will be a greater understanding of the importance of structured and opportunistic support for the NQN and their transition to the qualified role.

To provide greater understanding of the individual needs of the NQN on entry to qualified practice, all staff in the work environment (qualified and unqualified) should receive education on the different demographical and generational needs of NQNs and how those needs may not always align with expectations of staff in the workplace. Consideration of these individual needs should then be evidenced within the preceptorship documentation for each NQN, with details of the support available to meet those needs and the ongoing effectiveness of the preceptorship in supporting the NQNs transition.

Structured induction programmes should be available for all NQNs on entry to the workplace (NMC, 2020), and these induction programmes should introduce opportunities to engage with peer group networks, well-being activities, social activities, and support mechanisms within the organisation. All NQNs should be easily distinguishable within the workplace via a different coloured lanyard or badge, as an aide memoir for colleagues. This will help to reduce the assumptions that the NQN has been qualified for much longer (particularly for Generation X NQNs), and remind colleagues that support is needed during the preceptorship period.

Senior managers and HEIs should work closer to identify the unique challenges and support needs of each workplace area. Support and professional development opportunities should then be provided for staff, to promote a more positive workplace

culture, encourage career enhancement, and create a positive environment for the NQN's transition to qualified practice.

8.3.4 Recommendations for Further Research

To gain greater insight and understanding of NQNs' perceptions of practice readiness, further research is suggested into the following areas.

Knowledge of the influence of demographics and generational traits on transition has received little attention in the research to date. Greater understanding of how educational backgrounds, previous life and work experience, and generational traits, affect personal habitus and expectations, would enable greater individualised support for students and NQNs. Greater exploration of these factors linked to individual experiences during the pre-registration programme and transition period, would expand the knowledge base around their significance to development of practice readiness in the NQN. Moving forward, this research needs to also include the needs and influence of Generation Z on both the pre-registration curriculum and clinical practice, and how greater understanding of this additional generation in the workplace can be gained.

Findings from the current study identified that there are areas of particular interest relating to either Generation X or Generation Y NQNs that would be worthy of further exploration, supporting a suggestion made by HEE (2015). For Generation X NQNs, further research into their experience of preceptorship and wider workplace support would contribute knowledge on how their needs are perceived and managed during their transition experience. My study identified that the changes to social capital and personal habitus proved challenging and anxiety provoking for NQNs in this generation. Further research into their perceptions and preparation for adjustments in these areas would develop

greater understanding of their needs and inform development of future pre-registration curricula.

For Generation Y NQNs, further research into how they are perceived by the workplace would help to identify if their needs for regular feedback and reassurance are recognised and understood, or if these needs are seen negatively by colleagues. As with Generation X, greater exploration of their preceptorship and workplace support experiences would be beneficial. As a generation whose traits indicate an increased need for support (HEE, 2015), more understanding of the impact of any lack of support on their resilience and retention to the workforce would inform future pre-registration curriculum and preceptorship programme developments. My research identified that for the NQNs in this generation, the increased responsibility experienced on qualification was a stressful experience. Further research into the preparation of these students for the responsibility of qualified practice, particularly if those students do not have many transferable life skills to draw from, would help to identify an area requiring further attention in the curriculum.

In addition to the impact of demographics and generational traits on the NQN, greater understanding is also needed around the impact of these factors on the perceptions and assumptions of others. More research is needed into how students and NQNs from different generations and backgrounds are perceived by academics and the clinical environment, and how those perceptions influence the support they are offered. Through the exploration of perceptions of qualified nurses who educate and support student nurses and NQNs, areas of misunderstanding or professional development can be identified and addressed. This would then inform both pre-registration curricula and preceptorship programmes, to better support the individual needs of students and enhance NQNs' practice readiness.

Further research is needed into the impact of the NQN on workplace dynamics, the workplace habitus and the needs of staff in that environment. Greater understanding of workplace perceptions of the impact of the NQN addition to the team would be beneficial. Support and education can then be provided to help individuals in the workplace adapt to the change and provide a welcoming culture for the NQN, to support a positive transition experience.

Oppressive and negative experiences continue to be reported by some NQNs (HEE, 2018). There needs to be greater understanding of the types of oppressive practice that occur, reasons for those practices and their impact on the different generations of NQNs. Research would be valuable into workplace staff experiences of working with NQNs, their perceptions of the value of preceptorship and their approaches to support for NQNs. There remains little evidence around the impact of preceptorship on the attrition of NQNs to the profession (Watson et al, 2020), and this research would provide additional knowledge and understanding into this area.

8.4 **Conclusions**

This chapter has summarised the original contribution this study makes to the knowledge base around practice readiness. Although this thesis confirmed some findings seen in previous research, the consideration of the study findings through the lens of Bourdieu's habitus and capital, provides fresh insights and new understandings of practice readiness and transition experiences for NQNs. This thesis offers new knowledge about the influence of generational traits and personal backgrounds to the NQN perceptions of their experiences. By addressing the questions posed at the onset of this research, the new knowledge enhances the understanding of NQNs' experiences of entering qualified practice, and the role the pre-registration curriculum, clinical partners and preceptorship can play in developing more effective practice readiness.

A strength of the theoretical underpinnings of this study was the opportunity to explore demographic and generational differences that affect individual's experiences, through Bourdieu's lens of capital and habitus. Limitations of the study were acknowledged and my role as an insider in the research was considered.

Ultimately, findings from the study have enabled new understanding of this important period in the NQN's career and the influence of the pre-registration curriculum, practice education and preceptorship provision. Recommendations have been offered to enhance practice readiness throughout the pre-registration journey and entry to the qualified workplace through the curriculum and practice placement experiences. Recommendations for the practice environment have been produced which focus on healthcare organisations providing greater support and CPD opportunities for all staff in the workplace, and greater value and support for preceptorship programmes.

Recommendations for further research reflect the need to increase the knowledge base around generational differences, and the influence of individual demographics on student nurses' and NQNs' developing resilience and changing capital and habitus. Alongside this, greater understanding of the NQN's impact on the workplace, and expectations of workplace colleagues is needed. Through the recommendations made, students, NQNs, and workplaces can develop greater awareness of the significance of capital and habitus to practice readiness. The pre-registration curriculum and practice environment can enhance support for students and NQNs to adapt their personal habitus to align more to the realities of contemporary nursing and society's perceptions of the qualified nurse. Increased individualised support and resilience for the NQN alongside greater support and CPD opportunities for staff in the workplace, can improve the transition experience.

Through more positive transition experiences and a nurturing workplace environment, NQNs can be encouraged to develop their nursing career, reaching their full potential while providing high quality patient care and contributing to the health economy. NQNs are proud of their profession and their contribution to society; they have awareness of their changing professional and personal identity and need opportunities as students to explore and prepare for these changes. With further research and understanding, NQNs can be supported to continue to prepare for and develop long and fulfilling careers in the nursing profession.

8.5 **Final Comment**

Completing this thesis was always a personal doubt, but every step was an achievement and celebrated as a milestone. To complete the doctorate whilst working fulltime and dealing with family commitments was not for the faint hearted. Someone once told me that doctoral study was about perseverance and determination. To reach this stage is a personal accomplishment, never thought possible; but the journey and experience was a privilege, that I shall be forever grateful for.

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APPENDICES

APPENDIX 1: Data extraction table of Government and Professional Body reports and standards

No	Report details	Purpose of the report	Key findings through the lens of practice readiness and professional identity for the NQN
1	Beech, J., Bottery, S., Charlesworth, A., Evans, H., Gershlick, B., Hemmings, N., Imison, C., Kahtan, P., McKenna, H., Murray, R., Palmer, B. (2019). *Closing the gap.* Available from https://www.health.org.uk/publications/reports/closing-the-gap. (Last accessed 21/06/2021).	Provide a set of high-impact interventions to improve the current healthcare workforce crisis, with a particular focus on nursing and general practice.	a) To increase numbers of nurses in the workforce a cost-of-living grant should be introduced for pre-registration nursing students in recognition of the time they spend in clinical placements. b) Providing a more equal balance of funding for placements between medicine and nursing to encourage an increase in available placements for nursing students. c) To reduce the attrition of student nurses and increase the number of NQNs joining the NHS workforce, HEIs and placement areas should set conditions on the quality, success and balance of the training for student nurses. This should be guided by Health Education England with accurate monitoring of attrition and reasons for that attrition. d) Increasing the number of nursing apprenticeships available to support social mobility and increase participation from the local workforce. The apprenticeship programme has proved popular with more mature entrants and from a diverse range of backgrounds. The apprenticeship programme can provide a career route for existing staff such as support workers.

			e) NQNs do not always have the support needed when they enter the workforce which can affect their engagement and mental health and may make them more likely to leave the NHS. This is exacerbated by the loss of more-experienced staff, reducing the support available to NQNs. f) There needs to be greater understanding of the generational differences in the workforce and the implications of this for meeting staff' needs. g) There needs to be more support available for NQNs at the beginning of their career which continues beyond preceptorship. There also needs to be sufficient senior staff available to offer support and CPD funding available to enable learning to continue. h) Successful staff retention programmes include expanding preceptorship programmes for NQNs and offering pastoral support from more experienced staff. i) Attracting the right candidates to nurse education programmes and preparing them well for their qualified role can improve the retention of NQNs. j) HEIs, commissioners and NHS partners need to work more closely together to recruit more local trainees.

2	Council of Deans for Health. (2016). *Educating the Future Nurse – paper for discussion.* Available from www.councilofdeans.org.uk. (Last accessed 27/05/2020).	Provide views on proposed NMC Standards (2018) for pre-registration nurse education.	a) NMC justification for introducing new professional standards for pre-registration nurse education is that there have been key policy statements and reports alongside a growing number of unregistered carers, which have changed health and care. As a result, nurses have increased responsibility and accountability relating to delegation and supervision. b) New standards need to promote learning throughout the nurse's career. c) Pre-registration curricula need to include education in delegating/supervising, mental health awareness, resilience, skills to challenge poor practice or raise concerns. d) There needs to be acknowledgement with the pre-registration curricula of the unique contribution of nurses and their impact on care. e) Students need to be prepared for the evolving role of the nurse which now includes responsibilities and advanced skills that used to be associated with the doctor's role. f) The competency-based curriculum must allow for innovation to address future needs and demands. g) Challenge for the pre-registration curriculum is to prepare NQNs for the skills required by employers but also the skills to adapt and continue to learn throughout their career.

			h) Future nurses need to be prepared during the pre-registration period to work autonomously, make independent decisions and act as a negotiator and facilitator. i) The curriculum needs to prepare future nurses to have skills and understanding that span the four fields of nursing, to be able to work across a range of contexts. j) To prepare future nurses to teach others, they should be involved in teaching less experienced students during their pre-registration studies. k) Student nurses need to learn the skills of safe delegation and develop an awareness that delegation and management will be a key area of their qualified practice. l) The pre-registration programme needs to provide the foundations for the student to become a nurse prescriber following qualification. m) Students need to develop greater leadership skills with more awareness of policy and political influences. n) To support the development of their professional identity when qualified, student nurses need to have good change management skills.

			o) Pre-registration professional standards need to encourage greater engagement in research and teaching. p) Learning in clinical practice is significant for students and practice education has a key influence over the formation of professional identity. q) Experiences in clinical practice influence the attitudes and expectation of NQNs on entry to qualified practice. r) There needs to be improvements in practice learning and the approach to the supervision and teaching of students in clinical practice. s) Expectations of, and on, NQNs are increasing and effective preceptorship is key to meeting these needs and supporting NQNs. t) There needs to be better reality of what can be expected of an NQN on entry to the workplace (from HEIs and employers). u) There needs to be greater linking between pre- and post-registration education.
3	Department of Health. (2010). *Preceptorship Framework for Newly Registered Nurses, Midwives and Allied Health Professionals.* Available from https://www.networks.nhs.uk/nhs-networks/ahp-networks/documents/dh_114116.pdf. (Last accessed 21/06/2021).	To provide a guide and resource for staff in NHS organisations who are	a) The preceptor is a registered practitioner with formal responsibility for supporting the NQN through their preceptorship. b) Preceptorship is within the spirit of the staff pledges in the NHS Constitution

		responsible for systems of management for developing preceptors and NQNs.	c) The value and importance of preceptorship is detailed in the DH (2008) workforce review. d) Preceptorship aims to enhance the confidence and competence of NQNS as they work as autonomous professionals. e) NQNs should be competent and safe; preceptorship forms part of the transition to qualified practitioner, to further develop confidence and competence, but not to meet shortfalls from pre-registration education. f) Preceptorship should be structured to support the NQN to develop as an autonomous professional and to refine their skills, values, and behaviours as part of their lifelong learning. g) Preceptorship should offer a personalised programme of development and support to embed the values and expectations of the nursing profession. h) NQNs should take responsibility for their learning and development, with continued life-long learning. They should understand and engage with the concept of preceptorship. i) Preceptors should have the right attributes for the role and should be prepared, acting as role models for the NQNs.

			j) Preceptorship programmes should demonstrate the organisation's commitment to learning, and delivery of the NHS Constitution. k) Preceptorship should increase professional socialisation into the workplace and enhance recruitment and retention of NQNs l) Organisational systems should be in place to ensure that all NQNs have preceptorship, are tracked through the preceptorship period and that there are sufficient preceptors available to support the NQN. m) Preceptorship arrangements should satisfy the requirements of the regulatory body. n) Effective preceptorship should allow the NQN to engage in a range of activities over the first 6-12 months of qualified practice.
4	Francis, R. (2013). Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. Executive summary. Available from Francis Report. (Last accessed 27/05/2020).	Inquiry into the serious failings at Mid Staffordshire NHS Foundation Trust.	a) Nurse education should have an increased focus on the practice of delivering care and compassion. b) There should be national standards to ensure that the practice element of nurse education is of consistent quality. c) All qualified nurses should be required to evidence annual ongoing learning and training. This should be made available to the NMC, if requested, as part of a revalidation process.

			d) Leadership training should be included in the pre-registration nursing curriculum and as part of post-registration learning and development. e) There should be more monitoring of the nursing workplace culture. f) Healthcare support workers should be easily distinguished from qualified nurses. g) The NMC needs to be proactive in investigating when concerns are raised about a nurse's fitness to practice. h) The NMC should introduce a system of revalidation (similar to the GMC) to ensure the ongoing competence of qualified nurses. i) There should be a statutory obligation on all nurses to observe the duty of candour. j) Practical experience in a care setting (at least 3 months) should be a prerequisite to entry to the pre-registration nurse education programme. k) Applicants for pre-registration nursing programmes should be tested for the attitudes to care, compassion and professional values. l) The NMC should work with HEIs to develop a national qualification assessment to ensure consistency across pre-registration nursing programmes.

			m) National training standards are required for registered nurse qualifications to ensure NQN's competence is consistent. n) Nurse managers should be role models for staff and support their development of leadership skills and clinical competence. o) Ward managers should ensure that professional staff maintain a caring culture. p) Regulation and monitoring of organisations should also review the organisational culture. q) The size and complexity of the NHS creates challenges for creating and maintain a patient-focused positive culture.
5	Health Education England. (2015). *Mind the Gap.* Available from https://www.nhsemployers.org/-/media/Employers/Documents/Plan/Mind-the-Gap-Smaller.pdf. (Last accessed 27/05/2020).	Summary of a project to gain insight into the needs of nurses and midwives in the early phase of their qualified career.	a) NQNs want care and support from their colleagues and their leaders. b) NQNs want to make a difference and meet the expectations of patients and the public. c) NQNs want to be accepted and valued as part of the team. d) NQNs want feedback and support to develop and have career progression. e) NQNs want a work-life balance.

			f) The needs of NQNs may be different depending on their age and generational traits. g) Generation Y NQNs are more likely to leave their post if they do not achieve job satisfaction. h) Generation Y NQNs require more constant support and feedback on entry to the qualified workplace, than previous generations. i) For Generation Y NQNs the informal support from the workplace may be more important than the type of specialism they are working in. j) A sense of belonging is important to Generation Y NQNs k) Generation Y NQNs are more likely to want to feel valued by the public and other professions. l) There needs to be greater awareness of the different generational motivators to maximise engagement and retention.
6	Health Education England. (2017). *Facing the Facts, Shaping the Future.* Available from https://www.hee.nhs.uk. (Last accessed 27/05/2020).	Provide a draft workforce strategy for health services in England through to 2027	a) The NHS needs to attract and retain more newly qualified staff. b) Training of more nursing associates to deliver hands-on-care to patients.

		(consultation document).	c) Development of a degree level nursing apprenticeship programme with facility to transition from nursing associate to registered nurse. d) Development of initiatives to improve human factors capability in healthcare. e) Implementing human factors training in pre-registration curricula. f) Organisational culture needs to promote equality and diversity. Retention will be easier if staff feel valued and respected. g) Greater flexibility in the workplace to provide a work-life balance. h) Nurse education must align with health system changes and academics should be involved in developing evidence-based practice, service delivery and leadership.
7	Health Education England. (2018). *RePAIR. Reducing Pre-registration Attrition and Improving Retention Report.* Available from https://www.hee.nhs.uk/our-work/reducing-pre-registration-attrition-improving-retention. (Last accessed 27/05/2020).	Report on the RePAIR project to reduce unnecessary attrition in pre-registration healthcare programmes and improving retention of newly	a) Students need to have a greater understanding of national healthcare policy. This is particularly important in their final year and during transition to qualified practice. b) The first year of employment can be particularly challenging for the NQN due to changes in their professional identity, socialisation within the hierarchy and understanding power relations in the workplace.

		qualified practitioners in the first 2 years of employment.	c) Healthcare providers need to work more closely with HEIs to prepare students for the role transition. d) Students near the end of their programme should be exposed to the high intensity and realities of the conflicting contexts of their qualified role, to better prepare them for the realities of practice. e) The attitudes and behaviours of colleagues towards the NQN on entry to the workplace affect how well the NQN is able to make the transition. f) NQNs should enter a career that is built on values for compassionate care. g) Efforts should be made to prevent emotional burnout in NQNs. h) Preceptorship programmes can improve the transition experience for NQNs and reduce attrition. i) There are now 4 different generations of nurses working in the healthcare environment. The differences between generations need to be understood and their needs met. j) Preparation for qualified practice needs to start in Year 2 of the pre-registration programme. k) NQNs found transition to qualified practice easier when they had a supportive workplace environment.

			l) Confidence of NQNs was associated with their perceived readiness for qualified practice. m) Service pressures and staff shortages can negatively affect the approach that healthcare providers take to supporting NQNs. n) Transition modules towards the end of the final pre-registration year have proven to be successful in preparing students for qualified practice. This is particularly successful when employers are involved and can discuss their expectations of NQNs. o) Developing resilience during the pre-registration programme can be beneficial for the NQN. p) Ensuring that NQNs are easily identifiable to other professions can be beneficial. For example, a different coloured lanyard can be used. q) HEIs need a clearer understanding of factors that affect the NQN's confidence at the start of their qualified journey. r) The period of transition from student to qualified nurse is referred to as "the flaky bridge" step of the journey. s) Preceptorship programmes vary from 4 – 18 months and most Healthcare Providers have not designed their preceptorship programme in partnership with their local HEI. The RePAIR

			preceptorship network advises that preceptorship programmes should last for at least 12 months. t) Students' expectations of the qualified role should be managed from the recruitment stage of the pre-registration process. u) Generation Y NQNs want different early career experiences than previous generations and are keen to build their skills then move on to new positions. v) Preceptorship programmes often address the needs of the Trust rather than the needs of the individual NQN. This can mean reassessment of skills already acquired by the NQN and assessment by staff in the Trust. w) Evidence suggests that the confidence of the NQN can be negatively affected if they are not given opportunities to demonstrate their skills and decision-making capabilities. x) Healthcare providers should gather data about the culture of placement areas, and its impact on student decision-making around first qualified workplace choices.
8	NHS Improvement. (2019). *Interim NHS People Plan.* Available from https://www.longtermplan.nhs.uk/publication/interim-nhs-people-plan/. (Last accessed 27/05/2020).	Report looking at how to create a better leadership culture within the	a) The most urgent challenge is the shortage of nurses needed to deliver the NHS Long Term Plan.

		NHS and make the NHS a better place to work in. Contributing to the NHS Long Term Plan (2019) to develop a new service model for the NHS.	b) The leadership culture in the NHS needs to improve to be positive, supporting and compassionate. c) Reports of bullying, harassment and abuse in the workplace rose in 2018. d) Staff shortages are causing stress and burnout for staff. e) There needs to be a more inclusive and compassionate culture. f) There needs to be more opportunities for career development. g) More work needs to be done to ensure that all staff feel able to have their voice heard. h) The effects of the Developing People – Improving Care report (2016) have made some difference but not led to a widespread culture change. i) There needs to be greater retention of qualified nurses through initiatives such as the NHS Improvement Retention Programme (2017). j) There needs to be greater exploration of using group coaching in clinical practice to train student nurses. k) There needs to be greater support for NQNs as they move into qualified practice.

			l) There needs to be an increase in clinical degree-level apprenticeships to allow staff to gain their qualifications whilst working, as apprenticeships support career progression. m) There need to be more volunteering opportunities within the NHS to help people to start to develop the skills needed for working in the NHS. n) The nursing associate role can enable qualified nurses to make best use of their skills.
9	Nursing and Midwifery Council. (2020). Principles of Preceptorship. Available from https://www.nmc.org.uk/standards/guidance/preceptorship/ (Last accessed 21/06/2021).	To provide a set of five principles to all those engaged in preceptorship to consider how to best support NQNs.	a) The objectives of preceptorship are to welcome and integrate the NQNs into the workplace, develop confidence and start their qualified journey. b) The length of the preceptorship programme will be determined by the needs of the preceptee. c) Preceptorship is in addition to organisational induction and mandatory training. It sits alongside individual performance appraisal processes. d) The period immediately after professional registration can influence the NQNs journey to becoming a confident practitioner. e) Preceptorship should offer structured support to enable the NQN to convert their knowledge and skills into day-to-day practice.

			f) Positive preceptorship experiences can increase confidence, a sense of belonging, and professional and team identity for the NQN. It is also linked to improved recruitment and retention. g) Preceptorship can help the NQN to be immersed in the working culture of their workplace and their new professional role. h) Preceptorship programmes should align with the NQN starting in their new role and should acknowledge the knowledge and skills the NQN brings to that role.
10	The National Improvement and Leadership Development Board. (2016). *Developing People – Improving Care.* Available from https://improvement.nhs.uk/documents/542/Developing_People-Improving_Care-010216.pdf. (Last accessed 27/05/2020).	To provide a framework for senior leaders to develop improvement in health and care systems and encourage NHS staff to have pride and joy from their work.	The report acknowledges the need for the following: a) Development of compassionate and inclusive leadership. b) Improved equality and diversity whilst challenging power imbalances c) Opportunities to meet development needs and support learning and improvement of the workforce. d) Development of an organisational culture of compassion, inclusion and improvement. e) Development of a no bullying culture where staff feel safe and empowered.

			f) Ensuring all staff receive appropriate skills and opportunities for career development.
11	West, M., Bailey, S., Williams, E. (2020). *The courage of compassion.* Available from https://www.kingsfund.org.uk/publications/courage-compassion-supporting-nurses-midwives. (Last accessed 21/06/2021).	To investigate how to transform workplaces to enable nurses and midwives to thrive and be better able to provide high-quality compassionate care (against the backdrop of the Covid-19 pandemic).	a) 24% of nursing students in England are withdrawing from their nursing programme or suspending their studies. b) NQNs can find entry to the qualified workplace very stressful and feel unprepared. c) All nurses should have an appropriately trained line manager to support them to work and develop effectively. There should be particular support for NQNs. d) HEIs must work more effectively with placement providers to support students on nursing programmes and ensure placement areas are well-prepared to receive students. e) Placement experiences should promote the values of the profession and compassion, providing a positive learning experience for the student. f) Educators in the clinical area should be well-trained, supportive, inspirational, caring and compassionate role models. g) Some NQNs experience a lack of confidence on entry to the workplace. This is more prevalent when the NQN has not worked in the workplace as a student.

			h) Some NQNs experience frustration and disillusionment when their workplace colleagues are resistance to change and the introduction of evidence-based practice. i) NQNs need support from colleagues in the workplace and a structured path for development. j) Employers need to have realistic expectations of NQNs in line with NMC standards and recognise the support and development needs of the NQN. k) Pre-registration curricula should provide student nurses with the tools to support their well-being, develop teamworking and leadership, and deliver compassionate care. HEIs should work with students to meet their specific needs in clinical placements and academic studies. l) Preceptorship programmes can help NQNs build their confidence and gain support, particularly when they start to work in an unfamiliar workplace. Preceptorship programmes should align with the NMC principles of preceptorship (NMC, 2020) and be for a minimum of six months.
12	Willis, G.P. (2012). *Quality with Compassion: the future of nursing education.* Available from https://cdn.ps.emap.com/wp-content/uploads/sites/3/2012/11/Willis-Commission-report-2012.pdf. (Last accessed 27/05/2020).	To explore how pre-registration nurse education can develop nurses for future practice and the	a) There is no evidence that graduate nurses provide poorer care. Instead they are significant in improving standards and developing future practice.

		support needed by NQNs.	b) Nursing education needs to develop professionalism with patient safety as a priority. c) Nursing education programmes need better evaluation and there needs to be more research linking to curriculum evaluation and outcomes. d) Clinical areas need to recognise their key role in pre-registration education and the effects of the workplace culture on learning and development. e) Nurse education needs to focus on developing nurses for the future health service and population needs. f) The changing skill mix in clinical practice and the increased role of assistant practitioners needs to consider the impact on patient outcomes. g) More research is required into how well-prepared new nurses are. h) Pre-registration should be viewed as part of career long learning and should be followed by preceptorship for NQNs. i) The traditional image of nursing does not necessarily reflect the reality. j) Nurse education needs to prepare nurses to manage and lead care, delegating to and supervising others. k) There is a challenge between the autonomous innovative curricula that HEIs wish to develop and

			the local requirements of employers and commissioners. l) Nurse education frequently creates social mobility with nurse graduates being the first in their family to achieve a degree. m) There needs to be greater public awareness and understanding of the role of the contemporary nurse. n) In clinical practice, mentors should be good role models, knowledgeable, well-motivated and well-prepared to support student nurses. They should have sufficient time and support to mentor students. o) The quality of many clinical placement experiences needs urgent improvement. p) HEIs and employers need to work more closely together. r) The culture of healthcare organisations should be assessed regularly to ensure that learning environments are suitable. s) There is no evidence of shortcomings in nurse education that can be held directly responsible for poor practice. t) Pre-registration nursing education is not the key driver in high quality nursing. The culture of the practice environment, issues in healthcare

			organisations, and commissioning, funding and regulation of nurse education are key.
13	Willis, G.P. (2015). *Raising the Bar*. *Shape of Caring.* Available from https://www.hee.nhs.uk/sites/default/files/documents/2348-Shape-of-caring-review-FINAL.pdf. (Last accessed 27/05/2020).	Review of the future education and training of registered nurses and care assistants.	a) Wide range of perceptions and opinions about what the role of the nurse is. b) The role of the nurse is constantly under scrutiny. c) Expectations of the role have changed - Registered nurses must be able to deliver evidenced-based care, have critical decision-making skills, be leaders and delegate care effectively. d) Registered nurses should have a flexible, generic skillset with a focus on whole-person care. e) Following registration, the NQN should be supported and supervised of one year by a preceptor in the workplace f) High quality, practice-based education in key to the preparation of students for qualified practice. g) "The newly registered nurse, at the point of registration is not the finished product" (Willis, 2015: 50). h) "Patients and other healthcare professionals are often unaware of their [the NQN's] level of

			experience, which puts additional pressure on new registrants" (Willis, 2015: 50). i) HEIs, employers and professional bodies should consider a year-long preceptorship programme for NQNs. j) The model of mentorship to teach and support students in clinical practice should be reviewed.

APPENDIX 2: Data extraction table of the international literature reviewed

No	Study	Aim	Design & method	Sample size and sample type	Country of study	Participant characteristics	Methods of data analysis	Outcomes/Findings
1	Boyle, D.K., Popkess-Vawter, S.P., Taunton, R.L. (1996). Socialization of the new graduate nurses in critical care. *Heart and Lung.*25(2): 141-154.	The effects of socialization for NQNs in critical care in the first 6 month using modified contingency theory of role socialization.	Descriptive Comparative Quantitative study using questionnaire with scaled measures, (initial questionnaire also given to experienced nurses as a comparison.	N=50 (reducing on follow up). Purposive sample.	United States of America.	NQNs from different critical care units, interviewed at 2 weeks, 3 months, and 6 months from start of employment.	Multivariate and Univariate Analysis.	a) NQNs scored significantly higher on professional boundaries, authority, and commitment to profession than the experienced nurses. b) NQNs scored lower on self-confidence. c) At 3 months NQNs indicated an expectation that nurses would delegate patient services but at 6 months they indicated a move back to their initial employment view that nurses should be the providers of nursing care. d) Commitment to the profession was

								higher on initial employment than at 3 months post qualification. e) There were no significant changes to attitudes for authority, self-confidence, or state anxiety. f) It appeared that group cohesion occurred rapid in the first 3 months, but it took longer for friendships to develop.
2	Delaney, C. (2003). Walking a Fine Line: Graduate Nurses' Transition Experiences During Orientation. *Journal of Nursing Education.* 42(10): 437-443.	To examine and describe graduate nurses' orientation experiences.	Phenomenological Qualitative study using individual interviews lasting between 30 – 60 minutes.	N=10 Purposive sample.	United States of America.	NQNs within one hospital following their orientation programme. Interviewed within 3 months.	Colaizzi's Descriptive Phenomenological Analysis.	*Although the research was focused on an orientation process and its effectiveness, it did identify some findings from the beginning of the orientation process when the nurses had just qualified* – a) Participants were proud to be qualified nurses

								and saw it as an achievement “I’m a nurse”. b) Participants were anxious about using their knowledge and skills in everyday nursing practice and decision making. c) Participants did not feel sufficiently prepared for the realities of practice to manage the increased workload expected as they had not been exposed to this level of workload and pressure as a student. d) They sometimes felt overwhelmed with the additional responsibilities and knowledge/skills they were expected to have as qualified nurses. e) They felt scared as they no longer had anyone to fall

								back on (accountability). f) Participants felt there was a difference between the ideology of nursing given during their pre-registration education and the reality of working as a nurse and this was frightening. g) Workload, time management and their ability were key areas of concern. h) Learning the ways of working in the new workplace could be frustrating. i) Fitting into the team was important to participants. j) Participants' perceptions of how they were viewed by the team greatly affected how they saw themselves and their confidence.

								k) They did not feel prepared to handle end-of-life issues.
3	Duchscher, J.E.B. (2001). Out in the Real World. *JONA.* 31(9): 426-439.	To explore how nurses perceived their first 6 months as professional nurses.	Phenomenological Qualitative study using semi-structured interviews and researcher journal reflections.	N=5 Purposive sample.	Canada.	NQNs in 3 acute-care hospitals interviewed at 2 months and 6 months.	Constant Comparative Analysis.	a) Frustration caused by a desire to deliver quality nursing care without having the knowledge, focus, time or energy to do so. b) Participants needed to be accepted by the team. c) Participants found it difficult to establish independent practice to give themselves a sense of being a professional, as consistently needed assistance from other team members to perform their role. d) They perceived “not knowing” to be a weakness in themselves.

								e) Feared that asking questions may stop them being accepted into the team. f) Participants say they felt alone because of their lack of knowledge. g) Self-perception that they should be able to be completely independent and a sign of incompetence that they were not. h) Self-perception that nurses are hardworking and resilient but not valued within the organisation. i) Anxiety at working with and acceptance by medical staff. j) Participants felt that fitting in to the traditions of the workplace were more important than addressing the needs of the

								patients, unless safety was compromised. k) Finishing tasks on time made them seem capable and efficient – their overall goal. l) No “cushion” now if they made a mistake. m) Not able to use their learning from their pre-reg programme as unable to manipulate their knowledge to the “real” world of nursing. n) Overwhelming responsibility. o) Never given full responsibility as a student and therefore not prepared for qualified practice. p) Felt that experience equated to expertise. q) Not questioning of senior colleagues/medical

								s and accepted their opinions as correct – positions of authority. r) Perceived they were being viewed with criticism rather than acceptance. s) Asked questions that would give them practical guidance rather than encouraging them to reason through the problem – wanted to get the work done on time "without killing anyone", rather than engaging in critical decision making. t) Started to feel more comfortable in their role as qualified nurse and more separate from the student role at 2-3 months – enculturation. u) Some participants felt that once they were

								able to let go of their idealism of the role, they were more able to develop their identity as a qualified nurse. v) Critical reasoning for all participants was limited. w) Participants were disillusioned with their perception of what the nurse's role should be (from their education) and the reality of practice. x) Participants had low self-confidence and great need for acceptance, influencing their decision making and clinical judgement.
4	Duchscher, J. E.B. (2008). A Process of Becoming: The Stages of New	To evolve a substantive theory of role transition to professional	Generic Interpretive Inquiry Qualitative study using	N = 14 Purposive sample.	Canada.	NQNs from same baccalaureate UG programme	Not detailed.	[*Findings from initial interviews performed at 1, 3 and 6 months].*

	Nursing Graduate Professional Role Transition. *The Journal of Continuing Education in Nursing.* 39(10): 441-450.	nursing practice for newly graduated nurses.	demographic survey and face to face interviews (research then continued using focus groups).			interviewed at 1, 3, 6, 9, 12 months and a demographic survey completed at the start of the research.		a) NQNs had expectations that were more idealistic than realistic. b) Surprised at the heavy workload. c) Struggled with non-nursing duties (job dissatisfaction). d) Did not feel their contributions were valued by the workplace. e) Mainly concerned with completing tasks on time (to fit in), doing tasks well (anxious about harming someone) and understanding what was expected of them (anxious that did not have specialist knowledge/skills for the workplace). f) Tried to conceal feelings of inadequacy so they could fit in and look credible.

								g) Had a solid identity on graduation but this disintegrated quickly due to performance anxiety and self-doubt.
5	Feng, R., Tsai, Y. (2012). Socialisation of new graduate nurses to practising nurses. *Journal of Clinical Nursing.* 21(13-14): 2064-2071.	To explore the socialisation experiences of new graduate baccalaureate nurses to practicing nurses.	Descriptive Qualitative study using semi-structured interviews.	N = 7 Purposive sample.	Taiwan.	NQNs from one nursing programme interviewed at average 5.5 months.	Content Analysis.	a) Idealistic expectations not the same as the realities of practice (not prepared). b) Not prepared for the increased workload of looking after numerous patients – frustrated as unable to provide the care. c) Not prepared for full responsibility of a patient - never had this before. d) Not able to use their knowledge from their undergraduate programme (too general).

								e) Perceived that not knowing was a weakness. f) Worried that would be yelled at if did not conform to the norms of the workplace. g) Important to fit in – but needed to know the workplace rules and knowledge to be accepted. h) Role conflict – professional values (patient-orientated care) versus organisational values (task-orientated care). i) Frustrated and lacking in confidence due to lack of specialist knowledge/skills and experience. j) Difficulties getting on with senior colleagues.
6	Hunter, K., Cook, C. (2018). Role-modelling	To explore new graduate	Qualitative descriptive study using semi-	N=5 Purposive sample	New Zealand.	Female NQNs from different Schools of	General inductive analysis.	a) Acute awareness of an increased

	and the hidden curriculum: New graduate nurses' professional socialisation. *Journal of Clinical Nursing.* 27: 3157-3170.	nurses' experiences of professional socialisation by registered nurses in hospital-based practice settings and identify strategies that support professional identity development	structured interviews.	followed by network sampling		Nursing with less than 6 months qualified experience.		responsibility and need to practice independently. b) Role modelling of experienced nurses altered their perception of what their professional identity should be. c) NQNs recognised that they were vulnerable to moving away from the best practice professional identity they had but felt that positive role modelling helped them to maintain that professional identity. d) Recognised the value and support of positive role models in practice. e) Some NQNs felt that they were a burden in the workplace. f) Felt that part of their professional identity as a NQN

								was to be able to manage a full patient workload and did not always feel prepared for that. g) Started to change their professional identity to focus on task completion within given timeframes rather than providing holistic care. h) The professional identify of the NQN was idealistic and caused tension with the reality of clinical practice. i) Being accepted as part of the team was important to the NQN and they quickly adapted their professional identity to a more task orientated role to fit in with the organisation working environment.

								j) NQNs were able to identify poor practice and behaviours and were able to act as advocates for patients.
7	Kapborg, I.D., Fischbein, S. (1998). Nurse education and professional work: transition problems? *Nurse Education Today*. 18(2): 165-171.	To investigate nurses' experience of the transition from the 3-year nursing programme to a professional role as a nurse.	Qualitative narrative study - participants kept a diary.	N=8 Purposive sample.	Sweden.	NQNs from one School of Nursing during first 2 months of qualified practice.	Content Analysis.	a) All found it hard to find sufficient time to take care of patients. b) They felt assistants were often doing tasks that should be done by qualified nurses. c) Dissatisfied because did not have sufficient time to complete their workload or to give full attention to patients. d) Uncertain about how to care for seriously ill and dying patients. e) Communicating with patients and relatives was problematic. f) No issues in developing

								relationships with other nurses and the MDT. g) Some difficulties in communicating with nursing assistants. h) Needed more time to complete their workload (slower than experienced nurses). i) Used textbooks to develop specialist knowledge in their own time. j) Admin work took them away from patients and they had difficulty prioritising. k) Unsure of delegating tasks to assistants. l) Unsure of when to call the physician. m) Difficulties breaking bad news to relatives. n) Difficulties prioritising.

8	Kelly, J., Ahern, K. (2009). Preparing nurses for practice: A phenomenological study of the new graduate in Australia. *Journal of Clinical Nursing.* 18(6): 910-918.	To explore expectations of final year nursing students before commencing employment and to describe the experiences of newly graduated nurses.	Qualitative study using Husserl's phenomenological approach with semi-structured interviews.	N = 12 Purposive sample.	Australia.	Student Finalists then as NQNs from one nursing programme interviewed pre-qualification then 1, 6 months.	Thematic Analysis.	a) Did not feel prepared for the reality of working as nurse. b) Unprepared for the nursing culture in the workplace. c) Unprepared for the cliques, power relations and hierarchy in the workplace – feeling not wanted "Eating the Young". d) Not prepared for the decision making, accountability and responsibility as did not really have experience of this as a student. e) Need to be better prepared in the undergraduate curriculum for adverse professional reactions they may encounter with more socialisation skills to deal with

								oppressive practices.
9	Leong, Y.M.J, Crossman, J. (2015). New nurse transition: success through aligning multiple identities. *Journal of Health Organization and Management.* 29(7):1098-1114.	Explore the perceptions of new nurses of their experience of role transition.	Qualitative study using Constructivist Grounded Theory with semi-structured interviews and reflective journal entries.	N = 26 Purposive sample.	Singapore.	NQNs from one nursing programme interviewed within 6 months.	Constant Comparative Analysis.	a) Wearing the nurse's uniform distinguished their professional identity from their personal identity. b) When in uniform always had to be professional, accountable, and responsible. c) Qualified nurse's uniform brought a sense of belonging (shared identity) but this was predominantly associated with responsibility and not being able to pass that responsibility on to others in the way that was possible as a student. d) Felt that when wearing the qualified uniform, they were expected by colleagues to know everything.

								e) Stress caused by not taking shortcuts expected in the workplace and therefore not fitting in. f) Fitting in by observing and questioning colleagues so they could align their personal, professional and organisational identities. g) Developed professional and organisational identity by not arguing or talking back to senior nurses, keeping a low profile and not showing emotions. h) The professional identity constructed during the undergraduate programme did not align with the professional identity operating in the workplace.

								i) The NQNs had to adapt and adjust to the expectations of others to acquire the professional and organisational identities required by the workplace. j) The misalignment of personal, professional and organisational identities can lead to less successful transition to qualified practice and affect retention of NQNs.
10	Ortiz, J. (2016). New graduate nurses' experiences about lack of professional confidence. *Nurse Education in Practice.* 19: 19-24.	To explore how new graduate nurses account for their lack of professional confidence and how this develops during the first year of practice in a hospital setting.	Descriptive Qualitative study. using two interviews 1- Semi-structured interview 2 – Interpretive approach to check for meanings from first interview.	N = 12 (n=7 qualified for less than 6 months) Purposive sample.	United States of America.	NQNs (qualified up to 12 months) from two hospitals. But length of time qualified clearly identified in results.	Content Analysis.	[*Findings from initial interviews performed at point of qualification].* a) Difficulties communicating with members of the healthcare team. b) Worried about making a mistake – affected their confidence. c) The real world of nursing was very different to being a

								student – ideal versus reality. d) Professional confidence increased when NQNs practiced independent decision making. e) Confidence developed with experience. f) Being accepted was important. g) Receiving positive feedback from colleagues was important for confidence.
11	Price, S.L., McGillis Hall, L., Tomblin Murphy, G., Pierce, B. (2018). Evolving career choice narratives of new graduate nurses. *Nurse Education in Practice.* 28: 86-91.	To gain insight into professional socialization.	Longitudinal Interpretive Narrative Qualitative study using semi-structured interviews, participant journals and field notes.	N =6 Purposive sample.	Canada.	NQNs from one nursing programme immediately after graduation.	Narrative Analysis.	a) Proud of their profession and wanted to make a difference. b) Felt being a nurse was a privilege. c) Needed to have a manageable workload to be a good nurse. d) Felt that excessive workload, burnout, exhaustion

								challenged their ability to practice the way that they wanted to. e) Felt support from mentors and peers who were good role models was valuable. f) Felt that having a good work-life balance was important to ensure they became a successful nurse and this was a key factor in choosing their first nursing position on graduation. g) Wanted to be a good nurse and defined this in relation to providing care and being with the patient. h) Said that if they could not achieve a positive work-life balance they would consider leaving the profession.

APPENDIX 3: Data extraction table of the UK literature reviewed

No	Study	Aim	Design & method	Sample size and sample type	Participant characteristics	Methods of data analysis	Outcomes/findings
1	Aldosari, N., Pryjmachuk, S., Cooke, H. (2021). Newly qualified nurses' transition from learning to doing: A scoping review. *International Journal of Nursing Studies.* 113: 1-15	To identify newly qualified nurses' experiences during transition to professional practice, and explore their and other key stakeholders' perspectives of nursing transition programmes.	Scoping review of electronic databases using the Arksey and O'Malley framework	60 international papers and grey literature – 16 from the UK. UK studies were purposive studies that included NQNs, systematic reviews, policies and reviews	UK literature included NQNs on entry to the workplace as part of their sample.	Thematic analysis.	From the UK literature only: a) Transition to qualified practice is a key time for NQNs and can influence their decision to embrace their new career or leave the profession. b) The individual needs and concerns of the NQN are not always explored or addressed. c) Further research into the NQN's experience of transition is required, to develop more effective transition support programmes. d) Many NQNs continue to find entry to the workplace difficult and this can lead to loss of confidence

							and attrition from the profession. e) Poor experience of support and introduction to the workplace can undermine confidence and increase attrition. f) Some experienced staff continue to have unrealistic expectations of NQNs on entry to the workplace.
2	Arrowsmith, V., Lau-Walker, M., Norma, I., Maben, J. (2016). Nurses' perceptions and experiences of work role transitions: a mixed methods systematic review of the literature. *Journal of Advanced Nursing.* 72(8): 1735-1750.	To understand nurses' perceptions and experiences of work role transitions.	Systematic review	26 international papers – 4 from the UK. UK studies used phenomenology, grounded theory and qualitative survey and included NQNs on entry to the workplace.	UK literature included NQNs on entry to the workplace as part of their sample.	Constant Comparative Analysis	a) NQNs reported feeling stress, anxiety and fear. b) NQNs experience both transition and reality shock which can cause extreme emotional upheaval as they work to gain recognition of their qualified status. c) NQNs reported feelings of frustration and disappointment causing

							dissatisfaction in their qualified role. d) NQNs changed their professional identity to reflect their qualified role and align with the identities of colleagues. e) Time management and managing workload can be problematic for the NQN. f) NQNs wanted clarity of their qualified role and needed to understand the boundaries of that role. g) The change to their social systems, workplace and relationships with colleagues can be anxiety provoking for the NQN. h) Effective preceptorship programmes are needed to support NQNs when dealing with the emotional

							challenges of the reality of entering qualified practice. i) Supportive work cultures and managers are important.
3	Child, J.C. (2015). *Creating partnership by aligning the support needs of the neophyte registered nurse and the healthcare organisation: An Appreciative Inquiry.* (Unpublished doctoral thesis). University of the West of England, Bristol.	To examine the effectiveness of a structured preceptorship programme for the NQN.	Appreciative Inquiry using a mini summit with NQNs and Nurse Managers in one organisation.	N=6 NQNs N=9 Senior Nurse Managers. Purposive sample.	NQNs qualified for between 9 – 18 months. NQNs working on a small island with British Crown Dependency but not part of the National Health Service.	Thematic Analysis.	a) The qualified workplace introduces new rules and responsibilities for the NQN to engage with. b) The NQNs arrival in the workplace has an effect on the established team as well as the NQN. c) The qualified workplace does not anticipate that the NQN will be ready to practise safely on entry to the qualified role. d) Experienced staff want to test out if the NQN can meet their standards before accepting them into the team. e) There needs to be a workplace

							culture with clear boundaries and a feeling of safety, for the NQN to gain a sense of individual value and security. f) The needs of the NQN should be balanced against the needs of the established team. g) A supportive team can enhance the learning and confidence of the NQN. h) Regular and frequent feedback is important for the NQN's ongoing development. g) NQNs need to feel accepted and equal within the team. h) For support to be effective NQNs need to feel wanted by the team. i) There needs to be commitment from the wider organisation to support the

							transition process and make the workforce feel valued. j) Preceptorship programmes need to be more individually focused for the NQN, to allow them to take responsibility for their own development. k) To feel valued the NQN needs to feel accepted and respected by the team and the ward manager. l) Nurse managers need organisational and educational support to enable them to effectively lead the NQN and the wider team through the transition process. m) NQNs' confidence in their role can be affected by the team behaviours and the

							working environment. n) NQNs value opportunities to learn at the bedside and opportunities to reflect and discuss away from the bedside. o) Preceptorship is an important but specialised role which needs preparation and support. p) A transition plan could alleviate potential tensions of introducing new knowledge and standards to the NQN and the established team. r) NQNs consider the ward manager as fundamental in leading the support process and allocating the most appropriate preceptor. s) NQNs find peer support valuable.

4	Clark,T., Holmes, S. (2007). Fit for practice? An exploration of the development of newly qualified nurses using focus groups. *International Journal of Nursing Studies.* 44: 1210-1220.	To understand the way that competence develops amongst nurses and how this is seen by their managers and those working with them.	Qualitative Exploratory study using focus groups with NQNs and experienced nurses, and individual interviews with ward managers.	N=105 in 12 focus groups, including 50 NQNs. Purposive sample.	NQNs on a rotational development programme or in a substantive post. Length of time since the start of their employment not stated.	Content Analysis.	From the NQNs only: a) Most NQNs did not feel ready for qualified practice during their first 6 months in the workplace. b) NQNs felt they had insufficient opportunities to develop specialist and management skills prior to qualification. c) Familiarity with the environment made it easier for NQNs to apply knowledge and transfer skills from other areas. d) Some NQNs felt their needs were overlooked in favour of service demands. e) NQNs felt they needed to be competent with specialist skills relating to the workplace to be accepted into the team.

							f) Some staff had greater expectations of NQNs which undermined the NQN's confidence. g) Support and opportunities to consolidate and further develop knowledge and skills through preceptorship were considered important. h) NQNs have to adapt to their new role whilst adjusting to their own personal development.
5	Darvill, A., Fallon, D., Livesley, J. (2014). A different world?: The transition experiences of newly qualified children's nurses taking up first destination posts within children's community nursing teams in England.	Exploring the experiences of newly qualified children's nurses in England who had taken up first destination posts in community children's nursing teams.	Qualitative study using fieldwork observations and semi-structured interviews.	N=8. Purposive sample.	NQNs from the child field observed and interviewed over the first year of qualified practice.	Thematic Analysis.	a) Some NQNs found opportunities to shadow experienced colleagues helped to develop confidence and gradually introduced the accountability that came with qualified practice. b) However, some NQNs felt they were

	Issues in Comprehensive Pediatric Nursing. 37(1): 6-24.						under surveillance and this caused them anxiety and frustration, negatively impacting on their confidence. c) For some NQNs a lack of recognition of their ability and low expectations of them undermined their confidence and made them feel less valued as part of the team. d) Where support was tailored to the individual needs of the NQN, their experience of settling into the workplace was more positive. e) Wearing the same uniform as colleagues and having the same access to facilities (e.g., desk space) helped the NQN to feel like a team member and

							accepted into the workplace. f) NQNs recognised that they needed to adapt and conform to the ways of the team and develop their identity to fit in and become part of the team.
6	Dearmun, A.K. (2000). Supporting newly qualified staff nurses: the Lecturer Practitioner contribution. *Journal of Nursing Management.* 8:159-165.	To elicit the perceptions of children's nurses about their first year as qualified nurses.	Grounded Theory Qualitative study using interviews and a pictorial narrative over the year.	N=10. Purposive sample.	NQNs from the child field, interviewed at 4 points over their first year following qualification.	Thematic Analysis.	a) NQNs had unrealistic expectations of what they should be able to do, comparing themselves to experienced colleagues and this caused anxiety. b) NQNs felt they had a good knowledge base but lacked expertise in technical and practical skills. They were concerned that they would be viewed negatively as staff nurses without this expertise.

							c) NQNs made a "psychological shift" when qualified and recognised their increased decision-making and accountability. They acknowledged that they could not be prepared completely for this and felt unprepared for the anxiety it caused. d) NQNs felt support was not tailored to their needs and they were not supported sufficiently when the environment was busy and were over supported when the environment was quiet. e) Confidence increased with experience of responsibility and decision-making, and when they had opportunities to reflect on their

							experiences and gained feedback.
7	Edwards, D., Hawker, C., Carrier, J., Rees, C. (2015). A systematic review of the effectiveness of strategies and interventions to improve the transition from student to newly qualified nurse. *International Journal of Nursing Studies.* 52: 1254-1268.	To determine the effectiveness of the main strategies used to support newly qualified nurses during the transition into the clinical workplace and, where identified, evaluate the impact of those individual and organisational outcomes.	Systematic review.	30 international papers – 2 from the UK. UK studies used purposive samples and comparative intervention and descriptive case study.	UK literature included NQNs on entry to the workplace as part of their sample.	Narrative Synthesis.	From the UK literature only: a) Support for the NQN is important to help them adjust to their new role and workplace. b) Providing transition programmes can aid retention and improve the experience of starting in qualified practice. c) Well prepared mentors and preceptors can ease the transition to qualified practice. d) Appropriate support can ease the transition to qualified practice, develop confidence and help the NQN understand their role.
8	Gerrish, K. (2000). Still fumbling along? A comparative study	To examine newly qualified nurses' perceptions of the transition from	Grounded Theory Qualitative study using	N=25. Purposive sample.	NQNs from the adult field who had been qualified and	Constant Comparative Analysis.	a) NQNs found the accountability anxiety provoking

	of the newly qualified nurse's perception of the transition from student to qualified nurse. J*ournal of Advanced Nursing.* 32(2):473-480.	student to qualified nurse and to compare those perceptions with those of nurses who qualified in 1985.	individual interviews.		working as staff nurses for between 4 and 10 months.		and feared losing their registration. b) Time management on delegating tasks was problematic for NQNs. c) Some NQNs felt they lacked important clinical skills on entry to the workplace. d) NQNs had difficulty with clinical decision-making. e) Some NQNs felt insufficiently prepared for the practical aspect of their qualified role. f) They felt they could only learn the qualified role once in post but felt able to ask questions when unsure. g) The supernumerary period was helpful and support from preceptors was valuable when it was a positive.

							h) Further work is needed to strengthen the period between qualification and the first six months of qualified practise through supernumerary status and preceptorship.
9	Halpin, Y., Terry, L.M., Curzio, J. (2017). A longitudinal, mixed methods investigation of newly qualified nurses' workplace stressors and stress experiences during transition. *Journal of Advanced Nursing.* 73: 2577-2586.	To investigate transition in newly qualified nurses through an exploration of their stressors and stress experiences during their first 12 months post qualifying.	Longitudinal, explanatory sequential mixed methods, cohort study using a Nursing Stress Scale on qualification, 6 and 12 months post qualifying; with 14 NQNs also completing individual interviews at 12 months post qualifying.	N=288 at point of qualification, Reducing to N=86 at 12 months post qualification. Purposive sample.	Four cohorts of NQNs from the adult field, from one English University.	Descriptive Analysis for the Nursing Stress Scale data. Thematic Analysis for the interview data.	From phase one (on entry to the workplace) only: a) Workload was the most common cause of stress. b) Being part of a "good team" helped the NQNS manage their stress levels and was influential to them remaining in post. c) Dealing with death and dying was very stressful on entry to the workplace. d) NQNs with prior healthcare experience had less stress on entry to the workplace and

							felt better prepared to work with other nurses and doctors. e) Older NQNs felt better prepared on entry to the workplace, to deal with death and dying, working with doctors, and clinical decision-making.
10	Hardyman, R., Hickey, G. (2001). What do newly qualified nurses expect from preceptorship? Exploring the perspective of the preceptee. *Nurse Education Today.* 21: 58-64.	To document and analyse the factors, both professional and personal, that influence careers newly qualified nurses follow.	Semi-structured interviews followed by a longitudinal postal questionnaire survey on qualification and at six months post qualification.	N=136. Purposive sample.	NQNs from the adult field of nursing on qualification.	Not detailed.	a) NQNs wanted support from preceptors but the length of the preceptorship programme desired varied between individuals. b) NQNs felt they needed further development with clinical skills and feedback on their performance. c) NQNs wanted support to settle into the environment and develop more confidence in their role. e) NQNs wanted advice on dealing with professional

							issues and emotional support.
11	Irwin, C., Bliss, J., Poole, K. (2018). Does preceptorship improve confidence and competence in the newly qualified nurse: A systematic literature review. *Nurse Education Today.* 60: 35-46.	A systematic literature review to assess whether preceptorship improves confidence and competence in newly qualified nurses.	Systematic Review.	14 papers, reviews and policies. Papers used purposive samples.	NQNs in the UK, qualified for less than one year.	Thematic Analysis.	a) Although NQNs felt “in at the deep end”, this helped with decision-making and increased confidence. b) Previous familiarity with the workplace environment increased confidence. c) There were conflicting views on whether support should be from one identified person or a wider team. d) Support was very important, but independence and autonomy needed to be encouraged. e) The increased expectations of colleagues and the need to continue learning negatively affected confidence in the NQNs.

							f) NQNs are more prepared for qualified practise and more confident than they were 30 years ago.
12	Johnson, M., Magnusson, C., Allan, H., Evans, K., Ball, E., Horton, K., Curtis, K., Westwood, S. (2015). "Doing the writing" and "working in parallel": how "distal nursing" affects delegation and supervision in the emerging role of the newly qualified nurse. *Nurse Education Today.* 35: e29-33.	To understand how newly qualified nurses recontextualise the knowledge learnt in university to enable them to delegate to, and supervise, healthcare assistants.	Ethnographic case studies using mixed methods (participant observation and semi-structured interviews).	N=33 NQNs. N=10 Healthcare Assistants. N=12 Ward Managers. Purposive sample.	NQNs from 3 different UK hospitals, 3 months after commencing preceptorship tool.	Thematic Analysis.	a) NQNs felt that documentation ("doing my writing") was a time consuming and key part of their role which took them away from patients. b) Some NQNs had difficulty prioritising tasks and managing time which impacted on their delegation skills. c) NQNs understood the important of appropriate delegation and the need to supervise healthcare assistants. d) Ward culture, personal working style and competency, affected the NQN's

							ability to delegate effectively.
13	Maben, J. (2003). *The fate of ideals and values: experiences of newly qualified nurses* (Unpublished doctoral thesis). University of Southampton, Southampton.	To investigate the ideals and values of newly qualified nurses.	Longitudinal Naturalistic Enquiry Qualitative study using questionnaires.	N=86. Purposive sample.	NQNs from 3 different colleges of nursing, sent questionnaires on qualification, 4-6 months post qualifying and 11-15 months post qualifying.	Constant Comparison and Negative Case Analysis.	a) NQNs started qualified practice with a strong set of high ideals. b) Professional and organizational factors sabotaged those ideals. c) Three types of NQN emerged – sustained, compromised and crushed idealists. d) Key factors in supporting or sabotaging their ideals was the practice environment, personal strategies for maintaining their ideals, and motivation. e) Support, role models, staff attitudes and staffing levels were particularly important and influential.

14	Marks-Maran, D., Ooms, A., Tapping, J., Muir, J., Phillips, S., Burke, L. (2013). A preceptorship programme for newly qualified nurses: a study of preceptees' perceptions. *Nurse Education Today.* 33: 1428-1434.	The evaluation of a preceptorship programme for newly qualified nurses to determine preceptee engagement with the preceptorship programme, and the impact, value and sustainability of the programme from the preceptees' perspectives.	Mixed methods Evaluative study using questionnaires, reflective journals and personal audio recordings.	N=44. Purposive sample.	NQNs within 6 months of entering the workplace in a UK NHS Trust.	Quantitative data analysed through descriptive statistics and t-tests. Qualitative data analysed using Thematic Analysis.	a) NQNs can be supported to integrate into the team by a preceptor. b) NQNs lack confidence in their ability to perform as qualified nurses, but preceptorship can help to develop confidence. c) NQNs value support from a named preceptor. d) NQNs were very stressed and anxious on entry to the workplace but found a structured preceptorship programme helped to alleviate this. e) For NQNs who did not find preceptorship beneficial, potential factors included personality clashes, insufficient time with preceptor, strong support networks in the workplace making

							preceptorship unnecessary.
15	Mawson, L.F. (2020). *Educational Preparation of Newly Qualified Nurses and Factors Influencing Transition: A Mixed Methods Case Study.* (Unpublished doctoral thesis). Lancaster University, Lancaster.	To explore how well a group of NQNs were prepared for autonomous professional practice and any key factors affecting the transition period from student to RN.	Mixed methods case study using an online survey and focus groups during the final 6 months of the pre-registration programme, and individual interviews 6-12 months after qualifying.	N=15 for semi-structured interviews. Purposive sample.	NQNs from one HEI.	Thematic Analysis of the interviews.	a) Some NQNs who did not feel supported by their employer changed jobs and others left the profession. b) Some NQNs did not feel sufficiently prepared for the workplace as they had not practised the technical skills required for the specialism of their workplace. c)Although preceptorship was considered helpful for upskilling the NQN, the issues with staff shortages reduced access to supportive meetings. d) Main anxiety sources included: accountability, fear of making mistakes, providing complex care and loss of confidence in competence and

							clinical decision-making. e) Less prepared for difficult communication situations f) NQNs felt guilty in trying to balance care giving with their other responsibilities. g) NQNs felt that supportive, experienced colleagues and support opportunities in the preceptorship programme helped to develop their confidence. h) There is a mismatch between employer expectations regarding more advanced technical skills, and the NMC expectations of the NQN and the pre-registration curriculum. i) Some NQNs felt that their working

							environment was toxic and struggled to challenge what they perceived to be poor practice.
16	Monaghan, T. (2015). A critical analysis of the literature and theoretical perspectives on theory-practise gap amongst newly qualified nurses within the United Kingdom. *Nurse Education Today.* 35: e1-7.	A critical analysis of the literature examining factors and theoretical perspectives contributing to the theory practise gap for newly qualified nurses within the United Kingdom.	Systematic Review of UK literature.	8 papers reviewed (7 studies and 1 position paper). Studies used convenience or purposive samples.	UK literature including NQNs as part of their sample.	Not detailed.	a) Theory- practise gap continues and NQNs are not ready for safe autonomous practise when they enter the workplace. b) NQNs do not perceive they have the required level of clinical skills competence on entry to the workplace. c) NQNs lack confidence in taking on the extra accountability and responsibility of qualified practice. d) Simulation and preceptorship programmes can increase confidence and clinical skills competence in the NQN. e) NQNs are less ready for practice

							since the removal of the apprenticeship model of nurse education but are more knowledgeable of the consequences of their actions.
17	Odelius, A., Traynor, M., Mehigan, S., Wasike, M., Caldwell, C. (2017). Implementing and assessing the value of nursing preceptorship. *Nursing Management.* 23(9): 35-37.	A scoping review of the literature published since 2009 on preceptorship.	Rapid Critical Literature Review.	16 papers reviewed (15 articles and 1 review report). Studies used purposive samples.	Papers related to preceptorship in nursing in the UK, published from 2009 (including view of preceptees).	Not detailed.	a) Staff shortages and demanding workloads can impact on the quality of support for the NQN. b) NQNs consider peer support the most important to improve their confidence and reduce stress levels. c) A Positive workplace culture is important to aid a positive transition of the NQN into the workplace. d) The workplace culture can be negatively impacted by high levels of pressure, frequent changes, and staffing issues.

							e) Preceptorship is valuable in supporting the NQN but needs to be part of a wider approach to supporting the transition into the workplace. f) There is a lack of published evidence that preceptorship improve retention of NQNs.
18	Owen, P., Whitehead, B., Beddingham, E., Simmons, M. (2020). A preceptorship toolkit for nurse managers, teams and healthcare organisations. *Nursing Management.* 1-18.	Introduction of a toolkit for preceptorship based on previous research.	Discussion paper.	N/A.	N/A.	N/A.	a) Suggests that preceptorship improves retention. b) A period of supernumerary status helps to increase NQN confidence and adaptation to the qualified role. c) Support for each NQN should be tailored to the individual needs. d) Workplace support from the whole team was perceived to be the most beneficial by NQNs.

19	Ross, H., Clifford, K. (2002). Research as a catalyst for change: the transition from student to Registered Nurse. *Journal of Clinical Nursing.* 11: 545-553.	To examine the expectations of student nurses in their final year and compare these with the reality of being a newly qualified nurse.	Mixed methods study using questionnaires and interviews.	Pre-qualification N=19 Post-qualification N=13. Convenience sample.	NQNs - Pre-qualifying questionnaire and interviews then questionnaire 4 months after qualifying.	Article focused on Thematic Analysis of the qualitative data.	a) Some NQNs did not feel prepared for qualified practice and found the transition very stressful. b) Completing the final student placement in the same area of the first qualified workplace may be advantageous and aid with settling into the workplace and developing professional relationships. c) NQNs felt they did not have sufficient knowledge of life science or pharmacology and insufficient clinical skills. d) Some NQNs had heightened levels of stress due to concerns about making an error in qualified practice. e) Support for the NQN is important but this is often

							inconsistent and negatively impacted by heavy workloads. f) Positive support from the workplace team is important as well as from preceptorship.
20	Watson, R., Wray, J., Barrett, D., Gibson, H., Aspland, J. (2020*). STaR Project: supporting transition and retention of newly qualified nurses.* University of Hull and Burdett Trust for Nursing.	The STaR project aimed to: (1) establish the current state of the art in the UK for nurse retention and transition from student to Registered Nurse; (2) provide UK healthcare organisations, higher education institutions and individual nurses with an evidence-based approach to plan for successful transition; and (3) develop an evidence-based toolkit that enables NQNs and their employers to identify, implement	A mixed methods study using rapid evidence assessment, interviews and reflections	N= 40 Sample type not identified in the report but suggestive of purposive.	Sample made up of final year nursing students, NQNs, clinical leaders and academics. NQNs were interviewed 1 month and 9 months post qualification.	Content and Narrative Analysis, Descriptive Statistics.	a) Formal and informal approaches are used to support NQNs' transition. b) Formal approaches include preceptorship; mentoring; clinical coaching; induction and orientation. c) Informal approaches include supportive organisational culture, effective communication within and across organisations, access to and informal support (peers, friends, the wider MDT/units). d) Effective strategies for

		and evaluate an individualised approach to transition.					improving retention include formal orientation period, the initial placement, satisfaction with the unit, clinical supervision empowerment, pre-registration employment, previous experience in the unit. e) Preceptorship significantly increases NQNs' competence. f) NQNs continue to experience transition shock and support is most important. g) Transition is a multi-dimensional process impacted by personal, professional and organisational influences. h) Personal characteristics such as reactions to stress, confidence

							and previous student experience in the workplace can affect the transition experience. i) Support for the NQN maximises the potential for a successful transition. j) There is no “gold standard” formal support for the NQN during the transition period. k) There is little research that directly addresses the issue of retention of the NQN to the profession or workplace. l) Despite research and investment in supporting NQNs transition to qualified practice, there have been no substantial changes in the NQNs’ experiences of

							entering the qualified workplace. m) Support programmes such as preceptorship and support networks can be helpful in easing the transition experience for NQNs. n) HEIs and future employers should work more closely together both in the period leading up to registration and in the immediate post-qualification period on seamless and bespoke transition plans for individual nurses.
21	Whitehead, B., Owen, P., Holmes, D., Beddingham, E., Simmons, M., Henshaw, L., Barton, M., Walker, C. (2013). Supporting newly qualified nurses in the UK: A systematic	A systematic review of the existing published research relating to the development of preceptorship to support newly qualified nurses in the United Kingdom.	Systematic Review.	24 papers reviewed (studies, literature reviews, and UK Government commissioned review and 3 articles related to the preceptorship of	A range of health and social care professionals on entry to or shortly after entry to the workplace.	Analysis based on Preferred Reporting Items for Systematic Reviews and Meta-Analysis.	a) Workplace culture can have greater impact than preceptorship programmes. b) Preceptorship can improve recruitment and retention of NQNs.

	literature review. *Nurse Education Today.* 33: 370-377.			student nurses). 9 of the studies were from the UK.			c) NQNs felt that preceptorship was important. d) Support was important for developing self-confidence.
22	Whitehead, B., Owen, P., Henshaw, L., Beddingham, E., Simmons, M. (2016). Supporting newly qualified nurse transition: A case study in an UK hospital. *Nurse Education Today.* 36: 58-63.	To interpret the social phenomena and produce an evidence based tool to improve preceptorship.	Case Study and Naturalistic Inquiry using semi-structured interviews, documentary analysis and focus groups.	Total sample size N-52, but number of NQNs in the sample unclear. Purposive sample.	NQNs undergoing a preceptorship programme in one NHS hospital formed part of the sample.	Analysis aligned to the Naturalist Inquiry Approach.	a) Support from the whole team as well as a preceptor was important to the NQN. b) NQNs felt that peer support was important and helped to stop them feeling isolated. c) If NQNs take off a qualified post in the area where they completed their final student placement they often need less time to adjust to their new qualified role. d) Some NQNs recognised that their high stress levels were linked to their high expectations of themselves.

							e) NQNs felt that preceptors should be advisers and positive role models. f) Support for the NQN should be individualised to their needs. g) NQNs need to have specific skills related to their workplace in addition to the general skills developed through the pre-registration programme. These skills should be developed as soon as possible following entry to the workplace. h) NQNs working within a familiar organisation but not a familiar workplace take longer to transition to their new workplace and role. i) NQNs working in an unfamiliar organisation need

							the most time to adjust to their new workplace and role.

APPENDIX 4: Ethics approval for study

Ref: ERP1243

14th August 2015

Kim Sargeant
School of Nursing and Midwifery
Clinical Education Centre
Keele University
Keele
ST4 6QG

Dear Kim

Re: Professional identity: A comparative exploratory study of the perceptions of newly qualifies graduate nurses from our fields of nursing

Thank you for submitting your revised application for review. The panel would like to commend you for your full and comprehensive response and amendments.

I am pleased to inform you that your application has been approved by the Ethics Review Panel. The following documents have been reviewed and approved by the panel as follows:

Document(s)	Version Number	Date
Summary Document	2	10/08/2015
Draft Leaflet	1	10/06/2015
Invitation Letter	1	04/06/2015
Information Sheet	2	10/08/2015
Consent Form	2	10/08/2015
Consent Form (for the use of quotes)	1	04/06/2015
Draft Interview Schedule	1	04/06/2015

If the fieldwork goes beyond the date stated in your application (30th June 2016), you must notify the Ethical Review Panel via the ERP administrator at uso.erps@keele.ac.uk stating ERP1 in the subject line of the e-mail.

If there are any other amendments to your study you must submit an 'application to amend study' form to the ERP administrator stating ERP1 in the subject line of the e-mail. This form is available via http://www.keele.ac.uk/researchsupport/researchethics/.

If you have any queries, please do not hesitate to contact me via the ERP administrator on uso.erps@keele.ac.uk stating ERP1 in the subject line of the e-mail.

Yours sincerely

pp C H Bonnerman

Dr Andrew Rutherford
Vice Chair – Ethical Review Panel
CC RI Manager
Supervisor

APPENDIX 5 : Study information sheet for participants

Information Sheet

Study Title: **Professional Identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing.**

Aims of the Research

1. To investigate the similarities and differences in how newly qualified nurses from four fields perceive their professional role in relation to the new professional nursing standards for pre-registration nursing education.

2. To identify factors that have influenced the development of those professional identities and to consider how these factors can influence the pre-registration under-graduate curriculum.

Invitation

You are being invited to consider taking part in the research study "Professional Identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing".
This project is being undertaken by Kim Sargeant.

Before you decide whether or not you wish to take part, it is important for you to understand why this research is being done and what it will involve. Please take time to read this information carefully and discuss it with friends and relatives if you wish. Ask if there is anything that is unclear or if you would like more information.

Why have I been invited?

As a member of the first cohort of student nurses to qualify from Keele University under the new Nursing and Midwifery Pre-registration Nursing Education Standards (NMC, 2010), Kim wants to find out about your views on what you see your role and professional identity as a Registered Graduate Nurse to be. There will be between 8 and 20 students from your cohort taking part in the study, from all four fields of nursing.

Do I have to take part?

You are free to decide whether you wish to take part or not. If you do decide to take part you will be asked to sign two consent forms, one is for you to keep and the other is for our records. You are free to withdraw from this study at any time during the data collection period without giving reasons. If you choose to withdraw from the study you will be asked if your data can still be used. If you would prefer however, your data will be destroyed. Any future study at Keele University will not be affected in any way if you choose not to participate.

What will happen if I take part?
You will be asked to take part in an interview with Kim Sargeant. The interview will last for no longer than one hour and will explore a range of questions about your experiences in becoming a registered graduate nurse. The interview will be recorded but the transcript of the recording will be anonymised. The interview will take place in either the Clinical Education Centre or a mutually agreed alternative venue and will be scheduled for a mutually convenient day and time.

What are the benefits (if any) of taking part?
By taking part in this study you will be helping to explore how newly qualified nurses in the 21st Century perceive their future role. This will assist in evaluating how the approach of the new professional standards to delivering a curriculum that is both generic and field specific informs your professional identity and the approach you have to care delivery for service-users. This will inform developments in the pre-registration curriculum for future students and the provision of quality nursing care for service-users.

What are the risks (if any) of taking part?
Every effort will be made to anonymise the data gathered from the interview so that no names or places will be identified, but there is a small risk that it may be able to identify you from the data.

How will information about me be used?
The information gained will contribute to the data collected and analysed for this piece of research and it may be used in the development of questions for future interviews. The anonymised data provided by you will contribute to the final thesis of the Doctorate and may contribute to future presentations or publications of the findings. A wider more national post- Doctoral piece of research may be undertaken and ethics approval has been obtained for your information to inform that larger study, if appropriate. However, any further pieces of research will also undergo thorough ethical scrutiny and approval prior to the information being used.

Who will have access to information about me?
Confidentiality will be maintained by access to the information that you provide being restricted to Kim Sargeant until it has been anonymised. Once your information has been anonymised the information will only be identified by a code. Only Kim will have access to the individual names linked to each code.
All efforts will be made to maintain confidentiality by storing the recording of your discussion and the identification codes on a password protected computer. The transcript of your discussion will be kept on a password protected computer and any hard copies of the transcript will be kept in a locked filing cabinet in a locked room. The data will be stored in accordance with Keele University's guidelines.

The anonymised data will be analysed to identify themes that newly qualified nurses feel are important to their professional identity as part of Kim's doctoral studies.

The data will be stored by Kim Sargeant for a minimum of 5 years. After 5 years all data that is not anonymised (the digital recordings and the identification codes) will be destroyed. When the data is disposed of this will be done securely and all hard copies of data will be shredded and destroyed.

The research has to take place within the confines of current legislation over such matters as privacy and confidentiality, data protection and human rights and so offers of confidentiality may sometimes be overridden by law. For example in circumstances whereby Kim is concerned over any actual or potential harm to yourself or others she must pass this information to the relevant authorities.

Who is funding and organising the research?

This research is being undertaken as part of Kim Sargeant's doctoral studies and is funded by Keele University

What if there is a problem?
If you have a concern about any aspect of this study, you may wish to speak to the researcher who will do their best to answer your questions. You should contact *Kim Sargeant* on *01782 679685 or k.e.sargeant1@keele.ac.uk*.. Alternatively, if you do not wish to contact the researcher you may contact *Jane Boylan on 01782 733895 or j.boylan@keele.ac.uk*

If you remain unhappy about the research and/or wish to raise a complaint about any aspect of the way that you have been approached or treated during the course of the study please write to Nicola Leighton who is the University's contact for complaints regarding this research at the following address:-

Nicola Leighton
Research Governance Officer
Research & Enterprise Services
Dorothy Hodgkin Building
Keele University
ST5 5BG
E-mail: n.leighton@uso.keele.ac.uk
Tel: 01782 733306

Contact for further information
Mrs Kim Sargeant
Telephone: 01782 679685
Email: k.e.sargeant1@keele.ac.uk

APPENDIX 6: Study consent form

CONSENT FORM

Title of Project: Professional identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing

Name and contact details of Principal Investigator:
Mrs Kim Sargeant
School of Nursing and Midwifery
Clinical Education Centre
Keele University
01782 679685
k.e.sargeant1@keele.ac.uk

		Please tick box if you agree with the statement
1.	I confirm that I have read and understood the information sheet dated 10th August 2015 (version no. 2) for the above study and have had the opportunity to ask questions	☐
2.	I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason	☐
3.	I agree to take part in this study.	☐
4.	I understand that data collected about me during this study will be anonymised before it is submitted for publication.	☐
5.	I agree to the interview being audio recorded	☐
6.	I agree to allow the dataset collected to be used for future research projects	☐
7.	I agree to be contacted about possible participation in future research project	☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

For Interviews

If you consent to participate in this study, it should be drawn to your attention that the researcher has a professional obligation to act upon any aspects of poor practice and/or unprofessional behaviour that may be disclosed during the research activity. Researchers should use the appropriate reporting mechanisms if they have witnessed or experienced poor practice and/or professional behaviour.

APPENDIX 7: Study consent form for quotes

CONSENT FORM
(for use of quotes)

Title of Project: Professional identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing

Name and contact details of Principal Investigator:
Mrs Kim Sargeant
School of Nursing and Midwifery
Clinical Education Centre
Keele University
01782 679685
k.e.sargeant1@keele.ac.uk

Please tick box if you agree with the statement

1. I agree for my quotes to be used ☐

2. I do not agree for my quotes to be used ☐

3. I understand that although data will be anonymised because of my role it may be possible that I could be identified in reports and publications ☐

_____	_____	_____
Name of participant	Date	Signature
_____	_____	_____
Researcher	Date	Signature

APPENDIX 8: Participants' Demographics

Andrea

Andrea was a 27-year-old lady (Generation Y) who had always lived in the local area. She had studied locally for her A-levels and a degree in an unrelated subject. Her family had been to university, and she felt there was an expectation that she would also study for a degree on completion of her A-levels. Whilst completing her first degree she worked part-time as a healthcare support worker and she continued to do this full time for 3 years once she achieved her degree. During this time, she developed an interest in a career in nursing, and this was supported by family members who were also qualified nurses.

She achieved her BSc (Hons) in Learning Disability Nursing with a 1st class classification, which she was very pleased with. When we met, she had been qualified and working for three weeks. The first two weeks had been a supernumerary period and she had then commenced a preceptorship programme for between three and six months. She was working full-time in the local area in a residential home for people with Learning Disability and physical care needs.

Becky

Becky was a 21-year-old lady (Generation Y) who had moved to the area to attend university. She had started her nursing studies on completion of her A-levels and was the first in her family to go to university and study for a degree. Whilst completing her A-levels Becky had volunteered at a local hospital near to home for 18 months, to give her insight into a career in caring. Her interest in nursing developed in childhood whilst caring for her grandfather and this was her incentive to study for a career in nursing.

Becky achieved her BSc (Hons) in Adult Nursing with a 3rd class classification which she was satisfied with as she felt that she had struggled with the theoretical elements of her degree. When we met, Becky had been qualified and working for four weeks; the first two weeks in a supernumerary capacity as part of a six to twelve month preceptorship programme. She had chosen to stay in the local area on qualification and was working full time in a local acute hospital on a surgical ward.

Carla

Carla was from overseas entering her nursing education as a mature student and was 43 years old (Generation X) when she qualified. She had moved to the UK and the local area initially as part of a different unrelated career but decided to change career and took up a position as a healthcare support worker shortly after settling in the local area. Her first language was not English, and she had completed all previous study abroad some years before. She therefore took a non-traditional route into nursing education by completing the Access Course alongside GCSE English and Mathematics. Prior to starting her nursing degree Carla worked for two years as a healthcare support worker in the local community.

Carla achieved her BSc (Hons) in Adult Nursing with a lower second class classification which she was pleased with, as she had found some of her studies difficult, particularly during the second year. When we met Carla had been qualified for eight weeks, working

full time in a private hospital in a surgical area. The first six weeks of her job had been in a supernumerary capacity, and this was followed by the commencement of a six month preceptorship programme.

Carla's parents were in the medical and nursing professions overseas and there had been an expectation that Carla would also become a healthcare professional. Although her early career had been unrelated to healthcare, ultimately her parents had been her inspiration for a change in career. She had developed friendships in the UK with several qualified nurses who also encouraged her to commence her nursing degree.

Carla had decided to stay in the local area to practise as a nurse and had no plans to return to her home overseas.

Donna

Donna was a Generation X student from the local area and completed her degree at the age of 46 years. Although she had completed an NVQ in Health and Social Care some years previously, her non-traditional route into the nursing programme was via the Access Course. Donna had been introduced to caring when she had helped to care for her grandparents as she was growing up, but she had initially chosen a career in retail. When she decided to change her career focus, Donna worked first as a care assistant in a nursing home and then as a healthcare support worker for the local authority. Prior to starting her nursing education Donna was working as a care manager for the local authority. Her inspiration to start her nursing education came from a friend who was a nurse and from her experience in the local authority.

Donna achieved her BSc (Hons) Adult Nursing degree with an upper second class classification and was very proud of her achievement. She felt that this pride was echoed by her family, as Donna was the first of them to attend university and attain a degree. When we met, Donna had been qualified and working full time for a local community Trust for seven weeks, starting with a two week supernumerary period. She was due to undertake a six month preceptorship programme but had yet to receive her preceptorship documentation or meet her preceptor.

Elsie

Elsie was a mature student from the local area and was 41 years old (Generation X) when she completed her nursing degree. She had had a previous successful career in a call centre, progressing to a management position on a good wage, but felt that she needed greater job satisfaction. When her father died suddenly, and her mother needed care in the last few months of her life, Elsie decided to consider a career in nursing. Although she had no care experience when she commenced her nursing programme, she had been interested in nursing from a young age and her recent family circumstances had reignited that interest. As part of her previous career Elsie had started a degree in business but she did not complete it and so she completed the Access Course as part of her non-traditional route into nursing.

On qualification Elsie achieved a BSc (Hons) Adult Nursing degree with a lower second class classification. She was disappointed in her classification as she had been hoping for an upper second class award, but she was pleased to have completed her degree. She was particularly proud as she was the first member of her family to go to university and be awarded a degree. When we met, Elsie had been qualified and working for a

local Trust in a specialised surgical area full time for four weeks. Her supernumerary period had just finished, and she was just starting a six month preceptorship programme.

Flynn

Flynn had moved to the UK some years ago and had settled in the local area. He was a Generation X student aged 37 years on completion of his nursing degree. As his previous qualifications were completed overseas and his first language was not English, he completed the Access Course as a non-traditional route into the nursing programme. After being made redundant from his job in a non-related industry, he worked for five years as a healthcare support worker in a local trust. From his experience as a healthcare support work, and encouragement from his wife who was a qualified nurse, he decided to complete his nursing education.

Flynn achieved a BSc (Hons) in Adult Nursing with an upper second class classification which he was very pleased with, and he felt this reflected his hard work and effort throughout his studies. Flynn as very proud to have attained his degree as he was the first from his family to do so. When we met Flynn had been qualified for three weeks. He was working full time in a local Trust on a medical ward and had completed two weeks of supernumerary practice as part of a six month preceptorship programme.

Gaynor

Gaynor was a 30 year old (Generation Y) lady from the local area, who had entered her nursing programme through the non-traditional route of the Access Course. Gaynor had worked in customer care from leaving school but worked as a healthcare support worker in the community for a month before starting her nursing education. Inspiration for entering nursing came from an ambition to ultimately be a Health Visitor, based on her experience of engaging with her own Health Visitor, when she had her children.

Gaynor achieved a BSc (Hons) in Adult Nursing with an upper second class classification, which she was pleased with; although she would have liked to have achieved a first class degree as she was the first in her family to attend university. When we met Gaynor had been qualified and working full time for six weeks in a local community Trust. Her first three weeks had been supernumerary as part of a twelve month preceptorship programme.

Helen

Helen was a 22 year old (Generation Y) lady who had come to the local area to study for her degree. She had entered her nursing programme through a traditional A-level route and then completion of a Foundation Year at the same HEI where she completed her nursing degree. Her parents had attended university and she had been encouraged to study for a degree too. Her inspiration for entering nursing came from a childhood ambition and caring for younger siblings. This was supported by experience of volunteering at a hospital in her hometown, on the children's ward and elderly care ward for three months.

On completion of her studies Helen achieved a BSc (Hons) in Children's Nursing with an upper second class classification, which she was pleased with. On qualification Helen had returned to her hometown to take up a full time position in a large neonatal unit. When we met Helen had been qualified and working full time in the neonatal unit for four

weeks. Her first two weeks had been supernumerary, and she had then started a six month preceptorship programme.

Isabella

Isabella was 21 years old (Generation Y), from the local area, and had entered the nursing programme through the traditional A-level route. Her inspiration for entering nursing came from observing her mother who worked as a carer in a residential home. She had volunteered in a care home for 3 months before commencing nursing education to gain greater insight into the profession of nursing.

On completion of her nursing programme Isabella had achieved a BSc (Hons) in Adult Nursing with a lower second class classification. Whilst she was pleased to have obtained her degree, she was disappointed at the classification; as the first in her family to attend university, she had hoped her classification would have been higher. We met when Isabella had been qualified and working full time on a local surgical ward for ten weeks. She had been supernumerary for the first four weeks of her job as part of a six month preceptorship programme but had yet to meet her preceptor.

Julie

Julie had been born and raised in the local area, entering her nursing studies as a mature student, and qualifying at the age of 34 years (Generation Y). She had entered the nursing programme through the non-traditional route of the Access Course, having completed A-levels and an NVQ some years before. Julie had previously worked in social care working with children in care homes for 18 months and worked as a carer for adults in the community and on the nurse bank in a local hospital whilst completing the Access Course. Her inspiration for entering nursing came from a family member who suggested a change of focus from social care, when Julie stopped working with children in care homes.

Julie achieved a BSc (Hons) in Adult nursing with a first class classification and was very proud of her achievement. Although she felt her family were proud of her, as only the second member of her family to go to university, she did not feel that going to university was valued very much within the family. Julie and I met when she had been qualified and working full time for four months. She had been supernumerary for six weeks as part of a six month preceptorship programme and was working full time in the local area in Intensive Care.

Kylie

Kylie came from the local area and was 25 years old (Generation Y), when she completed her nursing degree. On completion of her A-levels she worked first as a carer in a care home then as a healthcare support worker in a local Trust, prior to starting her nursing education. Her inspiration to enter the nursing programme came from the nurses she worked alongside as a healthcare support worker.

Kylie achieved a BSc (Hons) in Adult nursing with a third class classification. She had found the final year of her degree programme particularly difficult and was proud that she had persevered, finishing her degree and becoming a qualified nurse. Kylie was the first

in her family to go to university and she did not feel that her family understood the challenges of studying for a degree. When we met, Kylie had been qualified and working full time for three weeks in a local Trust on a medical ward. She was currently supernumerary as part of a six-month preceptorship programme.

Linda

Linda was a 37 year old lady (Generation X) who entered the nursing programme through a non- traditional route, completing the Access Course as a route into nursing. She came from the local area and had previously worked as a healthcare support worker in a local Trust for four years prior to starting her nursing education. Linda's manager had been her inspiration and encouragement to start her nursing education.

Linda completed her BSc Adult Nursing degree with an upper second class classification and was pleased with her achievement as she was the first in her family to attend university. When we met, Linda was working full time for a community Trust in the local area. She had been qualified for six weeks which had included a four week supernumerary period as part of a six-month preceptorship programme but did not have an identified preceptor.

Michael

Michael was from outside the local area and relocated to the locality with his family just prior to starting his nursing degree. He was 42 years old (Generation X) on completion of his studies, the first in his family to go to university, and had completed the Access Course as a non-traditional route into nursing. Prior to starting his nursing degree, Michael had worked as a healthcare support worker in mental health for four years and his inspiration to work in healthcare and then undertake his nursing degree had come from his wife who was also a qualified nurse.

Michael had achieved a BSc (Hons) in Mental Health Nursing with a first class classification and was delighted to have achieved the classification whilst juggling the demands of his family. When we met, Michael was working full time for a local Mental Health Trust in an acute area. He had been qualified for ten weeks and had undertaken a two week supernumerary period before starting a 12 month preceptorship programme. He had not yet met his specific preceptor.

Nora

Nora was a 47 year old (Generation X) lady who had entered her nursing programme via the non-traditional route by completing the Access Course. She came from the local area and had previously had 18 years working as a healthcare in a local trust. She had stopped working in healthcare seven years before starting her nursing education and had worked in an unrelated industry. However, her time as a healthcare support worker had inspired her and as her children became more independent, she decided to return to healthcare and study to be a qualified nurse.

Nora achieved a BSC (Hons) in Adult Nursing with a third class classification and was delighted with her achievement. As the first in her family to go to university, and as a mature student, she was very proud of her achievement. When we met Nora was working for three days per week in a local Trust on a surgical ward to fit in with her

childcare needs. She had been qualified for eight weeks and had undergone a four week supernumerary period as part of a six month preceptorship programme. She had not yet been given any information about her preceptorship programme and did not know who her preceptor would be.

Olivia

Olivia entered her nursing programme on completion of her A-levels and was 22 years old (Generation Y) when she finished her degree. The inspiration to undertake her nursing degree came from a childhood desire to be a nurse and she had volunteered in a residential home for 18 months prior to starting her nursing programme. Olivia was from the local area and was the first in her family to go to university.

On completion of her nursing programme Olivia achieved a BSc (Hons) Adult Nursing with an upper second class classification. She was very pleased with her achievement and felt that as a nurse with a degree she had greater status. When we met Olivia had been qualified and working for nine weeks. As part of a six month preceptorship programme she had had a period of six weeks supernumerary and was working full time in a local Trust in a specialised surgical area.

Peter

Peter was a 21 year old (Generation Y) gentleman who had moved to the local area to study for is degree in nursing. He had entered the programme through the traditional A-level route and started his degree straight after his A-levels. Whilst completing his A-levels Peter had worked for two years with the St John's Ambulance. His inspiration for a career in nursing came from working alongside paramedics and nurses as part of his St John's Ambulance work.

Peter was not the first in his family to go to university and achieved a BSc (Hons) degree in Adult Nursing with a lower second class classification. Whilst he was pleased with his degree he had been hoping for a higher classification. On qualification Peter had returned to his hometown to take up a full time position on a surgical ward in a large Trust near to his home. When we met, Peter had been qualified and working for three months. He had been given a two week supernumerary introduction period when he started in post and had then moved onto a twelve month preceptorship programme. His preceptorship programme was self-directed and he did not have a specific preceptor.

Rachel

Rachel completed her nursing programme at the age of 26 years (Generation Y), having entered the programme through the non-traditional route, completing the Access Course and GCSE English and Mathematics. Rachel was from the local area and had worked as a carer in the community for three and a half years before starting her nursing education.

She completed her BSc (Hons) Adult Nursing degree with a lower second class classification, and was pleased with her achievement and proud to be the first member of her family to go to university. When we met, Rachel had been qualified for eight weeks and was working four days per week in a local Trust on an elderly care ward. She had been supernumerary for the first four weeks following qualification and was waiting to

start her preceptorship programme. She had not yet received any information about the preceptorship programme or who her preceptor would be.

Susan

Susan was a 25 year old (Generation Y) lady who had grown up in the local area. She had no care experience prior to starting her nursing programme but had worked for 12 months as a domestic in a local Trust, and that had given her the incentive to undertake her nursing degree. Susan had completed her A-levels and commenced a degree in an unrelated subject but withdrew after the first year of study. She entered her nursing programme through the traditional route.

On qualification Susan achieved a BSc (Hons) degree in Adult Nursing with a lower second class classification. Whilst she was pleased to have completed her degree, she was disappointed with her classification as she was the first in her family to go to university and she felt that her family had not expected her to complete her degree. When we met, Susan had been qualified for four months and was working full time in a local Emergency Department. She had undertaken a six week supernumerary period as part of a six month preceptorship programme.

Tracy

Tracy was a 22 year old (Generation Y) lady and had always lived in the local area. She had no care experience before commencing her nursing programme but had work experience in a hospital as part of her A-level in health and social care. Inspiration for a career in nursing developed in childhood from her nana who worked in a local hospice. Tracy commenced her nursing education on completion of her A-levels, entering the programme through the traditional route.

Tracy completed her BSc (Hons) in Adult Nursing with an upper second class classification. She was not the first generation to go university and was pleased with her classification and proud of her accomplishment. When we met, she had been qualified and working full time for four months in a local Trust on a surgical ward. She had received a four week supernumerary period at the start of her job as part of a six month preceptorship programme but did not have an identified preceptor.

Vivian

Vivian was a lady from the local area and was the first in her family to attend university. She was 38 years old (Generation X) when she completed her nursing programme which she had entered through the non-traditional route of the Access Course and GCSE Mathematics and English. Vivian had fourteen years' experience as a carer in both residential care and in the community. She wanted to progress her career in healthcare, and this had been her motivation to undertake her nursing education.

Vivian achieved a BSc (Hons) in Adult Nursing with a first class classification which she was immensely proud of. Vivian had never thought she would have the opportunity to go to university and was quite shocked by what she had achieved. When we met Vivian was working full time in a local Trust in a medical area. She had worked there since qualifying four months previously and had been supernumerary for the first week of her job, as part of a 12 month preceptorship programme. However, she was still waiting to hear who her preceptor was.

APPENDIX 9: Study initial interview schedule with first participant

Interview schedule

Professional Identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing.

The types of questions asked in the interviews will be informed by data analysis of previous interviews and emerging themes. The following will give an indication of the types of questions and areas that will be covered.

Name of interviewer: Kim Sargeant

Introduction to the process

- Thank you for your interest and for taking the time to speak to me. As it says in the information sheet, the research study is exploring your perceptions of being a newly qualified graduate nurse.
- I have a few questions which will guide the discussion but this is an informal interview and I am keen to hear about issues that are important to you. I need to record our discussion to have a full and accurate account of everything that we say but this will be held confidentially and anonymised. This means that no one will be identified in any way.
- Can I remind you that you can withdraw from the study at any time and can stop the interview without consequence if you no longer wish to continue.
- I also need to remind you that as a professional registered nurse I have a duty of care to act on any disclosures of bad practice or safeguarding issues that may arise from our discussions.
- Provide the participant with a consent form to complete. Answer any questions that may arise as comprehensively as possible. Emphasise to the participant that:

1. The interview will take no longer than one hour

2. To accurately capture what is being said the interview will be audiotaped

3. All information that is collected about the participant during the course of the study will be kept strictly confidential

4. Any participants will remain anonymous in any dissemination work undertaken external or internal to the University

5. In addition to consenting to be interviewed, the participant will also be asked to give consent for direct quotations from the interview to be used in the write up of the evaluation

6. Any quotations that are used will be completely anonymous

7. The information provided by the participant will be used to inform the thesis for my professional doctorate and in dissemination activities (conference presentations/ paper etc.).

Ensure that the above points have been fully considered by the participant, prior to collecting the participant consent form. Ask if they have any questions. When written consent has been obtained, ask the participant if it is okay to turn on the digital recorder and conduct the interview.

TURN ON DIGITAL RECORDER

To start:

1. Please can you tell me how long you have been qualified for?

Prompt *a)* How long have you been working as a registered nurse?

2. Which field of nursing are you qualified in?
   [Adult, Child, Learning Disabilities, Mental Health]

I would like to ask you some demographic questions please to help with the analysis of the data. This information will also be kept strictly confidential.

a) Entry qualifications for the undergraduate pre-registration programme
b) Hours currently working per week as a qualified nurse
c) Area of work [Acute; Medical; Surgical; Community; Residential; Long stay; Rehab; Other *(please specify)*
d) Are you currently undertaking a preceptorship programme?

Factors influencing career choice

3. Please tell me about your experiences of working with people or caring for people before you started your pre-registration programme.

Prompt a) What was the significance of those experiences towards your career choice?

b) Why did you choose that specific field of nursing?

c) What were the key influences in making the decision to choose that nursing field?

Perceptions of newly qualified nursing role

4. What does the term “Professional Identity” mean to you?

Prompt – a) What does the term Professional Graduate nurse mean to you?

b) Has the meaning of the term for you changed over the last 3 years?

c) If so, how has it changed and why has it changed?

5. Please tell me about your new role as a qualified nurse.

Prompts – a) Describe a typical day as a qualified nurse.

b) How is the role different from being a student?

c) What are the challenges?

d) What do you enjoy most?

e) Describe an occasion when you felt like a staff nurse.

f) Is it what you expected?

6. On a scale of 1-5 where 1 is not at all and 5 is completely, can you tell me how well you feel you are coping with your role as a professional graduate nurse.

Prompts – a) Do you feel your colleagues in other fields are experiencing similar feelings to you?

b) Do you keep in touch with anyone from a different field?

7. What do you feel is your most important role as a professional graduate nurse?

Prompts – a) What do you feel are your priorities as a qualified nurse in the field of [Adult/Child/Learning Disabilities/Mental Health] nursing?

8. Please can you explain to me how you feel being a graduate nurse in the field of [Adult/Child/Learning Disabilities/Mental Health] nursing is different from being a graduate nurse from a different field?

Prompts – a) What different attributes do you feel you have?

b) How are your priorities different?

c) Do you feel that you have a different skill set?

Follow up question

9. In what ways are your roles the same?

Influence of Pre-registration Programme

10. Reflecting back on your pre-registration studies, can you please tell me how the programme helped you to prepare for your role as a professional graduate staff nurse?

Prompts – a) Expand on specific instances and why they were so important

11. If you could go back and change one thing in your pre-registration programme what would it be?

Prompts – a) Expand on significance of the thing you would change

b) How you feel that change would benefit you as a professional graduate nurse?

12. What message would you give to others thinking of a career in nursing?

Is there anything else that we have not considered that you would like to talk about?

TURN OFF RECORDER

Thank you for taking the time to talk to me and for your contributions to the study.

The discussion has been very helpful and will be beneficial to the study.

Once the study has been completed it will inform future pre-registration curriculum for nurses of the future.

Can I remind you that everything we have discussed today will remain confidential and any information used within the study will be anonymised.

Please feel free to contact me after today using the details on the contact sheet, if you have any questions or think of any additional points that you would like to make.

If anything we have discussed today has distressed you I can provide you with details of support services that can help you.

APPENDIX 10: Study final interview schedule with last participant

Professional Identity: A comparative exploratory study of the perceptions of newly qualified graduate nurses from four fields of nursing.

The types of questions asked in the interviews will be informed by data analysis of previous interviews and emerging themes. The following will give an indication of the types of questions and areas that will be covered.

Name of interviewer: Kim Sargeant

Introduction to the process

- Thank you for your interest and for taking the time to speak to me. As it says in the information sheet, the research study is exploring your perceptions of being a newly qualified graduate nurse.
- I have a few questions which will guide the discussion but this is an informal interview and I am keen to hear about issues that are important to you. I need to record our discussion to have a full and accurate account of everything that we say but this will be held confidentially and anonymised. This means that no one will be identified in any way.
- Can I remind you that you can withdraw from the study at any time and can stop the interview without consequence if you no longer wish to continue.
- I also need to remind you that as a professional registered nurse I have a duty of care to act on any disclosures of bad practice or safeguarding issues that may arise from our discussions.
- Provide the participant with a consent form to complete. Answer any questions that may arise as comprehensively as possible. Emphasise to the participant that:

- The interview will take no longer than one hour

- To accurately capture what is being said the interview will be audiotaped

- All information that is collected about the participant during the course of the study will be kept strictly confidential

- Any participants will remain anonymous in any dissemination work undertaken external or internal to the University

- In addition to consenting to be interviewed, the participant will also be asked to give consent for direct quotations from the interview to be used in the write up of the evaluation

- Any quotations that are used will be completely anonymous

- The information provided by the participant will be used to inform the thesis for my professional doctorate and in dissemination activities (conference presentations/ paper etc.).

Ensure that the above points have been fully considered by the participant, prior to collecting the participant consent form. Ask if they have any questions. When written consent has been obtained, ask the participant if it is okay to turn on the digital recorder and conduct the interview.

TURN ON DIGITAL RECORDER

To start:

1. Please can you tell me how long you have been qualified for?

Prompt *a)* How long have you been working as a registered nurse?

2. Which field of nursing are you qualified in?
   [Adult, Child, Learning Disabilities, Mental Health]

I would like to ask you some demographic questions please to help with the analysis of the data. This information will also be kept strictly confidential.

e) Entry qualifications for the undergraduate pre-registration programme
f) How did you find our degree experience?
g) What classification did you achieve in your degree?
h) Hours currently working per week as a qualified nurse
i) Area of work [Acute; Medical; Surgical; Community; Residential; Long stay; Rehab; Other *(please specify)*
j) What were your reasons for choosing your place of work?
k) Are you currently undertaking a preceptorship programme?
l) How long is your preceptorship programme?
m) How long are you supernumerary for?

Factors influencing career choice

3. Please tell me about your experiences of working with people or caring for people before you started your pre-registration programme.

Prompt a) What was the significance of those experiences towards your career choice?

b) Why did you choose that specific field of nursing?

c) What were the key influences in making the decision to choose that nursing field? (What were the drivers?)

Perceptions of newly qualified nursing role

4. What does the term "Professional Identity" mean to you?

Prompt – a) What does the term Professional Graduate nurse mean to you?

b) Has the meaning of the term for you changed over the last 3 years? – Is your mind-set different as a qualified nurse than it was as a student?

c) If so, how has it changed and why has it changed?

d) Does being supernumerary affect your Professional Identity?

e) Has preceptorship affected you Professional Identity as a NQN?

f) How has support from your manager/mentor helped you to establish your professional identity as a newly qualified nurse?

g) Is there anything particular that your manager/mentor is doing to help you to establish your professional identity?

h) Do you feel that being a graduate helps you to be the best possible nurse you could be?

i) How do you feel a graduate nurse is different from a nurse without a degree?

j) How does being a graduate influence your practice?

k) What skills do you have now that you did not expect to have when you started your pre-registration studies?

l) Did your perceptions of what it means to be a qualified nurse change after your first week as a Staff Nurse? If so how?

5. Please tell me about your new role as a qualified nurse.

Prompts – a) Describe a typical day as a qualified nurse. -– Do you feel that you now give more bedside care, less bedside care or about the same? What is the majority of your time spent doing?

b) How is the role is different from being a student?

c) What are the challenges?

d) What do you enjoy most?

e) Describe an occasion when you felt like a staff nurse.

f) Is it what you expected? – What are your expectations of yourself as a qualified nurse?

g) How do you feel that your expectations of being a NQN compare to the public's expectations and colleagues' expectations?

h) Who do you feel has the greatest expectations of you as a NQN – yourself, the patient/public or your colleagues?

i) Do you feel that your role as a qualified nurse has a different impact than your role as a student nurse? Why?

6. On a scale of 1-5 where 1 is not at all and 5 is completely, can you tell me how well you feel you are coping with your role as a professional graduate nurse.

Prompts – a) Do you feel your colleagues in other fields are experiencing similar feelings to you?

b) Do you feel your colleagues in your field are experiencing similar feelings to you?

c) Do you keep in touch with anyone from a different field?

d) Do you keep in touch with anyone from your field of nursing?

7. What do you feel is your most important role as a professional graduate nurse?

Prompts – a) What do you feel are your priorities as a qualified nurse in the field of [Adult/Child/Learning Disabilities/Mental Health] nursing?

b) What does the "graduate" element of your role mean to you and to your practice?

8. Please can you explain to me how you feel being a graduate nurse in the field of [Adult/Child/Learning Disabilities/Mental Health] nursing is different from being a graduate nurse from a different field?

Prompts – a) What different attributes do you feel you have?

b) How are your priorities different?

c) Do you feel that you have a different skill set?

d) How do you feel that the opportunities you had in your field helped you to develop your skill set?

e) Do you feel that all students should have more placements in other fields to develop generic skills for all nurses from different fields?

Follow up question

9. In what ways are your roles the same?
   a) What skills do your feel that the entire cohort has regardless of field?
   b) What other generic skills could your course have given to your?

Influence of Pre-registration Programme

10. Reflecting back on your pre-registration studies, can you please tell me how the programme helped you to prepare for your role as a professional graduate staff nurse?

Prompts – a) Expand on specific instances – from both an academic perspective and a clinical perspective

b) Why they were so important?

11. If you could go back and change one thing in your pre-registration programme what would it be?

Prompts – a) Expand on significance of the thing you would change

b) How you feel that change would benefit you as a professional graduate nurse?

c) What would you change about the course?

d) Do you feel it would be beneficial to assess all students on key areas from other fields of nursing as part of the undergraduate curriculum? If so, why would it be beneficial?

12. What message would you give to others thinking of a career in nursing?

Is there anything else that we have not considered that you would like to talk about?

TURN OFF RECORDER

Thank you for taking the time to talk to me and for your contributions to the study.

The discussion has been very helpful and will be beneficial to the study.

Once the study has been completed it will inform future pre-registration curriculum for nurses of the future.

Can I remind you that everything we have discussed today will remain confidential and any information used within the study will be anonymised.

Please feel free to contact me after today using the details on the contact sheet, if you have any questions or think of any additional points that you would like to make.

If anything we have discussed today has distressed you I can provide you with details of support services that can help you.

APPENDIX 11: Main study transcript for Julie

Doctoral Study-Transcription of Interview

Participant Pseudonym: Julie

Interviewer – I
Participant - IV

Verbatim Transcript

(see next page)

I: Can you tell me how long you've been qualified as a registered nurse?

IV: Er, four months.

I: So the end of September 2015?

IV: Yeah.

I: Okay and what field of nursing are you qualified in?

IV: Adult nursing.

I: I'd like to ask you some demographic questions to help with analysis of the data, it will be kept strictly confidential but if I ask you anything that you don't want to answer that's absolutely fine okay. So before you started your degree what qualifications had you got?

IV: Er, I'd got nine GCSE's, er, and I'd got one A level and one kind of NVQ type level and then my access course I did as well.

I: Right so what was your A level in?

IV: A level was in sociology.

I: And your NVQ?

IV: Was in performing arts.

I: Right and then you went on and did you access course?

IV: About ten years later.

I: Right okay and did you do that just before you …

IV: Did my nursing degree yeah.

I: Okay thank you. And how did you find your degree experience?

IV: Stressful, er, looking back on it you know it was, I enjoyed it but at the same time I put a lot of pressure on myself to do well because I felt like I had something to prove.

I: That's interesting why did you think you'd got something to prove?

IV: Er, just because like from my family I've got a very large family and I'm the only one, well I'm the second person to go to university so it's not something, going to university isn't really valued that much. And when I did try to get, well I did go to university the first time round when I was about 19 like my parents didn't really kind of, they weren't encouraging about me going and I – I think that might have been why I didn't stay not, a part of the reason why I didn't stay anyway.

I: What were you doing then?

IV: Er, I did sociology and educational studies because I was thinking about doing primary school teaching.

I: And how long did you do then that time?

IV: About a month.

I: Oh right so …

IV: Yeah it wasn't, I mean there was a lot of other things I just don't think I was ready for it you know I'd just got a new kind of part time job at the theatre and made a new group of friends and that kind of interfered as well, just don't think I was ready. Whereas this time round I was definitely, I was doing something that I wanted to do and knew that I would stick at it, I was interested in it so I knew I'd stay.

I: So, but you felt that you put a lot of pressure on yourself?

IV: Yeah because I just felt like for me as well I felt like I had something to prove to myself that I could – that I could do it because I failed the first time round, er, and like I say yeah just to prove to others as well because I think I've come across some people's attitudes towards me that don't you know they don't seem to think that I've you know got it in me to – to you know complete a degree or whatever.

I: Right so that's interesting because you – you use the phrase then because I failed the first time and I was going to say to you who says you failed in the first time, is that something you say or is that something that you felt from your family and friends then?

IV: Er, me, I've always put pressure on myself, nobody's ever turned round and called me a failure for not completing it, that's, I've put that on myself really. But

when I say that people's opinions of me and things it's not always been a nasty thing that it's always been a bit kind of jovial and jokey you know, oh you'd be best behind a bar you would you know just like little jokes and stuff but you know they're not that jokey to me because I've got this opinion of myself as well where I feel like you know I've not been able to achieve.

I: Right so did you enjoy your degree experience then?

IV: I did but then I also didn't because I put a lot of stress on myself to do well, I think I would have enjoyed it more if I kind of just focussed on it being a learning experience rather than I need to achieve from this as well, er, but I put too much pressure on myself to achieve.

I: And how did you do in the end?

IV: I got a first so you know it was worth, it was worth it – it was worth it.

I: I was going to say are you pleased but that seems a bit of a futile question to be honest.

IV: Yeah, er, yeah.

I: Well done.

IV: Thank you.

I: How did that go down with the family?

IV: They were really proud.

I: I'm sure they were.

IV: Very proud of me, er, yeah probably not as proud of I am of myself but.

I: I was going to ask you that those feelings of doubt you know and the pressure that you put on yourself do you feel they've gone then now, do you feel vindicated now?

IV: Yeah I do – I do definitely because you know like my family obviously they used to see how stressed out I was and they'd be like, what are you going to be like when you know you've qualified and you're working and – and I used to say to them placements when I was on placements they don't stress me out you know I enjoy my placements. It's the uni work, it's the academic stuff because that's where I'm putting pressure on myself really because I know, I know I can do the job I know I can you know and I enjoy it, I enjoy being around people and things you know but the academic side of it is – is the area where I felt like I had to prove myself really.

I: Yeah, er, so you're currently working as a qualified nurse, how many hours a week do you work?

IV: Er, like 37.5 like the normal full time hours.

I: And what sort of area do you work in?

IV: It's intensive care.

I: So very acute area.

IV: Yeah.

I: And why there, why did you choose that as a place to go for your first job?

IV: Er, because to be fair the whole, I didn't decide this until my third year, er, I had, it was my first, er, placement in the third year about 8 or 10 weeks I think and before then I didn't actually know where I wanted to go at the end of my training.

Before I started my training I wanted to be a district nurse because I start, that's where I started you know in the community with you know caring in people's homes for the elderly. But then when I did my district placement it just didn't feel like, I didn't feel like it was for me. So I think I realised I just, I preferred the acute, the more acute placements that I had in the hospital, er, and I liked the one to one nursing care like that I could do everything you know or support that patient to do everything you know the wash, the care, like I knew everything I wasn't relying on somebody else to tell me what you know a patient's pressure areas were like and things like that. Like I was being able to give that full kind of holistic care myself.

I: Okay, er, so is there a preceptorship programme where you are at the moment?

IV: Mmm yeah.

I: Yeah and how long does that last for?

IV: Well I think it's six months, er, my memory's shocking so bear with me, I think it's a six month programme, er, we've got pads that we've got to fill in, er, but it's a little bit different in ITU they also, er, kind of have these books that you've got to fill in for them. Er, so I've had a drugs book to fill in that's had to be done you know within the first three months, er, and now I'm concentrating on filling in my ITU, er, preceptorship book so we don't have to fill in the other preceptorship books that …

I: You've got a tailor made one?

IV: Yeah.

I: Yeah.

IV: Yeah and that should be filled in within the first six months so yeah.

I: And did you have any period of being supernumerary?

IV: Mmm yeah it was the first, er, six weeks I think we had as supernumery, er, but I'm pretty sure they cut it short [*laughs]* but, erm, yeah you know we had to shadow, er, other staff, more experienced staff for like the first six weeks.

I: And did you have any say in when that finished or not?

IV: Er, I think if you felt like you needed more time then you could probably request it, er, but in terms of shortening it they wouldn't have allowed that. However I do feel that it was bit kind of whatever suited them because I think the second week of preceptorship there was a couple of newly qualified nurses in a different pod to mine who were made to kind of, er, look after their own patients. Er, and I think the team at the time you know they were obviously desperate but also probably felt that they were able to do it because they'd both had placements on ITU as students, er, but it didn't go down very well with the, er, you know the education team that were kind of looking after us at the time.

I: And how did the newly qualified nurses cope with that?

IV: Er, they found it really stressful and hence why I think one of them went and reported it to the PDM's, er, because you know second week in the numbers it's not really, not fair really so yeah they found it stressful.

I: Okay if we go back then to before you started your studies, er, you mentioned before that you'd done some caring so can you just tell me about what experience you'd had before you started your course?

IV: Er, so I worked with children in care homes first of all for a good 12 months, year and a half, er, and then I left there, went travelling, come back and decided I wanted to do my nursing. So I looked into what I would need to do and I

realised that I hadn't got any experience with personal care, er, so that's when I went, I went part time working in the community for you know the private companies that go into people's homes and help them, er, to have the washes and things in the morning or get them into bed and give them some lunch and things. So I did that part time whilst I was doing my access course, er, and then I volunteered at a hospital as well, er, for a few hours every week and then from doing that I managed to get a job on the nurse bank at the hospital literally just before I came for my interview for Keele. So bit of a journey so it was nice and then I stayed on the nurse bank while I was doing my training.

I: So you worked with children then you worked with adults so what was the significance in you then choosing adult nursing?

IV: I preferred working with that client group, er, just because I found you know the job is emotionally draining as it is but working with children it's, I left that job because it got too much, it was – it was just, I was taking a lot of things home with me, er, and I guess it was a bit more intense really. I don't know, I wouldn't really know because I've not really worked in the children's nursing area but I would work three shifts on and then three shifts off and I'd be living in that home with them. So sometimes I would sleep in or sometimes I would come home and then go back but you know because they had you know most of them had, er, behaviour problems I wouldn't sleep, if I was supposed to be sleeping in they'd be running off, I'd be up, sometimes I'd be doing a 24 hours shift and then yeah, and then they'd be ringing you in on your days off as well. And it just got too much because you were there too much, you weren't getting enough sleep and because of you're trying to, you just want to mother them and - and help them but you know you go one step forward and then loads of steps back and yeah it just got, I just felt like I couldn't help like I wasn't helping really. I

wanted to be in a job where I could, where I felt like I was helping, I know that sounds awful because I'm leaving them

I: no it doesn't

IV: And they have a lot of staff come and go in those kinds of jobs and I don't want to be one of them staff but for my own you know, mental health and, I had to – I had to get out of it really.

I: So what was the attraction of nursing instead of social care then?

IV: Er, you know I hadn't even though to of it and it was my partner's mum that suggested because I was going to do social work because I was more familiar with that side of things, er, I don't know why because you know I was always cursing them when I was, looking after the kids but, er, yeah I spoke to a social worker and they pretty much put me off doing the job. Er, because they said that you know if you fancy sitting behind a desk pushing pen to paper for your entire shift then go for it, er, and that's just not me, I'm, I like to be up and about, I like more practical kind of side to things. And I just, it just seemed like the right thing, the right job for me because I could still provide that care for people and perhaps see results from it a bit more sooner, maybe I'm just impatient [*laughs*] don't know. But yeah it meant I could care for people and feel like I was you know making a difference.

I: Okay so we move forward three years, you have your first class honours degree, you're a registered nurse what does that mean, what is your professional identity then as a newly qualified nurse?

IV: I don't know, I feel like I'm still, I don't feel like – I don't feel like a qualified nurse, I don't feel like a professional, I'm still definitely finding my feet, I'm still definitely finding that you know courage to, er, you know take charge and – and kind of

say no this is what I want to do for my patient, still feel like I'm in that kind of student mode in a way where I'm still asking for advice a lot of the time, what would you do, you know I've got this, this, this and this to do, how would you do it, how's best to do it. Which is you know I think is needed, it's necessary, I don't want to just go in there and do things and it be wrong, I want that advice from the more experienced nurses. But then there's always kind of, there's times when you know I know my patient's due a turn, they need to be repositioned and I'll kind of mention it you know and it's kind of like well yeah so is everyone else but we'll kind of get to it when we get to it. And I just feel like sometimes I need to be a bit more assertive, I haven't found that confidence or courage yet to be more assertive and to be like well no I want to do this now because of X, Y and Z. I have once – I have once because my patient did have like a grade 3 pressure sore and I was kind of like you know no I want to turn him now because of this pressure sore you know like it needs to be done sooner rather than later. But I'm still finding that, finding my feet and …

I: What sort of response did you get when you did that?

IV: Er, kind of like well still very blaize and well you know the first time I said, no I'd like to do it now it was kind of like, right okay, er, you know and nobody really kind of moved to come and help me. And I had to then explain why you know it wasn't good enough for me to just say I want to do this turn now, I had to say well they've got a grade 3 pressure sore, oh well they didn't have one, they didn't have a grade 3 yesterday it was, and it was kind of like well that doesn't matter though does it really I'm telling you that that's what they've got now so they need to be turned so it was a struggle.

I: How did you feel after though?

IV: I felt really good about it because I got it done yeah.

I: Well done. So you don't feel that you're there yet to use your words so what is – what is there, what do you feel your professional identity should be then as a newly qualified nurse?

IV: As a newly qualified you see this isn't what I'm, this is what I don't think about, I don't think about what I should be at this moment in time, I'm always thinking about right this is where I should be, I'm looking at those experienced nurses going that's where I need to be now. And again it's probably my personality I'm putting a lot on myself and I'm expecting more of myself than perhaps what I should do. Because when you do talk to some of the nurses and I'll say and they'll ask you, how you settling in, how you getting on, er, and I'll say you know, depending on when it is I've got different things that are bothering me you know and say last week it was you know I feel like I'm a bit too zoned in on my patient and I'm not, er, you know environmentally aware of what you know the rest of the team and I want to be that person who is helping the rest of the team but also getting my jobs done. And at the moment I struggle with that sometimes depending on you know how sick my patient is and, or how awake they are really because the more awake they are you know they can take up more of your time. Er, but yeah I'm always, you know we're always told in uni you'll find the nurses that you look up to or you know who are your role models and I've found a couple and – and that's where I'm like wanting to …

I: So what is it about them then?

IV: They always, they're really supportive, they get what they need to get done, they get their job done but also helping, they help the rest of the team, er, and I just stand there going, how do they do it, I don't know how they're doing this. Er, they are you know they tend to be like the band 6's who are in charge so

they know, they've been there a good couple of years or so at least, er, but yeah.

I: But as a qualified nurse you feel that that's what you should be?

IV: Mmm because I'm fully aware that you know the rest of the team see newly qualified's as a bit of a pain really because even though you know you are helpful because you're there at least you're there and you've got a patient and what not, for those first three months where we've got a drugs book and we're not allowed to sign for IV drugs as a second checker. So you're still in student mode for those three months getting your drugs book signed, you're still having to get two nurses to come and check your IV drugs, on a busy shift it's just the worst thing, it's the worst feeling you know and you try to do things so that it takes the least, you try and get everything ready, they're already there, all and all you've just got to do is go right can I just grab two of you to come and check my drugs. But you still feel like a pain, you feel like a massive drain on the rest of the team because you can see how busy everyone else is and there you are saying can you just come and check my drugs as well so I can give them, er …

I: So you feel that you are a pain to use your words because you're asking people to come but you also said that you can see that other people think you're a pain?

IV: Yeah because they'll roll their eyes at you, you've got to grow a thick skin because you know you go and ask sometimes it can be anything, you know are you alright to just come and check my drugs, are you alright to just give a quick turn and all you get is this [*sighs*] and it's just like do you have to make it so obvious that you know ah. But yeah it just doesn't make you feel very good.

I: What does that do for your professional identify do you feel then?

IV: Er, don't know [*long* pause] it makes me you know it makes me feel like a nuisance, it makes me feel like I'm still like at that student, in that student place, it makes it difficult to kind of find that identity that you want because you know you used to get your eyes rolled at you quite a bit as a student so you know you just feel like you're still there, I just feel like I'm not yeah

I: Not arrived yet?

IV: Mmm yeah definitely.

I: So you're a graduate you're not just a nurse you're a graduate nurse what does that mean to you?

IV: It means a lot as I've already said, er, it means a lot to me as, on a personal level because like I said I feel as though I've been able to prove to myself that I could achieve that level of academia but now that you know I've got into work and it means nothing really, it means absolutely nothing, nobody asks you, nobody cares, not that that's why I've done it, er, but it also, I also feel like I'm starting, this is where I'm starting even though I've done three years of training I feel like actually sometimes some of the stuff I know that I've been taught here but it's just completely gone, it's gone out of my head and I feel like I'm starting all over again learning in that environment where I am.

I: Do you think the fact that you've done a degree though helps you with that?

IV: Yes and no because in, I feel like I've got a lot of confidence, er, I'm not scared to ask questions, I ask questions a lot, er, but the critical thinking side like sometimes I feel like it's helped me in terms of critical thinking and then other times I can be a bit ditzy and afterwards I'll kick myself because I'll think why have you, why did you not think about that you know. That's simple stuff you know if, er, a patient's got high aspirates and then I've not turned the feed down

or turned it off it's like well that's just kind of common sense really, that's you know, do you know what I mean like just some things have happened and I've just gone why, why have you not thought about that. Er, whereas other times you know I will – will be thinking about stuff and I'll ask questions because I'm thinking about you know what's happening with my patient.

I: So do you think being a qualified nurse and what a qualified nurse is, what it means is different for you now, than when you started your studies three years ago?

IV: Er, a little bit.

I: How – how have your views changed?

IV: Er, [*long* pause] I feel a bit more, I hate to say it but a little bit more negative because even though I was aware coming into my training that it was a tough time for nurses, er, you don't actually realise how tough it is until you start the job. And there are, there have been times when I've just thought why have I done this again you know because the stresses on you, the demands of you as a team are just shocking sometimes you know. Like the other day we had a shift, we hardly had any staff and I was still needing all my drugs checking, two of the staff have had to go on transfers and things, there's hardly anyone there in our pod and then the wards up above decided we've got to admit another very sick patient on hardly any staff, I can't give any of my drugs because there's nobody there to check them. It was just very stressful because I'm thinking my – my patient needs these drugs and you know I did all I could to kind of raise that but at the same time there's other things going on as well that are just as important if not more important. And it's just really stressful, really stressful and there's times, you know as a newly qualified nurse in my second shift in the numbers they moved me out of my pod into a different pod because

of staffing, er, with you know a patient who is more sick than really I should have been, I felt comfortable dealing with anyway. Er, so I just feel like a lot – a lot more is asked of you than really what – what you're capable of sometimes and it's tough. So I don't know if it's changed, I still want to be that caring nurse, I still want, but I'm one of those people who you know I want – I want to do the best for the patient all the time but I'm slowly realising that's not, I can't do that all the time and I've got, it's about prioritisation more than anything else. Because if you don't get this done then you know they're not going to live, like that's more important sometimes than you making sure that they're comfortable, that they're getting you know their turns every three hours you know there's other stuff that's more important sometimes. But that still makes me feel a bit rubbish because I've not done, been able to do the basic things like give them regular oral care, give them regular eye care, er, you know I feel rubbish at the end of the shift because it's just been so busy that I've not being able to do those basic things for my patient.

I: And when you started your training you thought those would be things that you would have just of …

IV: That I would be yeah that I would be able to do, probably a bit naïve really thinking it, er, but yeah. I don't think, you see it as a student like how busy it is but you're not actually, you're helping to be fair when I was in ITU on my placement those things were getting done because there's two of you for that patient you know whilst you know my mentor was doing one thing I could be doing the other thing. And you sort of share out those duties, er, whereas you know when you're on your own you're not always able to get everything done. And everyone says to you, you know, it's 24 hour care {*says name*], 24 hour care, never feel bad about leaving you know passing over jobs and things but

you do you still want to you know try your best to get everything done and what needs doing but …

I: Okay so you had that period of being supernumerary, you had a quite a, you know, you had six weeks, how do you feel that affected your professional identity as a newly qualified nurse? Did it?

IV: Er, [*pause*] no not really because the patients, my mentor she, because of the shift she does Monday to Thursday all of them early shifts whereas everyone else does like three long days a week, she tends to be given you know the double ups, the less sick patients, er, and who are likely be doubled. So she'll have two patients rather than just the one because they're less sick, er, which meant that I wasn't, er, really becoming familiar with any of the infusion pumps or any of the drugs and things like that. Er, and then I remember a shift that I had with, er, one nurse in particular with a very sick patient in a side room where they ended up biting down on their ET tube, er, the SATs dropped very low and we had masks on because we were in the side room for whatever reason so communication was a bit rubbish as well but you know she was asking me to bolus him er, sedation, I wasn't familiar with the pump so I couldn't, I didn't know how to do the bolus er, so then we had to swap over and then she was asking me to 100% oxygen, er, whereas I thought she meant on the ventilator not actually get the bag valve mask going. Er, and I felt useless, I felt absolutely useless and he was alright you know she got around to doing both of those things as I stood there going, I don't know what you mean, er, I got, I shouted for the doctor. But yeah after that I kind of just went to the blood gas room and had a little cry because I just felt useless, er, and even when I started looking after the patients myself I was you know I still felt, er, I feel as though it's taken a while for me to – to be comfortable with you know the infusion and things like that because those six weeks I wasn't getting that time with the sick patients.

I: So do you feel that in some ways that supernumerary period hindered your professional identity?

IV: Yes definitely because I wasn't given any variety you know the – the, it's not my mentor's fault but you know whoever put me with her they weren't, there was no variety there for me, I wasn't learning everything that I, you know I wasn't being exposed to everything that I needed to be exposed to because you know the minute that you're out of that supernumerary period they'll try and give you the less sick patient and things but even then you're going to have you know some infusions going and things and it was just yeah it did hinder me a little bit.

I: What about your preceptorship then how do you feel that's affected your professional identity?

IV: Er, we had the week of training, er, for our preceptorship at the beginning and to be fair to ITU you know they provided, er, like educational classes for the first well it was throughout those six weeks that we were supernumerary and anatomy and physiology like dusting up on the respiratory system and cardiovascular system and things like that. And you know it's kind of like a safety net really, er, so that was nice, it was nice to have that little safety net, that crossover bit between you know leaving uni and being this you know proper nurse, er, so yeah it was, it was a safety net and it was nice to have that and they looked after you and they still do you know they provide that support for you. Er, but yeah I don't know, I think what I'm struggling to understand here is what you mean by what, about my identity?

I: Okay so you – you told me that you've had these ideas of who you should be now you're a newly qualified nurse but you don't feel that you're there yet

IV: No.

I: Do you feel that your preceptorship period is helping you to be that type of nurse, to be that person? Or not?

IV: Er, I don't know I mean yes in some ways because there are times when they've given me, when – when the team feel like there's enough staff and things they've gone right [*says name*] you're going to have that patient there and it's like you walk in, you look at the board and you sit there and you think, why have I got that patient, what's going on, what are they doing. And they're like it's alright we just thought with a bit of support, you've got the best amount of support we've got here, better than any other day, do you want to go for it, do you want to have a go, yeah okay let's have a go. So you – you know the team have been supportive in that way of they'll try and boost your confidence by giving you the sicker patient, something more interesting and, er, where you've got to communicate with the doctors and you know other health professional a bit more and be a bit more kind of assertive I suppose in asking for help and things like that. So in that sense yeah that has helped, er, I am a lot more comfortable and confident with, er, yeah talking to or even refusing to give something, I refused to give some dextrose on Christmas day, er, and our ITU doctor wasn't very happy with me. But you know I went to my superior and I said this is the situation, everyone was fully aware that the neuro team didn't want us to give this and they'd documented it and then our doctor came along and prescribed it. And I went to my senior and I said look this situation I'm not comfortable giving this and she said well no I wouldn't be either, she knew the situation she said just ask our doctor to document it that he wanted to give it, but I said he's prescribed it so that's him you know kind of documenting it really and she was like no I'd get him to document it but then I couldn't find him and I thought I'm not giving it him, I only had a couple of hours left on my shift and I handed over to the next nurse that I'd not given it and the reason why. And

anyway the doctor turned up again and she said can you just let him know that you've not given it and I was like yeah fair enough so I did and you know he had a big massive rant at me you know why, why have you not given it, you know he felt – he felt undermined and he said that you know to me. Er, and I said you know I understand where you're coming from but you know his point was you know if the neuro team want this patient being looked after in ITU then they're going to follow our rules you know. And I was like well I just, I'm just telling you why I've not given it and I don't feel comfortable giving it and I spoke to my superior and that's what they've advised me to do. Another nurse stuck up for me at this point and kind of said well maybe you need to speak to that team and discuss it between yourselves. Er, so yeah there's been situations where because I have been chucked in the deep end a bit more I feel like I have stepped up and I have had that confidence and I'm finding – I'm finding the confidence to kind of speak up and advocate for my patient when needed, er, with the support of my team. But then I don't know, on the other hand I think it's just a time thing really I'm not sure whether you know the preceptorship itself is the thing that's helping me to, er, find my identity as a nurse, I think it's just I'm hoping it's just going to come with time.

I: You said something really interesting because you said you're not really sure what I mean by professional identity so you said it's the difference between being a student and a proper nurse so tell me what you mean by proper nurse?

IV: Er, making – making decision that you feel are in your patient's best interest yourself, er, and like I say having the courage and the confidence to – to speak up, I feel that that's probably one of the most important things and I feel like it's not, I feel like you get kind of bombarded sometimes by, there's a lot of strong characters in ITU and in my team in particular. And I think that's why sometimes you know as newly qualified nurses we feel a bit you know

frightened of speaking up or you don't like rocking the boat or putting noses out of joint and things like that. Er, I just want the knowledge, I want the knowledge and the experience to be able to have the confidence to be able to say you know this is what I want to do for my patient because it's in their best interest and I'm going to need you to help me and do that right now, er, that's – that's where I want to be.

I: Do you feel being a graduate helps you to get there or do you think if you hadn't have had a degree it would be the same?

IV: Honestly, er, I think without the degree it would be the same, I think – I think it's the placements that provide you with the confidence that you need, er, to progress and I think you, I see the benefits of having a degree.

I: What are those then?

IV: Er, kind of like the more critical thinking, the more you know being organised, er, you know you've got to be, to get your academic work done and your – your placement work done you've got to be organised and things like that, er, organisation, critical thinking, reflection, er, although people hate it I you know, I may have felt like at the time you know God this is annoying that I've got to do this but I find that it really helped, er, to …

I: Reflection?

IV: Yeah to clear things up, er, but I feel like there's a lot of things that you cover on the degree that just aren't, I don't, they make you aware, it makes you aware that you know that there are ethics to follow, it makes you aware that the laws and regulations and – and you know papers out there you know white papers and Department of Health strategies and things like that. But once you're out there being a nurse you don't, it's not about that, if there's anything

that comes in you, that's trickled down through the system and it's kind of like right this is how we're doing this now from this research that was found, this is what the policy says now, this is how were doing things now and you don't, yeah I don't know.

I: Do you think it influences your practice in any way, do you think maybe you look at these things that come down and absorb them or question them in a different way or not?

IV: Er, one thing I would say is that I'm very aware now of, that when I'm asking other experienced nurses, er, how I should be doing something I'm quite on edge about just asking them how I should be doing it because I know what they're telling me might not actually be you know the best evidenced way of doing things, that might just be something that they've learned through experience and I'm very kind of itchy, I just kind of want to, I do want to go and kind of look these things up, how should I be doing this you know what does the evidence say but you don't have the time, there's no time to be doing that. Er, but we do have the PDN team and they are the ones that are supposed to be up to date with you know procedures and policies and things like that and we do have the policies as well you know I can go to you know the intranet and look up something and print it off if need be but again it's finding the time. Er, there have been a couple of really useful junior doctors who've, I know yeah, er, I asked em about you know should I be giving the medication now if I've just had to you know lower the feed and things like that. You know and sometimes it's because they're not sure either so they'll be like, shall I go print off, yes go print it off, let's have a look. But yeah I am very aware and I think it's made me more, a bit more careful in that sense, er, because i know that there's best evidence out there but I know that that also comes inline with experienced nurses and

what they've experienced and that's not always the best for the patient. So yeah in that sense it's useful but you're not always able to utilise it properly.

I: Okay so what skills do you have now that you perhaps didn't expect to have when you started three years ago?

IV: Er, what skills, I don't know, er, everything I do I just think sometimes I stand there going I can't believe I'm doing this like you know, er …

I: What are the sorts of things that make you feel like that?

IV: Er, administering very potent drugs, er, being aware of the risks you know knowing which drugs I can run with what drugs and, er, just knowing how to improve someone's breathing if the breathing, you know the SATs are starting to drop and things like that you know I know what to do now. My blood pressure's starting to look a bit dodgy, what I should be checking, what I need to be doing, er, yeah managing the, a deteriorating patient I suppose, not so much managing it but noticing signs of you know certain aspects of you know the patient's that's deteriorating and being able to know how to manage that and deal with it. Er, and my time management even though I'm always quite hard on myself with that, er, I think you know that's, it's improved a lot so yeah.

I: Okay so you've been a qualified nurse for a few weeks now, quite a few weeks so how – how do you feel your perception of yourself as a qualified nurse is different to when you first qualified, has it changed?

IV: Perception of myself, er …

I: You said you're quite hard on yourself and what you should be doing.

IV: I, er, I think I've gone a bit easy on myself because I've looked back and I've realised that actually in such short space of time I've learned a lot and that shift

where I cried because I didn't know how to bolus I didn't know what she meant by 100% oxygenate him or whatever you know I was still supernumery it was like my third or fourth week in. Er, and looking back I know, I now know how to bolus the patient, I now know you know I've had a patient where you know they've deteriorated with the breathing and I've had to get the, er, breath bag on there and things. And I'm a lot more comfortable and I feel like I was expecting such a lot, an awful lot of myself and the other staff would say to me, "[*says name*] how long have you been here," four weeks, [*laughs*] "shut up then you know like it's fine." So yeah I've – I've decided and I'm making mistakes along the way, sometimes they're stupid little mistakes and sometimes you know the things that how was I supposed to know if nobody's told me I'm not to know. Er. but I've kind of just decided that as long as my patient is still alive at the end of the day I can't beat myself up about every little thing because otherwise that's going to affect my confidence and things so yeah.

I: Do you think you're realistic about who you are as a qualified, newly qualified nurse now?

IV: Yeah I'm getting there definitely more realistic yeah but I'm still pushing myself to like you know be like those nurses that I've seen that I want to be like every day like every time I'm on shift but I am more realistic yeah.

I: Okay so now you're a proper nurse in your words, tell me what a typical day's like as a qualified nurse for you?

IV: Er, typical day so yeah I walk in and the first kind of anxiety is checking the board to see, to make sure that I am actually in my pod and not being put somewhere else. Because that can make you feel really kind of on edge because it's not with the team that you're used to working with, they don't know you, er, you don't know them, you don't know how much support you're going to

get, it's just a bit you know a bit of the unknown. Er, but yeah so most of the time I'm like oh yeah I'm in my pod it's fine, we have a handover like a team handover about every single patient, er, and then I'll walk and I'll find out which patient I'm with. Er, and most of the time there is consistency you know if you've been with one patient already that week they'll try and keep you with the same patient, er, for all of your shifts, sometimes it doesn't go like that. Er, so I – I have this kind of anxiousness there that's just underneath the surface if it's with a patient that I've not cared for before and it might, it could be you know the simplest of patient to care for and I'll still have that like underlying because I don't know them, I don't know what needs to be done. Er, and I've noticed I'll write a little list of things that I need to do, I'll have a handover from that, from the nurse that's looking after that patient, I'll make a list of jobs that I need to do that day which has got better because my list when I first started had every single bit of my day kind of planned out with times at which point a junior doctor was like you must be the most organised nurse in here. Whereas now I just write down the things that you know that extra things that I kind of know, I've got like an awareness, more of an awareness now of what needs to be done when, er, in my general routine. Er, but yeah and then yeah it kind of, my day tends to start off really well and then towards the end of the shift it kind of tends to go to pot you know you're rushing round like a mad man, er, and you're trying or help other people with turns and things or yeah. Some days it's really I'll go home and I think you've done really well there and then other days I'll come home and I'll think you could have done better but hey ho. Is there something else that you wanted me to kind of elaborate on?

I: No that's fine. How, if you reflect then on when you were in ITU as a student how is a typical day as a staff nurse different to when you were there as a student?

IV: Less stressful.

I: Now or then?

IV: Then er, because even though you know as a third year student they're saying right okay you can manage this patient now they still took over you know you were never able to fully manage that patient's care and know exactly what it was like to be a qualified nurse looking after that patient because that nurse was always thinking there's two of us, I know she's managing that patient but if I do this now while she's doing that we'll have it all done. So you never really knew the pressure of you know you've got this, this, this and this to do but you've also got to do your hourly obs, you've also got to give your medications at these hours, you've also got to help with the turns at this time, oh and then you've got to go down to CT and when you get back you know you've got to get all your writing done or you've got to give them a bed bath. And aside from that you've still got this list of things that need doing, they need that dressing changing and they need you know whatever, they need a bed, an airbed getting and you never really fully feel the pressure because that other nurse, that qualified nurse is always lingering in the background going, I'll just do this while you do that, shall I do this while you're doing that. And yeah so you don't know and now it's like oh actually there's only one of you so I always look back and think God how would they have done that if I wasn't there helping out you know when the patient goes off. And I was helping to, I was making sure the obs were, you know the simple stuff, I was making sure the obs were documented every hour, if I wasn't doing that I used to think God how would you have got that done if – if another pair of hands weren't there.

I: So other than the fact that there was an extra pair of hands to reduce the workload to some extent, do you feel that your role is different in any other ways as a qualified nurse than when you were a student?

IV: Er, you're more responsible you know there's that, it's starting to become more, I'm starting to feel it more you know as the student you had a responsibility for the patient but not in the same way you know because really the nurse in charge of that patient's care was you know the most responsible person, they had their eyes on you. Er, whereas now you don't really have, this is something that I found depending on which band 6 nurse is in charge you know sometimes I'll see who's in charge and my heart sinks a little bit because I feel that sometimes now I'm more aware that you know I've got a responsibility, I've got a duty of care towards that patient and if I'm doing something wrong or I'm not doing something that I should be doing then you know that's my – that's my responsibility and I don't feel like when I get given more sicker patients or patients that I'm not used to, er, caring for like a neuro patient, er, with you know an EVD drain and things I've not come across before sometimes I feel like I don't get the right level of support. Er, you know I feel like I need that watchful eye and I haven't always got that watchful eye, er, making sure that I'm doing what I need to be doing. It scares me a little bit.

I: Okay so what do you think is your greatest challenge then now as a qualified nurse?

IV: Greatest challenge, er, kind of just gaining and maintaining that knowledge that I need, er, like you know knowing you know the task aren't they that you're doing for your patients but I want to be able to kind of, know what needs to be done to help that patient further you know I've got a reading, I've got a blood gas reading here instead of you know having to keep ask, keep asking oh right so

this is this and this is this, not being able to look at it and go right I know what I need to do there to help this patient.

I: What do you enjoy most then?

IV: Er, I enjoy learning, I enjoy the fact that it's you know not one day is the same and I could be with the same patient but my day will be completely different, er, I like that. Even though I put a lot of pressure on myself sometimes I think this is why and it's because I like the challenge, I do, er, I enjoy, er, yeah I just enjoy learning, I'm just enjoying learning about certain conditions like the more common reasons why a patient will end up in ITU. I'm trying to kind of trying to find out you know which patient I enjoy looking after more and things like that so yeah I enjoy talking to the family and most, I think I'm a bit strange, a lot of you know I can hear other ITU nurses they hate it when family come in, they hate it because they like, a lot of them seem to be in ITU because they don't have to communicate with the patient which is awful. Er, but I, so they don't like it when the family are there during visiting time and yeah it can be an added stress because they're there with the questions and you've got things to get done and you might have loads of different family coming and going and they're all asking the same questions but I enjoy it, I enjoy being there for people, I enjoy giving the support to them, I enjoy finding out about people and getting to known them so yeah.

I: So can you think of just one occasion where you're actually felt like staff nurse, when you've felt like you'd arrived even if it was only for a brief time?

IV: No, [*laughs*] [*pause*] er, I would say it has only been in snippets you know like when - when I did request that they come and help me with a turn because of the grade - because of the grade 3 pressure ulcer. And the time when they gave me a sicker patient to manage and the doctor was asking me which port

he could use on the central line and I'm having to show, I'm like oh well you can use this port, well which one's that you know I was kind of a bit like you know okay why am I telling you but it made me feel like I had that knowledge that I could share with you know the rest of the team. Er, and then I think I come across as more confident than I actually am, I do feel like I do portray the nurse that I want to be better than when underneath I'm just like kind of paddling away and I just don't let it show. Er, because I've had family members when I managed another quite sick patient with a sur-arac her family you know I met them from the word go, er, and I don't know if it's just because I was the first nurse they came in contact with but they don't know what colour uniforms people are wearing, they don't know what that means and, er, they tend to get a bit, I've noticed, I don't know if it's just general, I don't know if it's how I portray myself but they seemed to think I was more experienced than those experienced nurses that are coming up to them and saying, right okay well you know trying to, when I'm not there and I wasn't there they seemed to think, they were like well who was that then and I'm like oh they're – they're a lot more experienced than I am because they didn't like what they'd said to them. And oh no well – well we'll talk to [*says name*], we'd like to talk to [*says name*] please and I thought that was really nice but at the same time I just thought why, why do you think that, why have you got that impression that is just completely absurd and I've just kind of said to them you know they are a lot more experienced than me you know if they're telling you something then you know …

I: Did it make you feel good then?

IV: Yeah it did – it did – it did but at the same time I just thought that's strange.

I: So is it what you expected it to be?

IV: Er, yeah – yeah it is because I did have, when I was a student I did have this one shift where I helped with the outreach team and the nurse that was with me kind of we had two patients come in and she did just leave me with this patient, she didn't leave she was there by my side, we had a patient each side by side, er, but it was, I hadn't been left to manage like I've said before like fully manage the patient's care that nurse has always been there going, shall I just do this whereas there wasn't time for that because she was, she always kept coming over and saying, are you okay, do you need me to do anything, where are we up to. And I would tell her what I was doing and obviously I was saying right this is going, this drug's going to run out, er, you know you need to check it and what not. Er, but I felt that was probably the only time that I've truly got a taste of what it was going to be like as a qualified nurse in ITU, er …

I: So who do you think has the greatest expectations of you?

IV: Me for sure because even when you think that they, that the other staff you know are thinking God you should know this by now or you're not being quick enough or you're not helping enough or whatever you know when you do get a bit upset and you do make comments to them like well, or they've asked how do you think that's gone and I've said how I was feeling they'll always say to you like how long have you been here like, just give yourself a break it's going to take you a good eighteen months to feel comfortable with any patient that comes through that door like you've just you know giving yourself a hard time. And I know one of the other students, one of the other newly qualified, see still think of myself as a student, er, you know she's struggled a lot, she didn't have a placement there, er, but one of the band 7's, one of the sisters actually saw that she was you know really stressed out and went up to her and said you know you're the only person that's putting this stress on yourself, you're putting

it all on yourself you know nobody else has got these expectations of you, you know, so yeah.

I: So what about, I mean you've talked about the relatives and the bond that you build up and the trust that you built up with some of them, what do you think the family's expectations are of you as a newly qualified nurse and the public's expectations are of you, has that changed?

IV: I don't know because I don't like to tell them I like to, er, I just [laughs], I wouldn't lie to them if they asked me but I wouldn't, I don't like to turn round and say, oh I'm newly qualified so, I think they must have an idea because I'm constantly, not constantly but if I need to ask a question before doing something I will go and get somebody more senior and say, you know what do I do here or if something starts happening, if their blood pressure starts dropping and I you know I'm constantly going up with inotropes and things like that. And I've trouble shooted as much as I know how to trouble shoot and I start, I bring somebody else on board. So I think sometimes they must realise and when you know the PDN's come round and start doing some kind of teaching with me and they are there then they must know, they must have an idea but I don't, because I feel like I'm aware that there's been situations where family haven't had a lot of confidence in some nurses for whatever reason and this nurse is a lot more qualified than the nurse that was looking after them the day before you know and a lot more experienced but for some reason they've got this idea in their head that oh you can't possibly, you know, we want that nurse that was with them the day before. And I just think it would add to their insecurities about you looking after their family.

I: So are you saying then that you think that the expectations that come from the family are more around the rapport you've got with them and the trust that you've built up with them than your experience and …

IV: Er, I think – I think they value experience which is why I don't like to tell them that I'm newly qualified because I think that would perhaps add to their worries. Er, but at the end of the day really they've, I think the rapport and the communication that you have with them is a lot more important because for – for, if you are communicating with them and you have built that rapport with them and that relationship then they do seem to have more trust in you and seem to be more happy with you caring for their relative.

I: So on a scale of 1 to 5 if 1 is not at all and 5 is completely how well do you feel you're coping with this new role?

IV: Er, I'm going to say at this moment in time about 4.

I: Good how do you think that compares to colleagues from your cohort that you're perhaps still in touch with?

IV: Er, in different areas like of the hospital?

I: Yeah people that you're still in touch with generally?

IV: Yeah, er, it's a very mixed bag – very mixed bag, I would say initially when we first started we were all probably at some point about a 2, 3, er, and that for me it changes a lot, it's very up and down. Er, but one of my close friends she's struggling, I would, although yeah she gives herself a hard time she's just like me really.

I: Why do you think she's struggling?

IV: She didn't have a placement there and she just, she's very quiet - she's a very quiet person and like I said there's a lot of big personalities in ITU. And I you know I am, I wouldn't say I'm loud but I like a laugh and, you know, I just like being around people, I come alive around people whereas she is very quiet …

I: So do you think it's the area she's in rather than the fact that she's qualified?

IV: And the fact that, but then I do hear about her saying why - why have I bloody done this, you know, I'm going to go and get myself a job in Tescos. And I'm like, why don't, you know, she's doing so well and she does give herself a hard time but I think it's a stressful environment, er, and just you know I think she finds it hard how people speak to her sometimes as well, the rolling of the eyes, the attitude that you do get from some other staff. I'm – I can brush it off but you know water off a duck's back and crack on, I know that they're stressed or what not or whatever, er, she finds it harder to brush it off, er …

I: Are you in touch with anybody from any of the other fields?

IV: Yeah.

I: How do you feel they're coping?

IV: Er, oh no other fields, no I've not seen, I mean I've got, when I was here I had quite a few friends from the mental health, er, field but I've not actually spoken to them since.

I: Okay that's okay so what do you feel is your most important role now then as a qualified nurse, what's your priority?

IV: Being safe that's my priority at the moment. Er, because that's what I, you know, go home worrying about every shift you know have I – have I done that right or you know just being safe because sometimes with the amount of

pressure that's put on you, you can see how easy it can be to not be safe and to you know forget things or because you're rushing sometimes and yeah some, I just feel like being safe is my priority at the moment and making sure that yeah like learning and developing myself is important, I want to develop and stuff but I just, that's my priority.

I: How do you think that your priorities and who you are is different from a colleague in a different field?

IV: I don't know, I imagine there's a lot of kind of, er, I think some of the mental health roles I don't know I didn't spend any time in say like the local mental health hospital but some of the you know the teams that come round within the hospital and things they seem to have, they'll have their own stresses you know I get that, er, but I think they've got more time to kind of, er, manage their workload perhaps, find it easier to manage their workload.

I: So what skills then do you feel that you've got as an adult nurse that perhaps other fields haven't got?

IV: Well if I'm going to go off that then probably you know organisation, time management, er, I'm not - I'm not going to say communication because they've got to have like really good communication skills working in those kinds of field you know that kind of field mental health and learning disability. Er, a lot of practical skills for sure, er, …

I: Do you feel that they've got any skills that, any skill attributes that you haven't got or that are better than yours?

IV: Oh yeah sure definitely, I've always, even though I've always kind of rated my communication skills you know I've been, I spent time with a couple of like my friends who've like mental health and the way they're able to communicate with

somebody with, er, you know a mental health problem or with a learning disability, you know, I've really admired it because just you know you can see that they've developed those skills. Er, and because, er, we may only come across perhaps you know the odd patient who's coming into hospital, er, with a learning disabilityor, there's quite a few with mental health problems, er, I think that they've got the – I think they've got patience and like I say the ability to communicate with them in a way that we've not really had the chance to develop.

I: Do you think then, I mean that's a really interesting point, do you think then that you have any skills that you feel that they should also have or that they've got any skills that you think that you should also have to the same sort of levels?

IV: Er, I think that I would be really important, I think it's – I think it's more a case that we could benefit from having more of the skills that they have got because you do see it like you know if you have got patients with confusion or delirium or you know like mental health problems; the environment that you're in as an adult nurse a lot of the time you haven't got – you haven't got that time to, that they require, that they need, er, and it's really sad and you can try and give them the time and perhaps it would be good, a good idea to have some more kind of, er, skills around how to communicate with people, er, bit more efficiently. I don't know that sounds a bit weird doesn't it but

I: no it doesn't no

IV: But you know like kind of being able to explain to – to patients you know that I can do this for you for now but I'm going to have to go away, I don't know I just feel perhaps we would benefit from it. And I think attitudes, attitudes for sure yeah I've come across some adult nurses that have got the complete wrong attitude towards you know communicating with patients with mental health

problems, er, and just the way that you know they label them, people. And sometimes you know I have come across people and I've thought why are you even in nursing you know.

I: So thinking about your pre registration programme then, what could be changed then to bring that more in? [*Long* pause]. Do you think, you know you had your field days for your field, do you think if you had field days from a different field looking at conditions and things from different fields do you think that would help?

IV: Yeah definitely, er, I know we had we do touch on stuff as adult nurses don't we, we have sessions. Er, but yeah more, er, yeah more of them really and perhaps being, instead of it being a choice to kind of opt and do a – a placement maybe you know it should be compulsory that you do at least …

I: How long?

IV: I don't know I mean how long, you know how long, I don't know how long.

I: Do you think a six, eight week placement or do you think a two week short placement would be sufficient?

IV: See this is it I think a six to eight week placement is probably too long and a two week placement's probably not long enough so somewhere in between yeah.

I: So thinking about your pre-reg studies then can you think of specific instances that have helped you to be prepared to be a qualified nurse, we've talked about the extra things that would be useful but can you think of things that did help to prepare you?

IV: Yeah on my last placement, er, I, er, made a complaint towards a nursing assistant because I felt that he was neglecting some of the patients, er, for

selfish reasons really I felt like he just, he was being lazy and didn't care. You know we'd asked him to help, er, a patient in particular and just the way he spoke to the patient and, er, basically I went to reposition the patient, give him a turn, er, it was just obvious that he hadn't had a wash and things you know he hadn't had a wash and things you know he looked very unkempt and his gown looked a bit mucky and I just thought you know this, you couldn't have got like this in such a short period of time from morning. Er, and I asked him if he'd had a wash, he said no. He still had a dirty pad, wasn't dirty dirty but still, er, and on this particular ward you know it's the nursing assistant's kind of role to go round and – and help the washers. Because there don't tend to be a lot of dependant patients on there, they just need a bit of assistance, er, whilst the nurses are doing the drugs round and doing the paper work. Obviously if it was a double up or something like that you would help as the nurse and help them them but, so I asked if he'd you know helped the patient to have a wash and he was like, oh no you know he can do, I thought he could do himself or whatever. But this patient had come in and he'd got you know mental health problems, er, a little bit confused at times. Er, and then when he did come in to help him to have a wash and things he spoke to the patient as if it was their fault, er, and kind of had a bit of a go at him really you know and I just thought I don't like that. So, er, I did say something to him at the time, er, and because he'd also documented that he'd seen his pressure areas, I said so if you haven't been to help this patient have a wash or anything how have you seen their pressure areas and why have you documented it that you have. Er, and he just said oh I don't know, they were off the ward, he was down and, er, I said well you can't make stuff up when they're not here, just write they're not on the ward or something that you've not seen them. Er, so yeah I made a complaint because it wasn't the first time you know and I'd heard other, er, staff saying that they'd had similar experiences so I just thought you know …

I: And you felt like your course had prepared you to do that?

IV: Yeah it took a while for me to you know, I hadn't really come across anything like that in my training really that I needed to step up on. Er, but yeah I had the confidence and I don't know if that comes with age as well would I have been as confident if I was one of the younger, er, student nurses, I don't know. I know some of them have got a lot more confidence than I have but, er, I don't, yeah I felt – I felt able to you know write a statement, you know I felt able to approach the nurse in charge and write a statement and hand it in and go along you know those lines. So yeah I had, yeah I felt that the course had prepared for me that.

I: Okay so final question what message would you give to anyone who's considering a career in nursing?

IV: I would say it's a very, very rewarding career because even when I have those horrible, horrible days I still go home feeling like I've made a difference and you have got that satisfaction, you have got that job satisfaction. Er, but I would say make sure that you know what you're getting in to because it's tough you know yeah I would definitely say get some experience and especially in the hospital, er, before hand, speak to some nurses and – and get their opinions but don't necessarily let them put you off.

I: Okay, is there anything that we've not talked about that you want to add?

IV: I don't think so, no you see I'm not very good on the spot so I'm sorry if I haven't …

I: We've been here for an hour and a half so you've done well.

IV: Oh yeah I like to talk, I like to talk.

I: You've done well.

913 IV: But I'm not sure if it was you know what I've given you is useful.

914 I: Are you happy to turn it off?

915 IV: Yeah.

916 I: Thank you very much.