"Moving on:

An exploration of one nurse's experience of transition from one practice environment to another"

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ABSTRACT

"*Moving on: An exploration of one nurse's experience of transition from one practice environment to another*" is a qualitative research project exploring the transition of a registered nurse from a familiar work environment into a new and different clinical setting. The project using personal recollections as primary sources and informed by Heideggerian phenomenological methodology, has explored the lived experience of the researcher. The stories include such topics as emotions, success and failure, preceptors, L plates, progress and sticks and stones. These stories have been blended with and supported by a variety of other previously published material discussing transition and related themes such as education, preceptors, horizontal violence and belonging. The blended sources have been used to extrapolate from the individual reality, broader understanding of the main concerns and issues for nurses in transition. From this wider view foundational commonalities and meanings have been developed and a number of recommendations offered to progress this issue in the healthcare setting including acknowledgement and recognition, practical changes such as time to learn, collegial care and concern, and further investigation.

ACKNOWLEDGEMENTS

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PART ONE

Introduction

This research project entitled "*Moving on: An exploration of one nurse's experience of transition from one practice environment to another*" will explore the topic of transition of nurses moving from a familiar work situation into a new practice environment. During the course of their professional life many nurses experience movement from one area of practice to another. Such movements may be between departments within an institution, between hospitals, between a hospital and community facility, or even between countries, and will inevitably involve difference, change and challenge. A recent (2004-2006) New Zealand study showed annual rates of nursing turnover in District Health Boards to average 34.38%, thus confirming the pertinence of the research topic (North et al, 2006). This project, utilizing personal recollection as a primary source supported by a literature review of contemporary works of nursing scholarship including research and other previously published material, will investigate the lived experience of nurses who move from one area of practice to another.

Overview

The background of the work will first be presented to establish the origins and context of the study. The specific aim and purposes will then be defined, and any terms requiring particular clarification within the parameters of the research. The specific inclusion and exclusion criteria employed for the work will be presented and justified. This section of the study will conclude with an explanation of the significance of the study to firmly set the work in the current research environment. Part Two will establish the theoretical framework of the work by presenting the method and methodology. Ethical considerations relevant to the research will be discussed. The keywords utilised and information gathered from the literature review will also be presented. Part Three will present the research data comprising personal recollection developed and blended with data from other sources, followed by discussion which presents fundamental themes. Part Four will present recommendations followed by the conclusion. A reference list of works utilised during the research will follow.

Background

This research springs from the vivid and evocative memory of my own transition from a community facility into a busy hospital environment, where the learning was not a curve, but a cliff, where, with many 'white knuckle' moments, both exciting and apprehensive, I gradually integrated into the nursing team and department world. I remember how I felt and thought during that period, when moments of ecstatic success juxtaposed with near despair, but how has it been for other nurses during a similar transition period? Was my experience typical or unusual? What is the lived experience of other nurses? The phrase 'see one, do one, teach one' is probably familiar to many nurses especially those from an earlier generation. The adage in fact carries an implication of the insignificance of nurses' work and skill sets, or alternatively the trivial level of training and preparation of a transitioning nurse. Very much in the 'sink or swim' model, this phrase is usually accompanied by a rueful grin. This concept bespeaks an essentially derogatory view of nursing education, but is this situation still commonplace? By exploring the rich memories of my own and other nurses' transitions I seek to reveal meaning and understanding which may ultimately assist my colleagues to negotiate a significant professional episode and move forward in their practice with both well-founded confidence in clinical skill, and a real sense of professional fulfilment.

The situated context of the writer forms an essential part of the background of qualitative research, reflecting the importance of self-awareness and acknowledgment of the writer's preunderstandings inextricably entwined with the study as researcher and subject of the work. My context is embedded in transition experiences both good and bad, and encompasses the impact of historical events, social and professional constructs, worldviews and a multitude of perspectives contributing to the development of ontology comprising my lifeworld (van Manen, 2003). I come to the work as an experienced registered nurse with a passion for learning and education and a strong impulse to care not only for my patients but equally for my colleagues. My professional practice involves daily contact with experienced nurses newly arrived in my work environment. For these nurses I adopt a role as preceptor within an ontological framework shaped by my own experiences as a newcomer transitioning into new work environments. I work with these colleagues as workmate, teacher, coach, role model and friend, and am very much aware that they fulfil the same roles for me, our only point of departure being that they are less experienced than I in the clinical specialty wherein we currently practice.

Purpose

The purpose of the research project is to examine material dealing with the issue of nursing transition, with the intent of revealing something of the emotional, personal and practical impact upon the nurses involved in such changing situations. In addition the project may reveal some common factors contributing to or hindering ease of transition as expressed by the nurses involved. This work is and must be founded in the lived experience of the nurses involved. It is not about organisations or systems impacting upon the subject, rather it deals with the impact upon the lifeworld (van Manen, 2003) of the individual as he or she responds to those systems and organisational programs. The collection, categorization and articulation of current knowledge may provide some recognition of the topic and awareness of deficits in the body of nursing knowledge.

Aim

The aim of the project is to explore lived experience as revealed through the stories of experienced registered nurses, myself and others, who have undergone a transition from one work environment to another.

Key research questions

What was my lived experience of transition?
What foundational meanings can be drawn out of my reality to assist other experienced nurses in their transition experience?

Definition of terms

experienced nurse – a nurse with more than a year's post registration experience in nursing
transitioning nurse – any experienced nurse moving from one practice environment to another
established nurse – any group of nurses who are already working in a situation with whom the transitioning nurse will interact
preceptor – an established nurse who undertakes a supportive and educational role to assist the integration of a transitioning nurse into any new work environment

Groups of interest

This research project seeks to examine the transition narratives of experienced registered nurses working within a hospital or community setting, by exploring my own and others' lifeworld as nurses working as practitioners within the competencies equivalent to that required of New Zealand registered nurses under the New Zealand Nursing Council. The skill or competence level of the individuals under scrutiny will not be identified because the personal stories, memories and responses might be expected to transcend artificial and arbitrary professional and organisational boundaries. The research project will focus upon my experience as an example of a generic transition situation, but it is appropriate to bear in mind other groups of nurses with particular characteristics which may impact their transition experience. Knowles, Holton and Swanson (2005) suggest that differences between the established and transitioning staff may exacerbate difficulties experienced during the transition process, and there may be aspects quite outside the scope of the transition experience which, however, impact upon it. I will, therefore, note several groups whose data is included or excluded as appropriate.

New graduates

Perusal of the data currently available on the topic of transition reveals that much of the literature dealing with transition relates to the orientation of new nurse graduates into clinical situations, with databases providing a plethora of articles confirming the fact (Anderson, 2009, Delaney, 2003; Dellasega, Gabbay, Durdock & Martinez-King, 2009). The particular needs and management of such newly graduated nurses as they transition is related to their further educational development and advancement into a role as independent practitioners in a nursing environment. These individuals previously identified as students, must negotiate the journey from theory to practice and from ideal to reality. The needs and concerns of this group differ, therefore, from those of more experienced nurses and are already well documented, and for this reason will be utilised only secondarily in the study, as appropriate in providing contributory information.

Nurses transitioning internationally

The transition of nurses internationally is unique because such nurses require not only professional orientation to a particular nursing placement, but also acculturation to a new nation and potentially a new ethnic, cultural and linguistic setting of greater or lesser

magnitude (Ea, 2008, Konno, 2006). The impact of these wider issues, being for the purposes of this study undefined, it is appropriate to exclude this data from the research to avoid confusion and ambiguity resulting from factors essentially unrelated to the transition experience.

Second-level nurses

Data relating to second-level nurses is excluded from the study because of the significant differences in practice, in particular relating to responsibility and autonomy implicit in the scope of practice of registered nurses, and the consequent variation in expectations and assumptions of practice and clinical functioning. It is noted that the Nursing Council of New Zealand (2010) has made alterations to the scope of practice for Enrolled Nurses in New Zealand. These nurses must still work under the direction and supervision of registered nurses and are therefore exempt from the responsibilities which comprise so unique an aspect of registered nursing practice.

Agency and flexi nurses

Nurses such as agency staff from private companies and flexi nurses employed by large healthcare organisations, routinely and regularly change work environments thus transitioning as part of their working life. Because such nurses might experience some or all of the transition issues their stories may contribute to this topic.

Maori nurses

Nurses of Maori ethnicity may face particular challenges in the transition experience if either the established nurses or organisation are poorly disposed toward the foundational principles of Treaty partnership, participation and protection, or insensitive with regard to cultural safety. The articulation of the concepts of cultural safety (Ramsden, 2002) and adoption of Treaty of Waitangi principles as a foundation of nursing education sanctioned by the Nursing Council of New Zealand could appropriately be regarded as a safeguard and encouragement to the free expression of cultural identity by Maori nurses in Aotearoa New Zealand. The concepts of cultural safety, however, "extend beyond cultural awareness and cultural sensitivity" (Nursing Council of New Zealand, 2009, p 2) to an awareness of the individual as a unique cultural expression of a complex admixture of components including age, ethnicity, gender, socioeconomic, spiritual and sexual orientation. "The development of relationships that engender trust and respect" (Nursing Council of New Zealand, p 3) are conceived in the

personal reflection of nurses who understand their own cultural identity beyond ethnicity, and who understand their part in the historical, political and social world of healthcare. Cultural safety has been primarily articulated in reference to nurse/client relationships but clearly is equally relevant for the transitioning nurse who carries his /her culture forward into the new work environment.

Male nurses

It is noted that the fact of gender imbalance is still current in the nursing profession (Brown, 2009, District Health Boards New Zealand, 2008, Farrell, 2001; O'Lynn, 2004) The District Health Boards workforce review (2008) indicates that approximately 10% of New Zealand nurses are male. The potential for gender issues to cause variation in the transition process is, therefore, worthy of consideration with writers differing in their views on the presence or absence of barriers to male participation in the nursing profession (O'Lynn, 2004, Brown, 2009).

Training origin

The potential impact of differing training origin on the transition experience is also recognised. Woelfle and McCaffrey (2007) suggest "the ... nurses most affected were those with university education; they felt they were resented for learning too much theory and not enough practical training" (p129). With an aging nursing workforce (Deppoliti, 2008, District Health Boards New Zealand, 2008; Duchscher & Myrick, 2008,) and the progressive retirement of hospital–trained nurses being replaced by tertiary-trained nurses, the impact of training origin will logically reduce as more nurses enter the healthcare environment from a common source. Likewise, older, hospital-trained nurses moving into a situation where tertiary-trained nurses predominate might be equally subject to the difficulties of difference.

What makes an experienced nurse's transition different?

It is appropriate to discuss the unique and specific qualities which characterise transition of experienced nurses as this group would appear to have been somewhat neglected in research with a paucity of information available dealing with the issue (Dellasega et al, 2009). Research is therefore indicated into the particular transition needs and experiences of these

nurses which relate to clinical expertise, theoretical and practical knowledge, as well as expectations of practice, learning, status, and so on.

Expectations of skills, knowledge, aptitude and enthusiasm for learning, and awareness of the work environment, may differ widely between the transitioning nurse and the established staff who come, one might almost say, 'armed' with a set of expectations of the new staff member with whom they will work.. The expectations and assumptions of employing organisations, nurse managers and co-workers have impact in relation to what they variously think an experienced nurse is or should be. "A common cause of problems is a mismatch between a newcomer's expectations and reality ... in the organisation, resulting in frustration and negative attitudes" (Knowles et al, 2005, p311). These preconceptions are manifested in interactions between the transitioning nurse and others in the new environment, and may also be implicit within organisational protocols and policies. For example the presence or absence of learning opportunities and practical frameworks for ongoing education, mentoring and support may well bespeak the organisational attitude to the transition process.

The expectations of the various participants in the process are drawn from a myriad of past experiences, personal world views and assumptions which colour impressions of and behaviour toward the transitioning nurse, and cannot be divorced from the orientation experience. The multiplicity of assumptions engendered thereby may be partially or wholly contradictory, leading to confusion for the established nurses, let alone the transitioning nurse. The confusion is incalculably increased if these assumptions are held unconsciously, or poorly articulated between the established nurses and the transitioning nurse. A newly graduated nurse generally operates within a supportive developmental framework, being monitored and managed in an orientation program with mutually agreed goals and criteria of accountability (Bay of Plenty District Health Board, 2010, Evans, Boxer & Sanber, 2007; Dyess & Sherman, 2009). The experienced nurse by comparison may receive significantly less educational and collegial support and guidance and may therefore be in the unenviable position of not only being required to fulfil a set of expectations and assumptions of which he or she may be incompletely aware, but in addition, may be tacitly or overtly penalised when and if they are not fulfilled. Hammer and Craig's (2008) respondent graphically recalls the verbal assault of a colleague exasperated by the transitioning nurse's failure to carry out tasks. The respondent elicited these tasks from her frustrated colleague, but then articulated the essence of the problem thus: "When was someone planning on telling me ... that is what I was expected to do?" (Hammer & Craig', 2008, p364) These realities provide ample scope for

exploration of personal narratives and supportive literature to more adequately comprehend this issue.

Significance of the study

Caring for nurses

Nursing is a caring profession. Its raison d'etre is to help, nurture and assist individuals to achieve an optimal level of physical and psychological functioning in every aspect of their life combining "an important moral imperative with an ethical goal" through an ethic of care (Wengstrom & Ekedahl, 2006, p2, Rogers & Niven, 2002). The definition of 'caring' embodies a number of qualities, including "compassion, providing comfort, going the extra distance" (Hudacek, 2007, p124) concern, or worry (Van Manen, 2002). That caring impulse must surely be extended to the colleagues and friends with whom we work, lest we implicitly negate the very foundation of our professional life. Woelfle and McCaffrey (2007) suggest that nurses are "taught to be advocates but not advocates of each other" (p129). If this is true then denial of such advocacy and care is the ultimate irony (Woelfle and McCaffrey). By examining our own stories and drawing from them themes and nuances which explicate the meanings and realities of our lives, we may better understand and therefore more effectively assist each other in transitions into new work environments. In short we may better care for each other and in so doing fulfil the ethical imperative which undergirds and constrains our nursing role.

Restoration

This research may provide insight and meaning as practising nurses relate to and engage with the project. As readers and thereby intersubjective participants in the research (Munhall, 2007), nurses' own experiences may be reiterated in the recollections and descriptions recorded in the project. It may indeed be the case that a degree of healing and restoration may be gained by nurses whose experience of transition was difficult and personally damaging. As nurses read these personal accounts, the revelation of themes and meanings common to their own experience may assist them to open doors to events previously too painful to review, resulting in restoration to greater personal well-being.

Well nurse – well patient

The beneficial impact of personal well-being and confidence upon professional performance (Randle, 2003) necessitates consideration of this issue. As healthcare professionals, nurses seek the optimal well-being of their patients. This well-being is indissolulably linked to that of the nurse, whose highest level of clinical performance depends on intelligent focussed work utilising all aspects of nursing knowledge. "The provision of optimal healthcare is contingent upon the quality of the nursing work environment and, in particular, the extent to which nurses are empowered to deliver a high standard of care in that environment" (Duchscher & Myrick, 2008). The skilled nurse needs confidence to trust her/his grasp of the holistic range of awareness in dealing with patients in care and "in order to care for patients and self, the nurse must feel cared for by others" (Longo, 2009, p31). If that confidence is hindered by fears of criticism, mockery, bullying, or lack of support, the nurse will inevitably fail to attain an optimal level of functioning as a nurse. The "work environments of nurses have a direct and significant impact in the care that is delivered and also on nurses' satisfaction" (Lawless & Moss, 2007, p226).

Teamwork

The importance of collegial support on the effective functioning and coherence of a nursing team is foundational to the day-to-day operation of healthcare. A team is more effective and more productive when each member in it feels valued, supported, and worthwhile. "To the new recruit, collegial relationships founded on professional respect, ongoing encouragement and constructive feedback on job performance, are critical" (Duchscher & Myrick, 2008, p198). The impact of bullying or horizontal violence upon the transition experience must be considered in the light of this reality. A newcomer in any situation is vulnerable to a greater or lesser degree, because of unfamiliarity with protocols and workplace practice, as well as more personal factors including insecurity, performance anxiety and need to belong (Clegg, 2006). Conversely "in a caring environment, each member experiences the workplace as one where they are known, respected, and valued" (Longo, 2009, p31).

Organisational benefit

The more rapid and efficient the establishment of a nurse's confidence, clinical skill and expertise in a particular work area, the greater level of professional functioning available to that nurse's patients and colleagues, and ultimately the organisation. In the fiscally stringent environment of healthcare "many healthcare agencies expect and/or need new staff ... to 'hit the ground running'" (Fox, Henderson & Malko-Nyhan, 2005, p193) but an improved level of personal fulfilment is equally crucial in such aspects as retention, work satisfaction, engagement with and commitment to the employing organisation. Keefe, (2007, cited in Dellasega et al, 2009) suggests that the early stages of the transition period, namely the first 30 days, are crucial in determining whether the nurse will continue in the role. The nurse who experiences good relationships with supportive and respectful colleagues is statistically more likely to continue in the employment situation (Longo, 2009, Simon, 2004; Spence Laschinger, Letter, Day & Gilin, 2009) and therefore to commit skills and energy to the organisation. The real though often unidentified costs of short retention and rapid turnover of nurses (Longo, 2009, Morris et al, 2009) must be considered as a fiscally significant issue worthy of further examination. Logically, the more enjoyable, encouraging and supportive the initial experience of the transitioning nurse, the greater the likelihood of engagement with and commitment to the role and work environment, thus increasing the likelihood of longer term retention in the role. "Nursing management must strive for structures that foster stability in order to maximise nursing performance" (Benner, 2001, p182). The identification of contributing factors in this process is essential in assisting improved organizational performance in this regard with its attendant benefits in patient care, minimization of complications and overall gains in financial management.

Nursing knowledge

The paucity of current material discoverable in the databases and other works is in itself an affirmation of the significance of this research project, in that it clearly identifies a gap in the corpus of nursing knowledge (Dellasega et al, 2009). Although as previously noted, there is a large body of work on the topic of transition and orientation for new graduates, comparatively little exists for experienced nurses. This deficit provides justification for this work and direction for further research from any of a number of different research methodologies to further explore the topic.

Method

Personal recollection was chosen as the primary data source with support from a variety of research materials to provide background, reference, validation, or contradiction and comparison. The memories are historical events which were not documented at the time but retained their vivid immediacy because of their professional and personal significance. The need to select a research topic provided the catalyst to finally record these events, with anecdotal evidence from a number of colleagues confirming the value of the topic. A plethora of indelible images and analogies were rapidly and randomly recorded in order to capture the fleeting awareness of past reality. This was followed by review and rereading to find common and foundational concepts, exploring wider understandings out of my memories. As I worked with this personal data I found it necessary to reiteratively critique my words in order to exclude identifiable features and thereby maintain confidentiality, but also to reveal the nub of the issue, unclouded by irrelevant verbiage. Careful examination of my recollections, was followed by comparison and contrast with the other data, in order to identify both commonality and divergence of themes and concepts between the differing sources. In accord with the phenomenological methodology informing the work, sources exploring the lived experience of nurses were given primacy, but other material providing clarification and explanation was freely employed in order to bring meaning out of the memories. The development and discussion of themes sought to find commonality and shared meaning culminating in the development of recommendations.

Methodology

The methodological foundation of this work is Heideggerian hermeneutic phenomenology as explicated by van Manen. This methodology is deeply congruent with the topic because "phenomenology is a way of access to ... ontology" (Heidegger, 1996, p31), the very nature of being; to "let be seen" not only what initially shows itself, but also to reveal the hidden essence (Heidegger, p31). Because "phenomenological research aims at establishing a renewed contact with original experience" (van Manen, 2003, p30), this study utilises stories relating the rich and real events of nurses' lives. As researcher and reader I have explored the

moments of my own and others' memories because "stories help nurses share their nursing culture [to] better understand their lives at work" (Wolf, 2008, p324). I acknowledge that I may not come up with answers because phenomenological interpretation is perpetually dynamic and incomplete, requiring reitierative interaction with the information by the involved reader.

More importantly, however, I stand not in Cartesian isolation from my research but rather, inseparably united with it. In the process of deciding upon the appropriate approach to this topic I realised that I had been expecting to remain comfortably separated and insulated from the research. I wanted to stand apart and examine my past actions and responses a little like a mouse under the microscope, a lab rat performing for the edification and amusement of the white-coated scientist. But this is what phenomenology is all about. I need to really live in the research. That is the challenge. I cannot stand apart if I am actually going to do phenomenology. In fact phenomenology does not allow me to, because "we are not objective, theoretical spectators of our lives and of the world, but involved participants" (Benner, 1994, pix). This is my lived experience. I am either going to really do this or revert to a safer stance of separation, by utilising as primary data the work of others and using my own experiences in a more subordinate way, exposing less. Much safer. Not so challenging. More straightforward. It will still 'tick the box'. But. Is it the best I can do? To reflexively re-examine these moments and see who I was/am with neither maudlin emotion nor false bombast. This is the question. I feel like Shakespeare. To be phenomenological or not to be? That is the question.

"The phenomenological approach asks of us that we constantly measure our understandings and insights against the lived reality of our concrete experiences, which ... are always more complex than any particular interpretation can portray" (van Manen, 2003, p18) and then "to transform [that] lived experience into a textual expression of its essence – in such a way that the effect of the text is at once a reflexive re-living and a reflective appropriation of something meaningful" (van Manen, p36).

Heidegger (1996) suggests "that the methodological meaning of phenomenological description is interpretation ... through which the proper meaning of being and the basic structures of ... being ... are made known" (p33), not in an objective sense, but rather "to understand what it means to be-in-the-world" (Ortiz, 2009, p3). In examining my own and others' stories, I seek to understand what transition means for experienced nurses by employing Heidegger's understanding of temporality in which the individual constitutes past events whose significance remains current, present awareness, and the unexplored future

(Blattner, 2006). Phenomenological research involves a search for meaning in an experience through the rediscovery of emotions and the revival of vivid memories which still retain their evocative power to stir us just as at the very moment of occurrence.

I have employed the hermeneutic circle in a dynamic interplay of reflective involvement with the memories, to reveal not only the immediate and initial reality exposed, but also the emergent understandings contained within it. I repeatedly reviewed the literature to find common threads expressed by other writers which could give depth and validation to my findings. Equally, however, it was important to seek alternative or contradictory views which might correct and balance my misconceptions or misunderstandings. Through this process I utilised "interpretive scholarship ... to point to possibilities in order to enrich human existence through increasing understanding of the everydayness of being [a nurse in transition]" (De Witt & Ploeg, 2006, p23). I have articulated this understanding linguistically through the writing because "the aim of phenomenology is to transform lived experience into a textual expression of its essence ... a notion by which a reader is powerfully animated in his or her own lived experience" (van Manen, 2003, p36).

Ethical considerations

This research project being a review of personal recollections supported by previously published material readily available in the public domain, ethical considerations may differ somewhat from those relevant to the undertaking of original research. Such concepts as respect, freedom of choice, informed consent, confidentiality, emotional vulnerability and ownership of findings pertinent to the qualitative research paradigm are paramount in original research. These concepts rest upon such tenets as beneficence, non-maleficence, veracity, justice, fidelity, autonomy, guardianship and being professional (New Zealand Nurses' Organisation, 2010, Rogers & Niven, 2003). In this case, however, the use of previously published material placed significant dependence upon the diligence of other researchers in conducting their research in a manner congruent with the highest standards of ethical research practice. The Nursing Council of New Zealand present competencies relevant to nurses in research which are undergirded by the ethical requirements of professional responsibility (Nursing Council of New Zealand, 2007) with the New Zealand Nurses' Organisation Code of Ethics providing clear support (New Zealand Nurses' Organisation, 2010). Careful examination of the ethical management of other works was appropriate in endeavouring to

ensure compliance with accepted standards of ethical rigour in the original research. The works utilised are believed to have accommodated these constraints.

The stories of personal experience under consideration are my own and revelation of my memories is a personal decision. There is, however, a need to be scrupulously conscientious in the retelling of my stories so that no individual or group is able to be identified, and that no implication of inappropriate behaviour may be drawn from the text. For this reason the stories were presented in such a way as to focus on the essence of the event excluding reference to status, profession, role, organisation or other identifying feature.

In a smaller professional environment typical of the New Zealand scene, due sensitivity must be employed to avoid embarrassment of colleagues and employing organizations who have a right to respect and consideration in the undertaking of research. The dissemination of results and recommendations is also of ethical import in view of the outcomes which may be revealed by the research. Inappropriate disclosure or too pointed suggestions for change which may embarrass any person or organisation are equally to be avoided in the recommendations which may arise from the research findings.

The concepts of cultural safety are relevant to this project because they require of me, the researcher, "an openness to the cultural contexts of research [which] can lead us to rethink our ways of knowing" (Wepa, 2005, p85). Although the primary data are my memories and emerge from my cultural identity, that identity springs from a social and historical perspective of a pakeha New Zealand nurse. This work may involve nurses of Maori and many other cultures as readers and intersubjective participants. To be culturally safe I must be aware of my own worldview, respect and acknowledge the cultural identity of others and understand the possible influence of new knowledge which may emerge from the work (Wepa, 2005), thus exemplifying the principles inherent in the Treaty partnership and embracing the multicultural world of Aotearoa New Zealand.

Literature review

Initially this research project was to consist of a literature review of current material dealing with the topic of experienced nurses' role transition ideally from a phenomenological standpoint. With this aim in view database searches were undertaken, utilising Ebsco (Australia/New Zealand Reference Centre, Cinahl), Proquest, Ovid, Google Scholar, and Index New Zealand. It became evident, however, that although much information was

available dealing with new graduate transition, there was a dearth of data considering experienced nurses' transition. Personal recollections perforce became the primary data. The literature review, however, was continued and comprises a significant supportive aspect of the research process. Five studies described research on transition from a phenomenological stance utilising either interviews or focus group discussions with experienced nurses, and were used as secondary sources of data. Six further studies were accessed dealing with transition and orientation for experienced or newly registered nurses utilising a variety of other methodologies. In addition a number of works were examined dealing with such issues as horizontal violence, bullying, oppression, interpersonal conflict, belonging, education, and temporary nurses, which were reviewed to ascertain relevance to the topic and obtain contributory information. Information from these various sources was placed alongside the original stories to allow reflection, comparison, and in particular, contradiction to promote rigour during the research process. Divergent views appeared to be rather difficult to discover. A number of published works were explored to reveal relevant information including research, methodology, nursing education and practice and adult education.

Keywords

Nurses, transition, orientation, role transition, research, phenomenology, experienced nurses, preceptor, horizontal violence, agency nurses, pool nurses, flexi nurses, bank nurses, belonging

PART THREE

Memories

Emotional turbulence

Elation, fear, excitement, stress, pressure. worry about how much I didn't know, loving new learning, knowing unequivocally that I was in the right place, hoping I was right, exhausted and exhilarated by the buzz, balancing the demands of family and a new job, hoping my colleagues would approve of me, hoping I will be 'good enough', not sure that I am, doubting and trusting myself. Being the Little Red Engine - I *think* I can. I was on an emotional rollercoaster and I wasn't at all sure that I was going to be able to hang on 'til the end of the ride.

Success and failure

A first successful performance of skill - a perfect moment. I had, under the careful and supportive gaze of a senior nurse, completed the task successfully. Yay! What a feeling. And, such a small thing, but so significant – I got my chocolate fish. How silly really. Or perhaps not so silly. I had achieved an important milestone as an effective and useful team-member, and that achievement had been recognised. I felt useful because my, albeit small, skill had been affirmed. Conversely, I felt crushed when I 'failed' to achieve a result obviously anticipated by my senior. The actual standard of success or failure was never articulated, and no criticism was voiced, but I felt I had not fulfilled the expectation.

Preceptors and power

I admired my nursing colleagues who seemed endowed not only with extensive clinical skill based on wide experience, but also with the quality of compassion and care which seemed to me to exemplify the best in nursing. It was the observation of this perceived excellence which imbued me as a newcomer with the desire to emulate this clinical and professional expertise. The transition process though informal and unarticulated was emancipatory as I was empowered and enabled to move more confidently into successive areas of practice expertise. Very little was known or formally elicited of my skill set, in fact I felt in some ways that I had

very little to offer, but as I was encouraged to undertake more solo performances, my confidence grew. The ability of my preceptors to release me into successive activities was enormously affirming of my skill and productive of professional confidence. My preceptors modelled excellence in practice and patient care which I was fortunate indeed to be able to emulate. As a transitioning nurse I was, however, vulnerable, and had poor standards of care and behaviour been portrayed as the norm, would I have been strong enough to stand against the prevailing power hierarchy and practice in a more appropriate manner? One always asserts and hopes that one would perform in a professionally impeccable manner, but if denigration, criticism isolation were to follow, what would I have done?

Progress

I was still working under supervision in a particular task. Why? My colleagues were saying "you're ready", but I had not received the official nod and was therefore not advancing. The frustration and growing anxiety of remaining 'stuck' in one area of work with no apparent progress was deeply unsettling and concerning. Nothing was said. Was I doing something wrong? I began to fear that I was, after all, failing, not good enough, in some way inadequate for the role. Would I be able to continue?

'L' plates

How did others see me? How did I see myself? I felt insecure because I knew that I didn't possess all of the skills I felt I needed, and was anxious lest my inadequacy be too glaringly revealed. Was I merely an imposter emulating a real nurse? I feared the exposure and vulnerability of being identified as a registered nurse in the work area when so aware of my own shortcomings. Why couldn't I have L plates? For a time I would be able to hide behind the notional unfamiliarity, but when was I going to step up and assume the autonomous role of a competent practitioner? Should I be autonomous and competent now? My colleagues seem so confident and comfortable in the job and its responsibilities. Why am I not? How long have they been in the game? Do they ever feel like me? When will I feel like that? Will I *ever* feel like that?

Sticks and stones

The epithet of 'the new girl' was both amusing – I was several years older than that person – and at the same time uncomfortable and demeaning. I was embarrassed to be so named as though I was some sort of unskilled servant, of little value, or at best, a rather quaint addition to the team for whom allowances would be made. I was very obviously not expected to stand as a professional on equal terms. Was I in fact not really a nurse, not really a professional, or neither? What was my value status in the hierarchy of power in this organisation? Did I have any?

Transition

An experience of working briefly in another practice environment brought to mind the research question as it encapsulated a number of the emotions and issues familiar in my earlier transition experiences. This was to be a temporary transition, but a transition nevertheless as I moved from my department. The very words are significant. I moved from 'my' familiar workplace. In that situation I have ownership and a degree of control or management. What were the emotions and thoughts engendered as I entered someone else's 'patch'? The first response was one of anxiety followed rapidly by awareness of deep concern, if not near desperation, to be able to do the job well and succeed. The second response was the 'deep breath moment' as I determined to take the risk of proceeding with the work, and stepping up. I was very conscious of the observation of peers who had no knowledge of my skills, knowledge, or ability to carry out the procedure. There was also an awareness of nonverbal information through posture, body language and expression which, to my anxious eye, rightly or wrongly conveyed doubt and scepticism of my ability. In this transition moment my hypersensitivity discerned very subtle clues to the impressions held by my peers. My assessment of the expectations of my peers may have been false, but they were my perceived reality in the moment. I felt that I would need to prove myself in this new and alien environment. The successful achievement of the task brought a feeling of relief and a sense of validation of considerable skill and expertise. A moment for the clenched fist "Yes!" What was I feeling? Assertion in the face of scepticism. A 'so there' moment. A moment of proof against this group. An adversarial moment. And was any or all of it valid or even accurate?

PART FOUR

Meaning in the memories

The following discussion and analysis of each of my personal recollections related above, seeks to explore something not only of my story, but also to draw deeper understanding of this significant nursing experience from blended examination with other sources.

Emotional turbulence

In reflecting upon the foundational themes most common to my personal memories, four topics or emotions surface repeatedly. Namely stress, anxiety, expectation and performance. Stress was the common denominator for a significant period, because every emotion or event whether negative or positive involved energy, effort and engagement. The desire to do well and fit in with my colleagues created anxiety as I developed my persona in a different sphere, and endeavoured to understand my own and others' expectations and assumptions about who and what I should be. As I became immersed in this new environment and began to make it 'my' world the negative impacts of anxiety, fear, and self-doubt initially outweighed the positive, though the positive were value-laden in comparison. The 'Little Red Engine' moments were progressively succeeded, a word advisedly chosen, by the positive declaration "I know I can". And what factors contributed to this movement? What were the things that made the difference between moving on into a new and stimulating role or stalling in a morass of insecurity and limited practice? The kaleidoscope of emotions and perceptions of the transition experience are evoked by such words as "disorienting", "turbulent", "overwhelming", (Steiner, McLaughlin, Hyde, Brown & Burman, 2008) and result from a veritable flood of information which must be successfully assimilated by the transitioning nurse.

Success and failure

In the early days of transition the issue of success and failure is perhaps the most stressful of all. Who defines these events in the bustle of a busy workplace? Who is the arbiter? And why do I remember the 'failures' so well, when the many 'successes' seem to be lost in the mists of time? The successes were thrilling and exciting but the negative comments or responses

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had significant and even inordinate impact, being perceived not only as an assessment of professional performance but as a personal judgment. Perhaps this springs from a 'Perfectibility Model' (Leape, 1994, cited in Crigger, 2005, p2) which suggests that healthcare practitioners are and should be infallible, and mistakes made result from personal incompetence and indeed faults of character, rather than from the shortcomings of organisational systems (Crigger). The motto of the Competencies for Registered Nurses which define the scopes of practice for registered nurses in New Zealand is revealing in its assertion of "regulating nursing practice to protect public safety" (Nursing Council of New Zealand, 2009, p1). The rather negative but logical assumption is that the public needs protection from nurses rather than opportunity to receive creative and confident care from nurses who practice out of knowledge, skill and nursing wisdom. In such an adversarial and punitive climate within a profession founded on ethical bases such as fidelity, beneficence and non-maleficence, the emotional impact of failure may cause significant and long-standing distress (Crigger, 2005) potentially inhibiting self-confident practice. Steiner et al (2008), however, suggest that nurses can manage and deal with difficult experiences satisfactorily as long as ameliorating influences such as excellent preceptor assistance, self-belief and educational opportunities are encouraged to counterbalance the negative experiences.

Preceptors and power

The supportive and non-judgmental input from skilled nurses tasked with the job of teaching and guiding me was crucial in my development as a skilled practitioner in the specific skills pertinent to my practice, in the process of acculturation to the work environment and in supporting me emotionally during a stressful interlude. The preceptor largely controls the dynamics of power in the transition relationship, and may maintain or eschew the dominant position by managing teaching and practice opportunities, thereby ultimately retarding or facilitating the newcomer's advancement. When power is appropriately shared from a stance of collegial support and mutual encouragement between established nurses and the transitioning nurse, motivation and openness to creative expression of nursing expertise is facilitated. Careful management of the learning situation is requisite because "accurate preceptor discernment is essential not only to ensure competent nursing practice and safe patient care, but also to determine successful accomplishment of ... goals" (Paton, 2009, p115). It is clear that the choice of professionally competent and appropriate preceptors is crucial in the transition experience (Steiner et al, 2008).

This issue is particularly delicate in the transition of an experienced nurse, because the preceptor walks a fine line between excessive review and supervision, and insufficient oversight. The experienced nurse comes with a skill set and clinical ability, and the perceptive preceptor wishes to support and encourage rather than demean by inappropriate control. It required care to encourage me in what I did know and identify the gaps in my knowledge. This process confirmed my colleagues' motivational ability to encourage growth of independence, whilst assisting me to acknowledge, understand and learn from failures in a safe and egalitarian environment (Knowles et al, 2005). Although differences in unit-specific expertise existed, the overarching attitude was one of collegial support and esteem. Nurses placed in the preceptor role clearly became models of practice, and played a vital role in the acculturation and socialisation process as I assimilated professional norms and redeveloped my nursing persona (Randle, 2003). "Social comparison plays a central role in developing and maintaining professional self-esteem and, in order to enhance their own self-esteem in the eyes of other nurses, it is likely that ... nurses will conform to the roles and standards that seem to be expected of them" (Randle, 2003, p396). My colleagues, by presenting an expectation and example of skilled nursing provided unequivocal leadership in clinical excellence.

Progress

The importance of a sense of progress in the role is vital in maintaining interest and self-belief during the transition period. As a newcomer I needed to know that I was reaching goals and fulfilling the expectations of my superiors, but in the absence of goals or timeframes for their achievement I was floundering. Onishi, Sasaki, Nagata, & Kanda, (2008) explore the need for "respectful orientations and consultations" between nurse leaders and transitioning nurses in order to maintain motivation (p799). An orientation plan or transition program articulated, communicated and used as a means of guidance, feedback, measurement of goals, assessment and accountability, would have assisted me in a realistic appraisal of my true capabilities (Danna et al, 2010). By identifying historical skills as well as knowledge deficits, both successes and difficulties can be acknowledged and appropriately managed in a safe situation of transparency, thereby significantly reducing performance anxiety for the transitioning nurse, (Dellasega et al, 2009) and stress for preceptors and nurse managers. The transitioning nurse is enabled and encouraged to confront the challenges rather than fearing error and reproach. "It is important to help [transitioning nurses] realize that the role transition takes

time to occur and that knowing how to learn, rather than knowing how to handle every potential clinical situation, is more important" (Steiner et al, 2008, p446). I needed guidance and supervision to appropriately nurture and develop my abilities balanced by the acceptance of personal responsibility and accountability for my new role, my own learning and self development, in concert with a wise mentor or preceptor advising and encouraging my progress. Not leaning on another but walking side by side.

'L' plates

The concept of the "looking glass self" posited by Cooley (1902) is persuasive in the transition context, as it suggests that individuals find and construct themselves in processes of socialisation by what is perceived in the opinion and judgement of others (Wengstrom & Ekedahl, 2006). Yeung (2003) suggests three steps in the development of the looking glass self. We at first imagine how others see us, we then impute a judgement based upon that view, and then we develop a self concept in response to that perceived judgement. Therefore "self-esteem is built up or damaged in social interaction, as people receive feedback about how others view and judge their behaviour" (Randle, 2003, p395). Personal confidence is enhanced and professional performance facilitated or conversely impeded as the newcomer gains either the respect or distain of others.

As a newcomer into a work environment I consciously or unconsciously perceived the attitude of my peers responding to my behaviour and performance. Affirmation of achievement or success in a clinical skill greatly enhanced my own perception of my nursing ability. "Self-esteem is considered to be a major predictor of human behaviour" (Randle, p395) and indeed my belief in my ability in fact created ability. My consequent behaviour, in fact my created self, reflected the plethora of perceptions both accurate and erroneous. A perception of affirmation created confidence in practice, whereas a perception of doubt created an insecure and hesitant nurse.

The initial behaviour of the transitioning nurse may have further impact requiring "impression management" (Knowles et al, 2005, p312) as it affects the established nurses' assumptions about whether the newcomer will 'fit in'. If colleagues are supportive and encouraging we do well but if the "wolfpack mentality" of criticism and jealousy reigns (Fox et al, p195), we may struggle not only with feelings of personal distress, but with professional failure to excel. My desire for 'L' plates was a significant and pertinent concept. I needed to have dedicated time as a learner and observer in order to focus upon, assimilate and make sense of a plethora

of information before becoming sucked into the whirlpool of clinical activity. The impact of such supernumerary time is crucial in the process as it conveys real concern and understanding of the transitioning nurse, rather than a mere commodification of a nurse as just another pair of hands (Lawless & Moss, 2007; Wiek; Dols & Landrum, 2010). In addition it raises awareness that transitioning nurses, no matter how experienced, have learning needs which must be acknowledged and given primacy (Little, 1999). Agency and flexi nurses regularly transition into new environments but nevertheless require educational and resource support to more effectively practice at an optimal level (Boswell et al, 2008; Kelly, Berridge & Gould, 2009). An experienced nurse out of his/her environment of specific expertise may function at a materially different skill level (Benner, 2001; Dellasega et al, 2009, Deppoliti, 2008; Steiner et al, 2008) and Northcott (2002) reminds us that "it is wrong to think that all nurses are alike; after all an orthopaedic surgeon is unlikely to be asked to be an anaesthetist for a day" (p11). Without knowledge of and familiarity with particular patient groups, motivation, and job-specific education and resources, the experienced nurse may, indeed may need to, regress to a novice level for a period. By allowing both transitioning nurse and established nurse to admit and accept nescience and need for knowledge, the ability to question and seek information materially facilitates the learning experience.

And what is or should be the duration of transition for an experienced nurse into a new work environment? Days? Weeks? Months? How quickly should the transitioning nurse settle in and be regarded as oriented to the new area and tasks? Who defines the period, the protocols, the practical resources required? So many questions with so few answers. Danna et al (2010), assert that "transitioning ... involves a period of adjustment" (p86) and Anderson (2009) describes a progressive process of increasingly confident immersion in the new role, completed only when disruption and confusion are finally succeeded by restoration of order and equilibrium. Transition may continue for as long as one or two years (Knowles et al, 2005; Heitz et al, cited in Steiner et al, 2008,), but whatever its duration it is clear that transition takes time, and in fact needs to take time as a number of complex processes must occur. Initially separation from the previous work situation occurs, which may entail separation from memories of past events good or bad. This is followed by movement forward into a situation of unfamiliarity, with new culture, tasks, systems and not least, new colleagues, all of which may provide ample opportunity for anxiety, fears, as well as optimism and enthusiastic confrontation of challenge. Even in the excitement and exhilaration of new experiences change is well known as a stress point, requiring as it does the psychological work of dealing with the change and constructing identity as well as managing

the relational issues of establishing the new role. The socialisation inherent in the transition process includes assimilation of the culture, with which the transitioning nurse must become familiar, comfortable and able to conform if she/he is to become fully immersed in the role.

Sticks and stones

The discourses of power and control prompt deep concern for many nurses in the contemporary world of New Zealand nursing, and transition is but one outworking of these realities. Lawless and Moss (2007) write persuasively of the issue of dignity for nurses and its impact upon our lifeworld as professionals interacting with a multidisciplinary team and clients, all with assumptions about nursing and nurses. As a nurse stigmatised with the name of 'the new girl', what was my place? In the healthcare environment the transitioning nurse must negotiate a veritable 'no man's land' where obstacles of power and authority of various groups press in, presume and persuade. How often are the needs and status of nurses subordinated to the requirements of the organisation, medical staff, clinical tasks, and clients, as professed virtues of selflessness, commitment and altruistic care are proposed as justification for what is in essence neglect of transitioning nurses. The principles of cultural safety (Nursing Council of New Zealand, 2009*)* have particular pertinence to the exercise and experience of power in healthcare, articulating the need to understand and balance the dynamics of power, primarily for consumers but surely also for nurses in order to better redress the deficit traditional to the profession.

Transition

The temporary change of environment stood as a vignette of transition, encapsulating as it did many of the aspects of transition raised in the earlier experiences. I established certain perceptions and assumptions drawn from highly subjective information, which may have been right or wrong. I did, however, take up the challenge and confront my fears head on. Anderson (2009) in discussion of transition frameworks, suggests that there are two psychological aspects of transition, including coping with change, and adjusting identity to the new role which requires psychological work. In this situation I needed to manage my own response to the stress and anxiety in the event in order to fulfil my tasks. I also required to construct and assume an identity of competence and expertise, as much for myself as for the peers observing my work. I needed to rehearse, review and reiterate my knowledge and self-

belief of my capability for the task and to assert *to myself* the reality that I was able to carry out this procedure. This self talk was my personal strategy to enable navigation of the minefield of perceived disbelief, and cope with difficulties. The importance of personal drive, self awareness and commitment to achieve goals is highly pertinent in this moment because as professional practitioners we must avoid a dependency culture awaiting others to support and facilitate our progress. We sometimes need to take hold of our courage and step into the new role. The incalculable value of a colleague's presence in this moment providing unspoken support and comprehension of my concerns was germane in my response to the challenge and anxiety. The phrase 'in my corner' raises an adversarial perspective, however, at times we sometimes do have a sense of embattlement, siege, and conflict. A significant predictor of nursing performance is provision of peer support (Delaney, 2003) and in this situation having a supporter not only giving practical clinical assistance but more importantly, 'cheering me on', was a highly significant contributor to my professional success.

Themes

The discussions above have explored various aspects and implications of my recollections blended with comparison and consideration of other works to provide reference, validation and depth. Some common themes seem naturally to emerge from the memories and other material above, which will then be brought forward into the practice setting by development into the recommendations following.

Comparison between themes in the published works utilised during this research project and those drawn out of my own experiences (Appendix One) reveals some congruence and commonality, as well as divergence. The themes of the emotional nature of transition, need for transition planning, significance of organisational and particularly management involvement, preceptor provision, collegial support and time to negotiate the experience, all present with some frequency. Issues such as good and bad events, expectations, cultural safety and respect, commitment to learning and self-motivation were less overt in the literature. The concept of expectations for example was at times manifest in other guise, for example Deppoliti (2008) discusses the theme of perfection as being an "integral component of professional integrity" (p257), with an implicit assumption of one aspect of nursing identity. This writer likewise describes nurses' reaction to lack of respect from physicians (Deppoliti, 2008) and several writers discuss humiliation and bullying of new staff, a very obvious

negation of the concept of cultural safety and respect (Delaney, 2003, Farrell, 2001, Fox et al, 2005). The themes presented therefore may be implicit rather than overt, but in general I believe there is reasonable support for the themes drawn from my stories.

Whether uncomplicated or fraught with difficulties, the very nature of change being stressful and potentially exhausting means that transition may be an emotional episode. Conflicting and contradictory emotions may hold sway at various times or even co-exist, with anxiety battling with excitement, elation outweighing fear as the transitioning nurse finds a place in a new culture.

Transition will probably have good moments when the transitioning nurse feels like he/she 'has it sussed' and bad experiences where he/she feels embarrassed or just 'dumb'. It seems appropriate and prudent for the transitioning nurse to acknowledge this reality, accept and process the bad, and hold fast to the good.

Expectations and assumptions appear to play an important part in the transition process, no more so than when they are unarticulated or unclear. Whether they are our own or others', expectations which are unrealistic and excessive may create a climate of insecurity and anxiety. The transitioning nurse therefore may need support from the established nurses in the new environment, and ideally a preceptor and nurse leader, to clarify such expectations at the outset.

The creation and articulation of a systematic plan of training and transition may be helpful in assisting transitioning nurses to develop confidence and grow in new skills and a new environment supported by goals, guidelines and feedback.

The employing organisation may have a significant part to play in providing an environment conducive to the efficient and supportive assimilation of transitioning nurses.

The friendship and guidance of a caring preceptor may be valuable in assisting the transitioning nurse to navigate the shoals of the new situation. When coupled with the exercise of clinical excellence, care and concern for the newcomer is greatly enhanced.

Friendship and collegial support from established nurses may be inordinately significant to the transitioning nurse who needs care and practical help in the day to day minutiae of a new work environment. Whether it be the interpretation of unfamiliar systems or advice on individuals to seek for particular skills, a kind word may ameliorate the management of the settling in period.

Cultural safety including but extending beyond ethnicity is relevant to the transition experience as each nurse brings his/her own identity into any new environment. Affirmation

of the concept of cultural safety would seem to imply respectful welcome and acceptance of diversity.

It seems clear that the transitioning nurse needs time to learn new skills and systems, to assimilate the flood of information and to begin to function as a valuable member of the nursing team. The process may be neither instantaneous, nor uniform in duration. Once again, communication and consultation between the newcomer and his/her leaders and preceptors may ameliorate the process.

The transitioning nurse who wishes to advance into a new role may need to consider his/her commitment to enthusiastically embrace learning in order to grasp new skills and knowledge

The transitioning nurse's advancement into the new role may necessitate assertion of self-belief and self-confidence in historical knowledge and skills. Though the face in the looking glass may appear doubtful and insecure, at times the only recourse may be to take up the challenge and take the risk of exploring the new world.

Recommendations

From the above themes which appear to logically emerge from the examination of my memories, I respectfully offer a number of suggestions which may provide means by which individuals or organisations may address some of the concerns relevant to transitioning nurses.

Acknowledgement

Acknowledgement of the issue and its importance by organisational management and nurse leaders in the clinical environment would appear to be foundational to any realistic endeavour to progress this issue. Jameison and Taua (2009, p26) suggest that "Both educators and employers need to work collaboratively with the Nursing Council to ensure the ongoing needs of [transitioning nurses] are met" if nurses are to remain involved in their chosen careers. The concept of 'respect' and 'gentle patience' (Onishi, Sasaki, Nagat & Kanda, 2008, p800) from organisations and nurse administrators may be challenging in the fiscally constrained environment of contemporary New Zealand healthcare where staff shortages and increasing pressure are an everyday reality. Without such care of nurses, however, the transition process may become so alienating as to preclude the long-term retention of experienced nurses.

"Solving the hospital labour shortage will only be accomplished if nurses who seek employment in the hospital sector stay there." (Wiek, Dols & Landrum, 2010, p8)

> "As administrators and managers need to attend to the everyday operations of a healthcare facility to assure quality of services and positive patient outcomes, concern about the interpersonal relationships on a unit may seem insignificant. However, these relationships potentially can impact job satisfaction and intent to stay, both which ultimately influence patient care and outcomes." (Longo, 2009, p31)

Although acknowledgement of transition needs by organisation and nursing leadership is the first step, real progress will require practical manifestation of this recognition.

Practical workplace change

Time to learn

The funding of a supernumerary period and provision of educational opportunities signals acknowledgement and acceptance of the learning needs of transitioning nurses. The duration and extent of this period may be appropriately tailored to the individual as part of an entry process in consultation with managers and preceptors, to identify, develop and carry out strategies, and evaluate learning needs (Knowles et al, 2005). Articulation of expectations and assumptions on both sides may be pivotal in establishing a transparent and equitable process, including definition of the needs of the transitioning nurse, clinical setting and organisation, methods of assessment, and clarification of lines of accountability and support. Dedicated funding provided by the organisation may materially relieve the nurse leadership from the invidious task of balancing ever-increasing need for clinical staff with learning needs of new staff.

Preceptor provision

The selection, training and facilitation of preceptors may significantly impact transition, as the preceptor provides the connection to and interpretation of the organisation, and the support and guidance of the transitioning nurse. Provision of financial support both for training and recompense signals recognition of the effort, time and expertise committed to the task as well as clear encouragement for development of the role.

Development of guidelines

The development of generic transition guidelines and protocols to assist nurse leaders and preceptors may facilitate the process for staff under growing pressure to provide services in an environment of shortages of staff, time and skills. Such guidelines might be created by educators and tailored in concert with unit staff to suit particular needs of specific services, but even in generic format could provide the outline and start point to commence the transition process.

Personal collegial support

The suggestions offered above may assist the development of strategies to ameliorate the transition experience. The transitioning nurse, however, may need the support of his/her colleagues for support, care and understanding. Established nurses who take responsibility for the plight of the newcomer into their world by adopting a caring and compassionate stance, may fulfil a vital role in the transition experience. "Support of nurses by nurses does not come from the hospital; it comes from each other." (Woelfle, 2007, p129).

Further research

This research project has briefly examined an issue of significance in the world of nurses. It would seem that a deficit exists in knowledge of experienced nurses' transition, and further work could be undertaken from a number of different methodologies. Original work utilising a phenomenological approach would give voice to nurses. Discourse analysis, critical social theory and feminist theory could very effectively consider the discourses of power inherent in the nursing world and manifest in such issues as horizontal violence. Nursing leadership may gain significant understanding and direction from such an approach. Ethnography would step into the lifeworld of nurses to examine the socialisation and acculturation of newcomers. Examination of educational theory and the role of preceptor would also provide worthwhile opportunity to develop foundational support for role development and practice. This research project may be of some small use in adding to the corpus of nursing knowledge but there remains a significant opportunity to contribute further.

Conclusion

This research report has examined the issue of nursing transition for experienced nurses. Using personal recollections as my primary sources I have explored the lived reality of my own transition adventure through a phenomenological lens. I have blended these memories with a variety of other data to attempt to draw out deeper issues which may be extrapolated to others' similar experiences. A number of groups are identified as having characteristics relevant to transition, and other nurses who consider the topic may find recognition in these groups. The validity of the study is clearly identified as an appropriate area of interest for this and indeed future studies as proposed within the recommendations, which may also offer positive response to and outworking of this research in the clinical setting.

The memories related in this study are my own, but may be part of many nurses' life experience. They stand as one representation of transitional change for experienced nurses in New Zealand, and as the focus of a phenomenological study, are to be explored freely by those who read them. Some may feel that I have misrepresented the experience, others may feel vindicated and understood, but the essence is that the reader engages with the stories to find his or her own reality within them. My professional imperative is to assist experienced nurses to better manage their transition between different nursing environments, by so doing ultimately to deliver nursing care of the highest quality. I hope that this project may go some small way to achieving that goal.

Appendix One

Thematic congruence in research literature utilised in research project

Author	emotion	good/bad	expectations	transition plan	organisation	preceptor	colleagues	cultural respect	time	learning	self motivation
Anderson	y		y				y		y	y	
Benner						y	y		y	y	
Boswell				y		y			y		
Danna				y	y	y			y		
Delaney	y			y	y	y			y		
Dellasega	y	y	y	y		y	y		y		y
Deppoliti						y	y	y	y		
Dyess				y	y	y			y		
Duchsher	y						y	y			
Farrell							y				
Fox	y	y	y	y		y	y		y	y	y
Hammer	y	y		y		y				y	
Jameison											y
Little				y			y		y	y	
Longo	y				y		y				
Morris											
North					y						
Onishi					y						
Randle	y				y						
Spence											
Steiner	y				y	y			y		y
Woelfle					y		y				

References

Anderson, J. (2009). The work-role transition of expert clinician to novice academic educator. *Journal of Nursing Education,* 48(4), 203-208. Retrieved from CINAHL with Full Text database.

Bay of Plenty District Health Board, (2010). Graduate Nurse Programme. 3http://www.bopdhb.govt.nz/TrainingResearch/gradnurseprogram.aspx

Benner, P. (2001). *From novice to expert: Excellence and power in clinical nursing practice (*commemorative ed.). Upper Saddle River, NJ: Prentice Hall Health.

Blattner, W., (2006). *Heidegger's being and time.* London: Continuum

Boswell, C., Gatson, Z., Baker, D., Vaughn, G., Lyons, B., Chapman, P., Cannon, S., (2008). Application of evidence-based practice through a float project. *Nursing Forum,* 43(3), 126-132. Retrieved from CINAHL with Full Text database.

Brown, B. (2009). Men in nursing: Re-evaluating masculinities, re-evaluating gender. *Contemporary Nurse: A Journal for the Australian Nursing Profession,* 33(2), 120-129. Retrieved from Academic Search Elite database.

Clegg, J. (2006). A phenomenological investigation of the experience of not belonging. *Journal of Phenomenological Psychology,* 37(1), 53-83. doi:10.1163/156916206778150448.

Cooley, C.H., (1902), *Human Nature and the Social Order.* New York: Scribner's, pp. 179-185. Retrieved from http://web.archive.org/web/20070810213352/www2.pfeiffer.edu/~lridener/DSS/Cooley/LKGLSSLF.HTML

Crigger, N. (2005). Two models of mistake-making in professional practice: moving out of the closet. *Nursing Philosophy,* 6(1), 11-18. Retrieved August 19, 2009, from CINAHL with Full Text database.

Danna, D., Schaubhut, R., & Jones, J. (2010). From practice to education: Perspectives from three nurse leaders. *Journal of Continuing Education in Nursing,* 41(2), 83-87. Retrieved from CINAHL with Full Text database.

Deppoliti, D. (2008). Exploring how new registered nurses construct professional identity in hospital settings. *Journal of Continuing Education in Nursing,* 39(6), 255-262. Retrieved from CINAHL with Full Text database.

District Health Boards New Zealand. (2008). Health Workforce Information Programme – Base Data September 2008 Quarterly Report http://www.dhbnz.org.nz/Site/Future_Workforce/HWIP/DHB_Base_Data_Reports.aspx

Dyess, S., & Sherman, R. (2009). The first year of practice: New graduate nurses' transition and learning needs. *Journal of Continuing Education in Nursing,* 40(9), 403-410. Retrieved from CINAHL with Full Text database.

Delaney, C. (2003). Walking a fine line: Graduate nurses' transition experiences during orientation. *Journal of Nursing Education,* 42(10), 437-443. Retrieved from CINAHL with Full Text database.

Dellasega, C., Gabbay, R., Durdock, K., & Martinez-King, N. (2009). An exploratory study of the orientation needs of experienced nurses. *Journal of Continuing Education in Nursing,* 40(7), 311-316. Retrieved from CINAHL with Full Text database.

de Witt L, Ploeg J (2006) Critical appraisal of rigour in interpretive phenomenological nursing research. *Journal of Advanced Nursing,* **55**(2): 215–29

Duchscher, J., & Myrick, F. (2008). The prevailing winds of oppression: Understanding the new graduate experience in acute care. *Nursing Forum,* 43(4), 191-206. Retrieved from CINAHL with Full Text database.

Ea, E. (2008). Facilitating acculturation of foreign-educated nurses. *Online Journal of Issues in Nursing,* 13(1), 5. Retrieved from CINAHL with Full Text database.

Evans, J., Boxer, E., & Sanber, S. (2008). The strengths and weaknesses of transitional support programs for newly registered nurses. *Australian Journal of Advanced Nursing, 25*(4), 16-22. Retrieved from CINAHL with Full Text database.

Farrell, G. (2001). From tall poppies to squashed weeds: Why don't nurses pull together more? *Journal of Advanced Nursing, 35*(1), 26-33. Retrieved from CINAHL with Full Text database.

Fox, R., Henderson, A., & Malko-Nyhan, K. (2005). Research Paper 'They survive despite the organizational culture, not because of it': A longitudinal study of new staff perceptions of what constitutes support during the transition to an acute tertiary facility. *International Journal of Nursing Practice, 11*(5), 193-199. Retrieved from E-Journals database.

Hammer, V., & Craig, G. (2008). The experiences of inactive nurses returned to nursing after completing a refresher course. *Journal of Continuing Education in Nursing, 39*(8), 358-367. Retrieved from CINAHL with Full Text database.

Heidegger, M. (1996). *Being and time ; a translation of Sein und Zeit*; translated by Joan Stambaugh. Albany, NY: State University of New York Press,

Hudacek, S. (2008, March). Dimensions of caring: A qualitative analysis of nurses' stories, *Journal of Nursing Education, 47*(3), 124-129. Retrieved June 8, 2009, from CINAHL with Full Text database.

Jamieson, I., & Taua, C. (2009). Leaving from and returning to nursing practice: Contributing Factors. *Nursing Praxis in New Zealand, 25*(2), 15-27. Retrieved from Australia/New Zealand Reference Centre database.

Kelly, D., Berridge, E., & Gould, D. (2009). Twenty-four hour care: implications for the role and developmental needs of nurses in acute and community settings. *Journal of Nursing Management, 17*(5), 594-602. Retrieved from CINAHL with Full Text database.

Knowles, M.S., Holton, E.F., & Swanson, R.A. (2005). *The adult learner*: *The definitive classic in adult education and human resource development* (6th ed.). London: Elsevier Butterworth Heinemann

Konno, R. (2006). Support for overseas qualified nurses in adjusting to Australian nursing practice: A systematic review. *International Journal of Evidence Based Healthcare,* 4: 83-100. Doi:101111/j.1479-6988.2006.00037.x

Lawless, J., & Moss, C. (2007). Exploring the value of dignity in the work-life of nurses. *Contemporary Nurse: a Journal for the Australian Nursing Profession,* 24(2), 225-36. Retrieved July 6, 2010, from ProQuest Health and Medical Complete. (Document ID:1313259881).

Little, C. (1999). The meaning of learning in critical care nursing: a hermeneutic study. *Journal of Advanced Nursing,* 30(3), 697-703. Retrieved May 14, 2009, from CINAHL with Full Text database.

Longo, J. (2009). The relationships between manager and peer caring to registered nurses' job satisfaction and intent to stay. *International Journal for Human Caring,* 13(2), 26-33. Retrieved from CINAHL with Full Text database.

Morris, L., Pfeifer, P., Catalano, R., Fortney, R., Nelson, G., Rabito, R., Harap, R. (2009). Outcome evaluation of a new model of critical care orientation. *American Journal of Critical Care,* 18(3), 252-259. Retrieved from CINAHL with Full Text database.

Munhall, P.L. (Ed.). (2007). *Nursing research: A qualitative perspective.* (4th ed.). Sudbury: Jones and Barlett

New Zealand Nurses' Organisation (2007). *Code of ethics.* Wellington: New Zealand Nurses' Organisation, http://www.nzno.org.nz/Portals/0/publications/Code%20of%20Ethics%202010.pdf

North, N., Hughes, F., Rasmussen, E., Finlayson, M., Ashton, T., Campbell, T., Tomkins, S. (2006). Use of temporary nurse mechanisms by New Zealand's District Health Boards. *New Zealand Journal of Employment Relations,* 31(3), 36-50. Retrieved from Australia/New Zealand Reference Centre database.

Northcott, N. (2002). The expectation and reality of bank and agency nursing. *Nursing Management,* 9: 7, 10-11, Retrieved from CINAHL with Full Text database.

Nursing Council of New Zealand, (2000). *New Zealand Registered Nurses, Midwives and Enrolled Nurses: Workforce statistics.* Wellington: Nursing Council of New Zealand

Nursing Council of New Zealand, (2007). *Competencies for registered nurses,* Wellington: Nursing Council of New Zealand
http://www.nursingcouncil.org.nz/download/117/rn-comps-final.pdf

Nursing Council of New Zealand, (2009). *Guidelines for Cultural Safety, the Treaty of Waitangi and Maori Health in Nursing Education and Practice,* Wellington: Nursing Council of New Zealand. http://www.nursingcouncil.org.nz/download/97/cultural-safety09.pdf

Nursing Council of New Zealand, (2010). *Competencies for registered nurses,* Wellington: Nursing Council of New Zealand
http://www.nursingcouncil.org.nz/download/117/rn-comps-final.pdf

Nursing Council of New Zealand, (2010). *Enrolled nurse scope of practice transition arrangements.* Wellington: Nursing Council of New Zealand
http://www.nursingcouncil.org.nz/index.cfm/1,120,html/Enrolled-nursescope-of-practice-and-transitionarrangements.

O'Lynn, C. (2004). Gender-based barriers for male students in nursing education programs: prevalence and perceived importance. *Journal of Nursing Education,* 43(5), 229-236. Retrieved from CINAHL with Full Text database.

Onishi, M., Sasaki, M., Nagata, A., & Kanda, K. (2008). Development of nurses with specialties: The nurse administrators' perspective. *Journal of Nursing Management,* 16(7), 795-803. Retrieved from CINAHL with Full Text database.

Ramsden, I. M., (2002). *Cultural safety in nursing education in Aotearoa and Te Waipounamu*. Thesis submitted to the Victoria University of Wellington for the degree of Doctor of Philosophy in Nursing.http://culturalsafety.massey.ac.nz/thesis.htm

Randle, J. (2003). Bullying in the nursing profession. *Journal of Advanced Nursing, 43(4),* 395-401. Retrieved from E-Journals database.

Rogers, J., & Niven, E. (2003). *Ethics: A guide for New Zealand nurses* (2nd ed.). Auckland: Pearson Prentice Hall.

Spence Laschinger, H., Leiter, M., Day, A., & Gilin, D. (2009). Workplace empowerment, incivility, and burnout: Impact on staff nurse recruitment and retention outcomes. *Journal of Nursing Management,* 17(3), 302-311. Retrieved from CINAHL with Full Text database.

Steiner, S., McLaughlin, D., Hyde, R., Brown, R., & Burman, M. (2008). Role transition during RN-to-FNP education. *Journal of Nursing Education,* 47(10), 441-447. Retrieved from CINAHL with Full Text database.

van Manen, M., (2002). Care-as-worry, or "Don't worry be happy". *Qualitative Health Research: An international, Interdisciplinary Journal.* Vol 12, No. 2, pp264-280. Los Angeles: Sage Periodicals Press.

van Manen, M., (2003). *Researching lived experience: Human science for an action sensitive pedagogy.* London Ontario: The Althouse Press

Wengström, Y., & Ekedahl, M. (2006). Research Article: The art of professional development and caring in cancer nursing. *Nursing and Health Sciences,* 8(1), 20-26. Retrieved from E-Journals database.

Wieck, K., Dols, J., & Landrum, P. (2010). Retention priorities for the intergenerational nurse workforce. *Nursing Forum,* 45(1), 7-17. doi:10.1111/j.1744-6198.2009.00159.x.

Woelfle, C., & McCaffrey, R. (2007). Nurse on nurse. *Nursing Forum,* 42(3), 123-131. Retrieved from CINAHL with Full Text database.

Wolf, Z. (2008). Nurses' Stories: Discovering Essential Nursing. *MEDSURG Nursing,* 17(5), 324-329. Retrieved from Academic Search Elite database.

Yeung, K-T., Martin, J. L., (2003). The Looking Glass Self: An Empirical Test and Elaboration. *Social Forces,* Volume 81, Number 3, March 2003, pp. 843-879

The University of North Carolina Press Retrieved from