A study to investigate newly-qualified nurses’ experiences of preceptorship in an acute hospital in the south-east of England

by

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Statement of Originality

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Abstract

Preceptorship refers to a period of support for newly-qualified professionals to enable them to make the transition from student to registered practitioner. This transition period has long been recognised as being stressful and preceptorship has been advocated in nursing for a number of years. However, its widespread introduction into healthcare settings in the UK had only been fairly recent and its application is variable. My role as a Preceptorship Facilitator involves running a programme for newly-qualified nurses and I have some evidence that they find this helpful. Nurses are also allocated a named preceptor in their clinical area, although they often report that resources present a challenge to this in practice. There is minimal research into the benefits of preceptorship programmes and in particular into the provision of preceptorship in the clinical areas. I was therefore interested in investigating which parts of the existing provision of preceptorship were helping the nurses in my Trust and what might be missing, in order that improvements could be made.

A phenomenological study was decided upon as this methodology recognises the unique experience of the individual. Open interviews were chosen for data collection as this method enables the researcher to cover the important research questions whilst allowing participants to expand on anything they consider to be important or relevant.

The findings of my study show that the transition period remains stressful, with nurses reporting a sense of unfair expectations on them. Supportive relationships make a difference for them and on-going teaching in the classroom and in the clinical areas is valued. However, factors which work against these support mechanisms were found, including unsupportive people, a lack of time to work with preceptors and to be released for study days as well as clinical environments that do not support learning. These findings raised concerns over patient safety as well as for the nurses’ learning and support.

Recommendations from the study include the selection of preceptors to be based upon their attitude and their willingness to support newly-qualified nurses, along with the provision of some preparation for the role. Protected time for preceptorship is advocated, through the provision of paid study time and through reduced workloads or the employment of Practice Development Nurses. Trusts are urged to consider the environment in which care is carried out, not solely for the sake of newly-qualified nurses but because the lack of a learning environment has implications beyond preceptorship.
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Chapter 1: Introduction

1.1 Background to preceptorship
It has long been recognised that the transition from student nurse to registered practitioner is a stressful time. Thirty-eight years ago, Kramer (1974) coined the term ‘reality shock’ and since then many authors have highlighted the difficulties experienced by newly-qualified nurses in many countries. In 1993, the United Kingdom Central Council (UKCC), then the governing body for nursing in this country, first stated the need for the provision of preceptorship for newly-registered nurses (UKCC, 1993). In 2006, the Nursing and Midwifery Council (NMC) further emphasised the need for newly-registered staff to have a preceptor (NMC, 2006). More recently the profile of preceptorship in the UK has been raised further. Lord Darzi’s (2008:8) review promised a “threefold investment in preceptorship” and referred to “protected time for newly-qualified nurses…to learn from their more senior colleagues”. The Department of Health (DH, 2008:3) further recognised the need to help nurses make the journey from “novice to expert” and recommended a period of preceptorship to assist with this. This commitment to providing access to training and development for staff was reflected in the pledges of the NHS Constitution (DH, 2009a).

Strategic Health Authorities (SHAs) began committing funds specifically for preceptorship in early 2009. A draft Preceptorship Framework for Nursing (DH, 2009b) was first published as best practice guidance and was then updated to include midwives and allied health professionals (DH, 2010). The topic seemed to be firmly on the national agenda, despite it being at a time when financial pressures could arguably challenge its delivery (Carter, 2010). Another more recent DH publication again highlights the on-going importance of preceptorships (DH, 2012).

1.2 What is preceptorship?
The Preceptorship Framework (DH, 2010:11) defines preceptorship as

“A period of structured transition for the newly registered practitioner during which he or she will be supported by a preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours and to continue on their journey of life-long learning.”
However, the framework is not always explicit and, from conversations with colleagues in the south-east of England where I work, it is evident that the application of preceptorship varies considerably across different healthcare organisations.

1.3 Why study preceptorship?

My interest in preceptorship stems from my role as an educator in an acute healthcare Trust. I have delivered a Development Programme for newly-qualified nurses since 2004 and since May 2011 this has been my sole job, as I became Preceptorship Facilitator for the Trust.

In supporting this programme back in 2004, my organisation recognised the stressful nature of the transition process. The programme already meets some of the criteria of the Preceptorship Framework but many nurses report a lack of time to work with their preceptor in the clinical area and a lack of feedback about their progress. This is perhaps unsurprising as no resources have yet been directed to the preparation of preceptors or to providing any dedicated, supernumerary time. The Preceptorship Framework is not prescriptive but does appear to indicate that the role of the preceptor is key and that preceptors will require preparation for the role. The framework also makes a brief reference to protected time for preceptorship but again is not explicit about this – for example, there is no mention of supernumerary status.

The lack of support for preceptorship in practice does not appear to be unique to my organisation as many authors continue to highlight problems with the transition process (Casey et al., 2004; Boychuk Duchscher, 2001; Murrells et al., 2008; Ashurst, 2008; Kuroda & Sato, 2009; Wood, 2007; Evans et al., 2008). Some of these studies come from the United States, Canada, Australia and Japan so this problem is clearly not unique to the UK.

Therefore, the need for preceptorship is acknowledged in policy, though the details of what is needed are unclear and delivery is variable. In my organisation, some of the elements of preceptorship suggested in the framework are already in place, such as the formal teaching programme and support groups in the form of action learning. Where clarity is needed is in identifying which parts of the existing process are helping the nurses, what is missing and what exactly newly-qualified nurses need from their preceptors.

Nurses’ experiences of working with their preceptors in the clinical area are of particular interest to me because the importance of preceptorship in practice seems to be less understood than it is in policy. The information elicited from my research would, it was hoped, inform the future delivery of preceptorship including consideration of a training session or programme for the preparation of preceptors.
1.4 Study design

The aims of my research were to discover nurses’ lived experiences of the preceptorship period. Therefore I chose to undertake a qualitative study using phenomenological interviews. An in-depth discussion of the methodology and method appears in Chapter 3. The presentation of findings follows in Chapter 4 and in Chapter 5 I discuss the implications of these findings in the light of literature. In chapter 6 I discuss the conclusions from the study and make some recommendations for practice, education and future research. Prior to undertaking my research I undertook a literature review on this subject which now follows in Chapter 2.
Chapter 2: Literature Review

2.1 Introduction
In line with phenomenological research, a full literature review was not completed but a scoping on the subject of preceptorship was undertaken in late 2009 and early 2010. NHS Evidence was used, which includes databases such as Medline, CINAHL, BNI and HMIC. Initially, the key words used were: nurses, preceptorship, newly-qualified and newly-registered. It became evident that sometimes the word preceptorship was used in relation to pre-registration students: these references were discarded. It also became apparent that, in many parts of the world, the term graduate nurse was used for newly-qualified nurses so this was then included in the search terms. No exclusions regarding date of publication were entered but the majority of literature that pre-dated the year 2000 was considered to be less likely to reflect the experiences of nurses training and working in the health services today, especially in the UK. The implementation of preceptorship in the UK has only really occurred over the last decade.

A comprehensive scoping review undertaken for the National Nursing Research Unit (Robinson & Griffiths, 2009) reported finding few robust studies focussing on preceptorship either in the UK or elsewhere. Robinson’s own study (cited in Robinson & Griffiths, 2009) only serves to highlight this: for example some nurses she interviewed were unsure as to whether or not their preceptorship period had actually ended. It seems that preceptorship has been studied before it has been embedded in practice. Thus a certain amount of the literature retrieved served mainly to show the inadequate implementation of preceptorship and to confirm the need for further research in this field. That said, a case can always be made in phenomenology for the legitimacy of further research as any study looking at lived experiences will – to a certain extent - be unique to those particular participants (Rinaldi Carpenter, 2003).

2.2 Research literature
Seventeen research articles were retrieved: these are tabled in appendix 1 with a full summary of the aims, findings and the methods used. Of the 17 studies, 7 used quantitative methods, 8 qualitative methods and 1 mixed methods. The final article was a systematic review. Quantitative studies tended to use questionnaires. Most qualitative studies used interviews whilst one used focus groups and one stated the use of a questionnaire citing the use of open questions, though no further details are

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1 Undertaken then as research proposal was submitted in February 2010
given. However, the methodology – the philosophical basis of the research was only stated in one case, where the use of phenomenology was cited at the beginning but not mentioned again, so its application is impossible to ascertain. There may therefore be implications as to the credibility of some of the studies.

The articles published focused on different issues or uncovered different themes, although several themes often arose in the same study. The main themes will now be discussed.

2.2.1 Main themes of the research literature

The retention of newly-qualified staff
Many articles cited concerns over failure to retain newly-qualified nurses as the driver for their research. Recognising that newly-qualified nurses had a higher turnover rate than other NHS staff and identifying that job satisfaction is highly significant in someone’s intention to stay or to leave, Shields and Ward (2001) found that one factor which proved to be highly related to job satisfaction was the provision of training. This was an extensive study carried out in the UK, surveying 9,625 nurses, though it is worth noting that the survey took place in 1994. Murrells et al. (2008) also identified that job satisfaction (amongst other factors) can improve retention, although data collection was also done a number of years ago, in 1997/8. Beecroft et al. (2001) discuss the benefits of an internship programme and report improved rates of retention, which concurs with some other studies (Leigh et al., 2005; Newhouse et al., 2007).

Skills acquisition and competence
Beecroft et al.’s (2001) internship programme mentioned above seemed to be quite skills-focussed and, following the programme, they reported that nurses rated themselves as highly as or even better than those in a control group. Leigh et al. (2005) also asked nurses to self-evaluate and found that they reported themselves to be more confident and competent after attending a preceptorship programme. However, there is very little detail as to what this actually means and the results of the whole study are quite hard to interpret. Interestingly, few research articles focus on the impact of preceptorship on skills acquisition. This might be seen as surprising, bearing in mind that nurses’ fitness for purpose at the point of registration has been under much discussion, as Leigh et al. (2005) highlight.

The need for preceptorship programmes
Many authors have made recommendations regarding the need for preceptorship programmes, although it is not always clear as to what they consider the key
components to be. Sometimes preceptorship consists of a number of elements so it can be difficult to establish which aspects delivered the reported benefits. Beecroft et al.’s (2001) programme was initiated in response to a shortage of paediatric nurses so clinical training appears to have been a key component in this case: however, group reflection and preceptors in practice were also put in place.

Some studies identified that the programmes in themselves act as a support (Beecroft et al., 2001; Leigh et al., 2005; Evans et al., 2008). This latter study assessed programmes in seven hospitals; the programmes were quite different so it is not easy to compare them. Most of what is reported relates to the clinical areas rather than to the theoretical teaching element of the programmes.

The need for feedback

Newly-qualified nurses’ need for feedback, or complaints that they did not receive enough feedback, came out consistently in many studies (Casey et al., 2004; Murrells et al., 2008; Thomka, 2001; Hardyman & Hickey, 2001). Generally this was seen as being a preceptor role. However, it is worth noting that Hardyman & Hickey’s (2001) article only reports the first part of a two-part study, which therefore represents nurses’ expectations and hopes and not their actual experiences once qualified. Unfortunately, this second part of the study was not located. Thomka’s (2001) study is open to some questions over rigour as it involved a single researcher who designed her own tool and who completed the data analysis process alone. No information about her experience is given to assure the reader of her qualifications for this role or of the reliability of the tool. Furthermore, in order to gain enough participants, nurses who had been qualified for up to fifteen years were included in this study. The author fails to state how long each had been qualified, so the reader cannot judge how much this may have affected the quality of the data. Finally, half the participants were nurses working in mental health, so the results may not necessarily be transferable to the acute setting. Casey et al. (2004) also devised their own tool for their research. However, they state that it was piloted, which can enhance reliability (Cohen et al., 2007) and they declare a Cronbach’s alpha of .78, which gives the reader further assurance.

Murrells et al.’s (2008) research was a quantitative, longitudinal study carried out for the National Nursing Research Unit. An impressive 88% response rate adds weight to the credibility of this study, although, as stated earlier, the data is not as recent as the date of publication might suggest.
The need for emotional support

A number of studies focussed on the emotional aspects of being a newly-qualified nurse. Some showed that preceptors are not always sensitive to nurses’ needs and anxieties (Boychuk Duchscher, 2001; Casey et al., 2004). Others cited the need for emotional support because their studies showed that the environment in general is not always supportive (Maben et al., 2007; Bowles & Candela, 2005). Unfortunately, this latter study had a response rate of only 12%, which may mean the data is not so trustworthy, although 352 nurses still participated. Maben et al. (2007) used mixed methods, starting with questionnaires given to senior student nurses followed by interviews with 26 of these once qualified, and quotations help illustrate the findings, although no methodology is stated. Data was collected between 1997 and 2000.

Kuroda and Sato (2009) looked at the relationship between an educational programme for novice nurses and their anxiety levels, but struggled to prove a connection. For reasons that were not stated, Healthcare assistants were included, which I would suggest calls into question the credibility of the study.

Protected time for preceptorship

Some studies, including a literature review by Higgins et al. (2010), identify that the provision of dedicated time for newly-qualified nurses to work with their preceptor can be limited or inconsistent within an organisation. Ellerton & Gregor (2003) found that the eleven nurses they interviewed worked between three and twelve shifts with their preceptor. The nurses in Evans et al.’s (2008) study had a rotation system which may have made them feel a greater need for preceptor support. Gerrish (2000) recommends a supernumerary period following registration but does not suggest how long a period this might need to be. Two further studies highlighted the need for protected time for preceptorship: Maben et al. (2007) and Henderson et al. (2006) who reported that preceptors themselves complained of insufficient time for the role. Other studies go further, with one calling for rewards for preceptors (Bowles & Candela, 2005) and another for time off in lieu for preceptors (Boychuk Duchscher, 2001).

Preceptor preparation

Consistent with the Preceptorship Framework, there is some agreement that anyone acting as a preceptor needs preparation for the role (Bowles & Candela, 2005; Casey et al., 2004; Leigh et al., 2005; Henderson et al., 2006). It is interesting then, that few give details as to what this should include. Newhouse et al. (2007:52) actually refer to preceptor preparation as having occurred but state only that it focussed on the “special issues traditionally faced by new nurse graduates in the acute setting”.

2.3 Grey literature

In addition to the research literature, four publications of practice accounts were found in which authors reported the benefits of their preceptorship programmes. Two opinion papers were also retrieved. These are tabled in appendix 2.

Kingsnorth-Hinrichs (2009) describes an intensive training programme for new graduates recruited directly into the emergency department, with several weeks of supernumerary time. She reports that the concentration of resources was beneficial as nurses’ competence appeared to have increased following the introduction of the programme. A reduction in nurse turnover was also seen. This author agrees with those who support the call for the preparation of preceptors, specifically saying that experienced nurses need to be taught how to give feedback. This concurs with Strauss’ (2009) practice account in which nurses complained of a lack of feedback from their preceptors. Goode and Williams (2004) and Wood (2007) also published practice accounts and both advocate preceptor preparation. Wood (2007), who refers to a programme in a secure mental health unit, suggests that preceptors need to be able to identify the learning needs of newly-qualified nurses and help them apply their knowledge in practice. Goode and Williams (2004) suggest that preceptor training should cover the giving of feedback and goal setting.

Two other authors writing on preceptorship consider the function of the preceptor to be that of a role model (Lau-Robinson, 2008; Ashurst, 2008) to help newly-qualified nurses apply theory to practice and Lau-Robinson makes a specific call for this function of the preceptor to be strengthened.

Most of these authors specifically advocate the need for formal preceptorship programmes, with Goode and Williams (2004) recommending that they be introduced for nurses across the United States.

2.4 Summary

Review of these publications reveals the benefits of preceptorship as well as some areas for improvement. It is evident that the implementation of preceptorship is quite variable. There is a broad recognition of the need for both formal preceptorship programmes and protected time for preceptorship in the clinical area. However, what has been carried out so far is by no means exhaustive and sometimes the quality of the research can be called into question, due to factors such as low response rates and often a lack of clear methodology which in some cases has led to a confused focus. There is still a need for further research to be undertaken, including the need to examine the “effects of the practice environment on the transition process” (Higgins et al., 2010:508). This would certainly include a focus on the preceptor/preceptee
relationship. The area of preceptor preparation would also benefit from further research and it was my view that examining preceptees' experiences of this relationship might give some guidance on this.

With the above in mind, I decided that I wanted to explore newly-qualified nurses' lived experiences of the preceptorship year. In addition to relationships with their preceptors this would include their experiences of the various aspects of the formal preceptorship programme, such as teaching sessions and action learning groups. My aim was to uncover a little more about what improved the experience of being newly-qualified or, indeed, what made it worse, so that appropriate changes could be made in the future. The methodology and methods chosen for this study now follow in chapter 3.
Chapter 3: Research Design: methodology and methods

3.1 Introduction
In this chapter I discuss in depth the methodology and methods selected for my study on the lived experiences of newly-qualified nurses undergoing preceptorship. Ethics and rigour are addressed and I provide some reflections on both my chosen approach and on how well I believe I carried out the whole research project as ways of demonstrating rigour.

3.2 Methodology
Phenomenology has been described as both a philosophy (Giorgi, 2006; Rinaldi Carpenter, 2003) and “a philosophic attitude and research approach” (Flood, 2010:7). This methodology recognises and emphasises the importance of obtaining participants' own descriptions of an experience and what it means to them (Rinaldi Carpenter, 2003; Gray, 2004). In my research, I wanted to gain an in-depth understanding of the phenomenon so I needed to hear nurses' descriptions of preceptorship in their own words. Hence, phenomenology seemed a highly suitable methodology.

It is important for researchers to understand the relevance of the philosophical assumptions behind their chosen method of research (Koch, 1995; Paley, 1997; Norlyk & Harder, 2010). Phenomenology sits under the umbrella of Interpretivism, an anti-positivist viewpoint which emphasises the uniqueness of individuals and therefore the need to investigate the natural world and the social world quite differently (Gray, 2004).

There are different schools of phenomenology and for my study I decided that Husserl’s descriptive phenomenology was the most appropriate, for several reasons. Fundamental to Husserl's approach is that the researcher remain “true to the facts and how they reveal themselves” (Husserl, 1960, cited in Whiting, 2001:61). Gearing (2004:1430) describes Husserl’s philosophy thus:

“to know is to see, and to see is to look beyond constructions, preconceptions and assumptions (our natural attitude) to the essences of the experience being investigated”.

In order to achieve this, Husserl introduced the concept of reduction or bracketing. Bracketing has been described as “a suspension of attitudes, beliefs and prejudices” (Holloway & Wheeler, 2002:173) and as “the adoption of a presuppositionless approach” (Beech, 1999). To achieve this, Price (2003) calls upon researchers to
examine their own values and attitudes about the phenomenon being studied and Lopez and Willis (2004) urge researchers to continually assess any bias or presuppositions they have, in order to prevent these from influencing the study. Of course our interest in the subject comes with opinions and beliefs, but the point is to recognise and be constantly aware of these, in order to stay true to the intentions of the approach - which is to find another’s meaning and not one’s own.

I considered this to be particularly important for me in undertaking this research project as the phenomenon being studied was one with which I was very familiar, having met many newly-qualified nurses who have shared their experiences with me. Furthermore, although I identified that there was insufficient literature focussing on preceptorship, the influence of the literature I had read about the subject could not be ignored.

Some authors are critical of the idea of bracketing, suggesting that it is never truly possible (Koch, 1995; Paley, 1997) and others support the notion but are critical of researchers who claim to be doing this but fail to articulate how they achieved it (Gearing, 2004; Beech, 1999). Thus, prior to commencing data collection, I undertook a reflection on my preconceptions about the subject of preceptorship, to which I will return when addressing rigour.

One further important concept in Husserl’s phenomenology is the assumption that in any phenomenon there are universal essences. When a number of people describe their lived experience of a particular phenomenon, there will be some elements that are common to all (Cohen & Omery, 1994). These essences are then “considered to represent the true nature of the phenomenon being studied” (Lopez & Willis, 2004: 728). The aim of this study was to uncover something of the true nature of being a newly-qualified nurse undergoing preceptorship, hence the phenomenology of Husserl seemed highly suited to this study. On reflection, I believe this proved to be a good choice of methodology and this is best seen and demonstrated in the data presentation and analysis chapters.

3.3 Methods

Having made the decision to carry out a phenomenological study, consideration had to be given to the method of data collection. Interviewing is common in phenomenological research (Gray, 2004) but this does not mean that interviews can be carried out without much thought (Wimpenny & Gass, 2000). The use of focus groups was considered but decided against due to the concern that group dynamics may hinder expression of the individual viewpoints and descriptions fundamental to Husserl’s phenomenology (Webb & Kevern, 2001). Bradbury-Jones et al. (2009) make the counter argument that focus groups can be consistent with
phenomenological studies, but they suggest that it requires a skilled researcher to ensure that all participants are able to give their own, individual experience. I certainly did not feel that I would be able to achieve this in my first attempt at carrying out a research study.

I decided that interviews would suit the needs of my study, but there are different ways of carrying out interviews and again this needs to fit the aims of the study (Gray, 2004). Phenomenological interviews with a fairly open structure were chosen, in order to allow participants to expand on anything they felt to be significant. An interview schedule was designed to provide a guide, especially as I was a novice researcher, but also to ensure that the research questions would be addressed (Carter & Henderson, 2005). A copy of the interview guide is shown in appendix 3.

3.4 Sampling
All newly-qualified nurses at my Trust are registered onto one of the preceptorship programmes that I run. Because it is recognised that research participants can seek to please and give answers they think may be required (Price, 2002) it was important not to ask nurses currently undertaking the programme to participate in this study, as they may have been influenced by their on-going relationship with me. Therefore, these nurses were excluded.

The programme runs over one year so nurses who had most recently completed the programme were approached to participate in the research, with a plan to approach nurses who had been qualified for longer should there be insufficient numbers. This is purposive sampling (Holloway & Wheeler, 2002).

For a qualitative piece of research where the data will be rich and detailed, a small sample size is important or the data will become unmanageable. The original estimated number of participants was six to ten, but insufficient nurses from the first group responded so nurses from earlier groups were approached. In total, five nurses responded to the letter that was sent, a response rate of 21%. Another response unfortunately came too late to be included, but it brought the response rate up to 25%. Although these were slightly disappointing numbers, this may not be so surprising considering that people were being asked to give up their own time. In contrast to quantitative research where a statistical framework may well require a set sample size (Carter & Henderson, 2005), numbers are not too significant in qualitative research. Furthermore, phenomenology values each individual contribution as unique (Rinaldi Carpenter, 2003).

The five participants were all female and worked in either general or specialist departments of the hospital. Some had rotated as part of their first year in practice, others stayed in one area. Some had only had one preceptor, others more than one –
either due to the rotation or because this seemed to be the practice in their ward. Participants are referred to here as P1-5. Where the word [preceptor] appears in these brackets it is because they used the term mentor instead of preceptor, but I have used preceptor for consistency.

3.5 Rigour
3.5.1 Introduction
The issue of how to establish rigour in qualitative research is much debated and contested (Donovan & Sanders, 2005; Morse, 2006; Ryan-Nicholls & Will, 2009). Arguably, demonstrating rigour is particularly challenging for the less experienced researcher, especially in qualitative research where the researcher plays such a key role in the generation of the data and where the interview is the site of knowledge creation (Kvale, 1996). Various possible means of establishing rigour will now be discussed.

3.5.2 Pilot interviews
Pilot interviews are often advocated, especially for novice researchers (Gray, 2004; Sorrell & Redmond, 1995) and this was planned and carried out. Following the pilot interview, I completed an entry in my research journal, critiquing the process I had followed. I then met with my supervisor who had a copy of the transcript of the entire interview. I was reassured that, if anything, I may have been over critical about issues such as having asked a leading question. At one point, I felt that I had made an assumption about something the participant had said, and although my supervisor agreed that I had done so, she also pointed out that the participant had corrected me. She was clear that this therefore did not call into question the credibility of the subject under investigation at that point. This was a useful exercise for me.

3.5.3 Supervisor’s role
The role of my supervisor overall has been crucial. In particular, data analysis is complex and should not be carried out by a novice (Pope et al., 2000) so her participation here was critical to the credibility of my study. Data analysis is dealt with in detail in chapter 4.

3.5.4 Reflexivity
One well-supported means of demonstrating rigour is the use of reflexivity. This involves continuously appraising one’s thinking and viewpoint and making this explicit to any reader (Koch & Harrington, 1998). Writing a research journal or reflective diary can be the means to achieve this. My reflections on the success of the bracketing
process are particularly important as they help the reader to judge the credibility of the data. I referred earlier to the reflection on my preconceptions which I undertook prior to commencing data collection: the full reflection appears in appendix 4. In summary, I identified four main areas of preconceptions about newly-qualified nurses in their preceptorship year:

- Need for belonging, needing to fit in
- Shock at the workload and unfair expectations on them
- Lack of time with preceptors, often seen in not having time to complete signing of the competency assessments in their portfolio of learning
- Concern that they were not always involved in the choice of preceptor.

My hope was that identifying these preconceptions would reduce their influence on the research study, notably in the data collection stage (seen in the way in which I asked questions) and in the data analysis stage. Following completion of the study I sought to evaluate how well I managed to achieve this process of bracketing, and here I examine the data collection stage of the project.

Table 1 overleaf represents examples of my questioning on the four identified areas and some initial reflections on these.

Part of my reflective diary was a more detailed reflection on the third and fourth points and this appears in appendix 5.
<table>
<thead>
<tr>
<th>Preconceptions</th>
<th>Questioning used</th>
<th>Reflection on this</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Need for belonging and fitting in</td>
<td>Did not use direct questions about this. Subject came up naturally with some participants.</td>
<td>Believe I did not allow my preconceptions to influence my questioning in this area.</td>
</tr>
<tr>
<td>2. Shock at workload, unfair expectations</td>
<td>Did not ask direct questions about this. The subject did sometimes arise</td>
<td>Happy that I did not lead participants to say something that they were not thinking. Although I was asking directly whether other people had expectations of her, I feel this was not a leading question as she herself raised an issue which I felt needed clarification.</td>
</tr>
<tr>
<td>3. Lack of time with preceptors</td>
<td>I asked about completion of competency assessments.</td>
<td>I see that I asked the question quite differently to each participant, which may have affected the data. I did avoid asking “Did you have enough time?” which was my key aim following the reflection on my preconceptions. However, P2, 3 and 5 were all asked closed questions. Only P4 was asked a very open question.</td>
</tr>
<tr>
<td></td>
<td>P1 - the subject came up naturally by her</td>
<td></td>
</tr>
<tr>
<td></td>
<td>P2 - “the portfolio, did you use that, find that helpful? Did you talk about it with your [preceptor]?</td>
<td></td>
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<tr>
<td></td>
<td>P3 - “when you came to do the folder…did you get support and feedback as to whether you were progressing?</td>
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<tr>
<td></td>
<td>P4 - “and the competencies, how did you work through that?”</td>
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<tr>
<td></td>
<td>P5 - “Was it your [preceptor] that signed your portfolio?”</td>
<td></td>
</tr>
<tr>
<td>4. Issues about involvement in choosing their preceptors</td>
<td>I asked this of P2, 3 and 5: P2 “how did you get to be given that person – did you ask for that, were you told it was happening or…” P3 “you say you had somebody allocated to be your preceptor – how was that arranged? Was it arranged for you or did you have to ask for that or how did that work?” P5 “Did you get to be involved in choosing who would be your preceptor or was someone allocated to you?”</td>
<td>I asked the question differently of each participant, according to how the interview was flowing. This may or may not have affected the data but has been a point of learning for me. On reflection, for P2 and 3, my question could have been briefer. I almost asked 2 or 3 questions in one. Did I think my question needed clarifying? Perhaps I can learn to wait longer for an answer before deciding this.</td>
</tr>
</tbody>
</table>
3.5.6 Participant confirmation

Prior to undertaking my research project, I identified that participant confirmation or member checking is sometimes cited as a means by which reliability can be achieved in phenomenology (Gray, 2004). I also noted that this was quite a contested area (Koch & Harrington, 1998; Gelling, 2010) but I did decide to offer participants the opportunity to view both the transcript and the dissertation abstract.

However, I came to question the usefulness of a participant reading an exact transcript of the conversation. I then considered sending the themes that I had identified to the participants, but this again raised issues. In looking for themes to emerge, the researcher seeks the true essence of the phenomenon being studied and this will be arrived at from a combination of all the data. Hence it could be quite difficult for a participant to identify their contribution (Koch & Harrington, 1998). I then considered returning all the themes to all the participants, with each person being able to see where their comment or description fitted (if it did fit that particular theme). During this consideration I read further on this issue.

Norlyk and Harder (2010) reviewed thirty-seven phenomenological research studies and noted that eleven of the authors had sent identified themes or findings to participants for verification (italics mine). At this point I questioned what exactly these participants might have been asked to verify, and what I would be asking my participants to verify if I chose this route. Bradbury-Jones et al. (2010) discuss member checking and conclude that it should be standard practice. However, the examples they give relate to hermeneutic phenomenology where the researcher’s role is to interpret. My view now is that, in descriptive phenomenology, the researcher does not need to ask the participants whether or not their meanings have been correctly interpreted, as this methodology seeks only to describe and not to interpret. Indeed, Giorgi (2006), a proponent of descriptive phenomenology, believes there is no justification for the use of participants as evaluators of research findings.

In the end, I offered to return the transcripts to the participants as this is what I had promised to do. Thus, I do not offer this as evidence of the rigour of my study but as an important learning experience for myself.

3.5.7 Data analysis

Finally, one other point at which rigour can be demonstrated is in the data analysis stage of a research project and this is dealt with in chapter 4.
3.6 Further reflections on use of the chosen methodology and methods

The choice of phenomenological interviews for this research has, I believe, been successful, as I have gained useful and interesting insights into the lives of the participants, this data being presented in chapter 4.

It has also been interesting to consider how well I utilised the interview schedule (see appendix 3) and how well designed the guide proved to be.

The initial questions seemed to work well as ice-breakers and proved helpful just to get the interviews started.

The one planned question proved to be a problem for a reason I had not considered, though this in itself has been a useful finding. Whilst the term preceptorship and all its associations are ones with which I am very familiar (both in my work and through this project), I had only really introduced the term into the work environment in the last year. Prior to the publication of the Preceptorship Framework (DH, 2010) our Trust did have a programme for newly-qualified nurses, but it was called the Staff Nurse Development Programme. All the study participants had commenced the programme (and some had completed it) before it was re-named the Preceptorship programme in 2011. Furthermore, the term preceptor is still one which many in the clinical areas are not using, and so most of the time the participants referred to their mentor(s). Hence, the planned question regarding their experiences of preceptorship had to be abandoned in that form as it was not a clear or appropriate research question.

However, I did soon realise this and was able to adapt my questioning accordingly. Had another researcher been involved though, considerable confusion might have arisen during the interviews due to this disconnect between policy and practice.

My learning from this is that when one is immersed in a topic one can assume that others also have the same level of knowledge and understanding: however, this is clearly not the case. This learning is also applicable in the workplace where I seek buy-in from managers on aspects of preceptorship such as releasing staff for training.

Finally, the prompt questions on the guide regarding what had helped them and what else they would have liked proved helpful and were used consistently.

3.7 Ethical Considerations

3.7.1 Ethics committees

Prior to the commencement of this study, ethical approval was sought and gained from the Regional Ethics Committee, the Trust Ethics Committee (as this was the location of the research and because the participants were employees of the organisation) and from the University Ethics Committee. Copies of these appear in appendix 6.
3.7.2 Confidentiality and Anonymity
A letter of invitation was sent to potential participants (see appendix 7) and those who responded were sent a participant information sheet (PIS) (see appendix 8) which explained that all information would be treated in the strictest of confidence. This included assurances that it would never be possible to identify them or their place of work when the study was published. Confirmation of participants' understanding of this is also referred to in the consent form (see appendix 9).

3.7.3 Safekeeping of data
Prior to carrying out the study, I made the appropriate arrangements for the safekeeping of the data, in keeping with the Data Protection Act of 1998. The PIS gave details and assurances about the safe storage of data. However, ethics in research is only partly about procedures, as identified by Cohen et al. (2007:65) who refer to the keeping of “shared secrets”, which I only appreciated after carrying out the interviews. Listening to recordings of the participants' stories somehow highlighted for me just how precious this data was.

On reflection, I would suggest that concern over safe-keeping of such personal data may be a reason for some people choosing not to respond to a request to participate in a research project such as this. This would be difficult to address without offering not to record the interview and in my experience this would severely limit the data collected.

3.8 Summary
In this chapter I have given details of the methods chosen for this study and its philosophical underpinnings. I now present the findings of my research in chapter 4.
Chapter 4: Presentation of findings

4.1 Introduction
Here I present the findings of my research and the data analysis process that I followed to arrive at the various themes. I endeavour to make this explicit to ensure that the process is auditable (Ryan-Nicholls & Will, 2009). Following data collection, I personally transcribed each of the research interviews verbatim. This was a useful beginning to the process as it enabled me to begin engaging with the data. Listening to the recordings as well as reading the transcripts was valuable: for example, in hearing the strength of feeling with which some issues were expressed.

Colaizzi’s nine stages were followed for the process of data analysis. (See appendix 10.) Stages three and four refer to reading all the participants’ descriptions of the phenomenon and extracting significant statements. The researcher is then required to spell out the meaning of each significant statement and organise these into themes. I read the transcripts and listened to the tape recordings several times and noted what struck me, coding the data under themes that were beginning to emerge.

The researcher’s job in qualitative research is to make sense of the data and Pope et al. (2000:114) state that this “should not be left to the novice”. Therefore, my supervisor’s role was key to enhancing the rigour of my research. She read all the transcripts and made her own notes with possible themes. As she reminded me, qualitative research is about seeking to include individual items (Pope et al., 2000) so initially we had a large number of themes. Initial themes from my first attempt at coding are presented in appendix 11, to allow readers to audit the coding process. After further thought and discussion with my supervisor three main themes emerged, with several sub themes, shown overleaf.

As stated in chapter 3, there were five participants in the study, referred to here as P1-5. Where participants used the word mentor instead of preceptor during the interviews, the word [preceptor] appears in these brackets.
4.2 Main themes and sub-themes

1. **Being newly-qualified is frightening: knowing people and not feeling alone make a difference**

   1a: The difference made by knowing people
   
   1b: The difference made by not feeling alone

2. **Preceptor behaviours experienced (positive versus negative behaviours)**

   2a: Recognising and acknowledging their feelings and anxieties vs failing to do so
   
   2b: Being approachable and supportive vs being unsupportive and patronising
   
   2c: Being available and making time for support and learning vs being too busy and not recognising the need for support or learning

3. **What the Trust can do to support newly-qualified nurses: Training and Environment**

   3a: Provision of post-registration teaching must meet the needs of all staff
   
   3b: Provision of protected time for study days should be equitable.
   
   3c: Provision of Practice Development Nurses is important and should be equitable.
   
   3d: There are unfair expectations of newly-qualified nurses
   
   3e: The clinical environment is not always supportive, both generally and of learning

4.3 Presentation of themes with examples from interviews

**Theme 1: Being newly-qualified is frightening: knowing people and not feeling alone make a difference**

Although this was not a study investigating nurses’ experiences of being newly-qualified, nevertheless, each nurse’s personal story of preceptorship is situated in their experience of being a newly-qualified nurse. Their descriptions of being newly-qualified were consistent with the plethora of research identifying that this is a stressful time. Four of the participants used the word “scary” and/or the word “terrifying”, whilst the other said it was “horrible”. There was much repetition which served to emphasise just how bad it was. Three of them talked about their fear of harming patients and the other two talked about not having enough skills and not
being prepared. What was interesting for me was the impact this had on me, despite it being a totally expected finding.

The difference made by knowing people and the need to not feel alone came out strongly in most interviews.

Sub theme 1a: The difference made by knowing people

One of the first things that came out in several of the interviews was the difference that knowing people in their clinical area seemed to have on their experience. Having had a student placement in the area seemed particularly significant. For example:

  P5: “The team there knew me and I knew them, having done my supervised practice there.”

P2 and P3 had also worked in their area as students and identified this as making a difference. P3 did not have a preceptor allocated to her but she decided that the person who had been her mentor when she was a student could fulfill this role. Here, the system seems to have failed but the consequences were insignificant because the nurse knew the staff.

In contrast, P1 had never worked in her area as a student:

  “When you’ve only been in a place five minutes you don’t really know who you can trust and who you can’t trust.”

Interestingly, it was all about the people they worked with and relationships, not the patient group. This was highlighted in a comment by P4, who talked about the difficulties of sometimes not knowing the staff she was on duty with:

  “you can’t ask the agency nurse…or if there’s no-one you knew particularly well enough, you felt awkward about finding someone to do your IVs”.

Sub theme 1b: The difference made by not feeling alone

All the participants found that meeting up regularly on the preceptorship programme with others who were in the same boat made a difference to how they felt, for example:
P5: “It was nice that that you could meet up with other newly-qualified nurses, irrespective of what area they were from, just because we were all having struggles of varying degrees and it’s nice to know you’re not the only one that’s struggling”.

Action learning sessions seemed to be a particular place for this sense of support:

P4: “everybody had difficulties or things to get off their chests...everyone in their own way was struggling as well.”

P3: “having that reflection, where other people are feeling the same as you, because they’re in the same situation on a different ward, that really did help.”

P1 talked about a bad experience she had had and said: “we had action learning...so I was able to talk about my experience....and that really, really helped me...I didn’t feel so alone and that sort of kept me in there”.

The fact that these comments were all so similar demonstrates how strong a theme this was. It was clearly important for them to know that their feelings and experiences were ‘normal’. This is interesting as obviously it does not change anyone’s situation, but it seems to provide an important support mechanism.

Even before being asked what had helped her, P2 made the point that it had helped that she started at the same time as two other newly-qualified nurses. Again, there appears to be a sense of support derived from being amongst others who are in the same situation.

**Theme 2: Preceptor behaviours (positive versus negative)**

Preceptors’ behaviours were often spoken of by participants, with references made to whether or not they recognised their feelings and whether or not they were approachable and supportive.

Sub theme 2a: Recognising and acknowledging their feelings and anxieties versus failing to do so

Some participants made a point of saying whether or not they felt that colleagues understood how they were feeling.

Two examples demonstrate different experiences of this sub theme:

P5: “they were aware of my being newly-qualified and a bit anxious…and the fact that that was acknowledged rather than not spoken about I think helped.”

In contrast, P1 expressed:
“I didn’t feel there was enough empathy out there for me”.

She thought preceptors should be told:

“newly qualified nurses, they’re scared, they’re vulnerable; just to remind them again, just to remind them”.

The emphasis given here really showed her strength of feeling about this.

P3 said that preceptors need to recognise when someone is struggling and not let things get to crisis point:

“if they see someone struggling they should maybe ask them if they want to sit down and have a chat, rather than getting to the point where they just burst into tears”

There were also some quite simple statements about the general attitude of someone in the preceptor role, for example that they should just be friendly and that they should be kind and caring.

It was evident that newly-qualified nurses want their feelings to be understood and need preceptors to notice and care about how they are feeling.

Sub theme 2b: Being approachable and supportive versus being unsupportive and patronising

It was common for participants to talk about how they felt about approaching their preceptor or other members of staff. It became evident that there were colleagues who they would happily approach for help and support and those who they would be less happy to approach.

A lot of positive comments were made about preceptors, for example:

P1: “She was really approachable which I think is a key thing. I certainly felt I could ask if I wasn’t sure about anything.”

P2: “I had a [preceptor] I could go to whatever problems I had”

P4 said that when she had a “mini breakdown” her preceptor pointed out how far she had progressed, which she found encouraging and P3 described how reassurance from her preceptor was crucial when she was feeling unsure of herself.
Negative comments related to some people being unsupportive, unapproachable or patronising:

P2: “I’ve had people say ‘that’s a really stupid question that you’ve asked’”

P5: “some people you’d feel a bit stupid in front of them saying ‘I really don’t know how to do that’ or ‘I really struggled with that’”

P3: “some people….I think highly of them because they’ve got a lot of knowledge but I don’t feel able to ask them questions because I think they will say to me ‘you should know that by now’”

These examples show that their experiences relate not just to their identified preceptor, but to all the staff they work with.

Sub theme 2c: Being available and making time for support and learning versus being too busy and not recognising the need for support or learning

P5 expressed how important time to talk was:

“I think that makes 90% difference in terms of whether you feel supported and whether you feel you can progress more readily, because you have time to ask questions and have things shown to you that you’re not quite sure about.”

The physical availability of a preceptor was mentioned by P2 who described how her [preceptor] was rostered on the same shifts as her and was in next bay if needed.

Others referred to their preceptors specifically making time, or not:

P3: “She used to take us away from the ward…and take the time out to listen to me as well, which was really nice, rather than just a quick chat in the clinic room... So she was a really good [preceptor]”

If people were perceived as being too busy to approach with questions, P4 reported that she tended to think:

“probably I should know this”.

I asked if it was hard in this situation to decide whether or not to ask for help and she said:

“Yes, very hard.”
This suggests that there might be implications for patient safety if inexperienced nurses do not always feel they will receive support if they ask for help.

Newly-qualified nurses are given a portfolio of learning which includes competency assessments. Some of the participants described the process of getting these signed:

P5: “I felt it was quite rushed, in terms of the sign off”
P1: “I never got the time to actually sit down and properly go through it, you know, it was a very quick process…it needed to be done, rather than me actually feeling supported”

On other hand, P2 described a proactive approach by her [preceptor] who took the initiative to go through the portfolio:

“she said ‘let’s do it now’….so we actually did it together, which obviously helped”.

This participant said how good it was to see her progress documented. This might have been missed had her preceptor not been so proactive in making the time for this.

It does appear that some preceptors make more of an effort to ‘find’ the time than others. It also seems that nurses can tell whether or not their preceptor really wants that role or not. Some pointed out that they believed preceptors should choose to take on the role, for example:

P5: “if it’s not something they’ve chosen to do and they’ve kind of been pushed into being a preceptor then they’ve not necessarily got the interest there or the inclination to make the time”

The provision of time for preceptorship will be discussed further under the heading of what the Trust can do.

**Theme 3: What the Trust can do to support newly-qualified nurses**

This theme was identified when it became evident that there were issues that the Trust itself needed to address. A number of points were raised which related to the subjects of training and environment.
Sub theme 3a: Provision of post-registration teaching is important but it needs to meet the needs of all nurses

Some of the nurses expressed the importance of on-going teaching for them as registered nurses and it seemed that it was more likely to lead to learning now they were qualified and out in practice.

P4: “suddenly everything becomes relevant. because you’re doing it on a day-to-day basis and practising it, whereas in university you’d have these lectures then sometimes you wouldn’t be out on placement for another 6 weeks and it might be a completely different placement…”

and

P3: “when you’re learning stuff at university, you’re not on your own. As a staff nurse it’s a different kind of thinking…you notice that poorly patient, you do something about it.”

The nurses working in acute adult areas all reported the teaching as being relevant and of a good quality. The fact that teaching sessions led to them gaining knowledge and confidence was also mentioned.

The two nurses who came from specialist areas found a lot of the teaching helpful but would have liked more teaching specific to their specialties. This is an inequality that currently exists in the delivery of the preceptorship programme.

Sub theme 3b: Time for study days should be protected and equitable.

Concern was raised that there was inequality when it came to protected time to attend the preceptorship programme. Interestingly, concern came from those who did receive all their study days as well as those who didn’t.

P1 described how she didn’t always get her study days and actually missed a particularly important one. She pointed out friends who did not get their study days and expressed the view that in this scenario, people lose interest and give up. This may offer an explanation of the poor attendance of a minority of nurses on the programme.

P5 did get all her study days but noted that not everyone did. She felt this was unfair. She thought that people might choose to attend in their own time but said:

“I think if you feel that your work place is supporting your learning, you are perhaps more happy about attending and your focus would be better.”
It was interesting that these participants had a view or an insight into how this provision of protected study time might affect both attitudes to learning and actual learning itself.

P3 identified the provision of protected teaching as one of the reasons the preceptorship programme was helpful, adding:

“...we did get support because we got all our study days”

The provision of paid study time was perceived as the provision of support. Possibly then, nurses who do not receive this may well view it as a lack of support.

Sub theme 3c: Provision of Practice Development Nurses (PDNs) is key and should be equitable throughout the Trust

Some of the participants worked in an area when a PDN was in place and others did not. The nurses working in areas where they did have a PDN noted that this made a positive difference. One of them described their department as fortunate:

“We’re quite lucky we’ve got the support we do – the fact that we have a PDN and she’s always there to support us.”

Another said that it was unfair that not all wards had a PDN. One of the nurses working in area which did not have this role identified that employing a PDN would be the single most important thing the Trust could do to improve the experiences of newly-qualified nurses. The reason she gave was:

P5: “you need some hands-on training with the opportunity to ask questions”.

It seems that both classroom based and ward based teaching are valued by nurses undergoing preceptorship.

Sub theme 3d: There are unfair expectations on newly-qualified nurses

There were statements made by participants about what had been expected of them, or what they had expected of themselves when newly-qualified.
P5 said:

“I think there is that expectation, whether we put it on ourselves or (pauses) but there is the expectation that we should be able to do it, and there are some things we just haven’t experienced as a student, that you need to learn about.”

And P1 expressed:

“They so easily feel, and you feel, that you should have this expectant knowledge”

P4 talked about not having enough skills; for example said she only did two catheterisations in her training:

“Technically you should be able to catheterise a patient but you think…’mm, I don’t know’”

It was interesting to note the use of the word ‘should’ in all these examples. Wherever it comes from, there was a sense of not being able to achieve what they ‘ought’ to achieve.

P5 highlighted that the standard two week supernumerary period is all very well but then, after that:

“It’s ‘off you go’, like suddenly after two weeks it’s just all going to click in and you know it all now!”

Some participants stated that, when possible, they were given a reduced workload when they first started on their ward. However, this did not always work out, especially if there were a lot of very junior staff on the same shift. This is especially relevant for our Trust at the moment as we are taking on an unprecedented number of newly-qualified and inexperienced nurses.

Sub theme 3e: The environment it is not always supportive, in general and of learning

In addition to the seemingly unfair expectations on them, some participants did not perceive the overall working environment to be supportive.

P4 felt that there was a blame culture in nursing:

“you’re recognised for what you don’t do and what you forget and mistakes”.
She contrasted this environment with her experiences of the preceptorship programme which was where the support was. She said that the person leading the preceptorship programme:

“should be there for us not the Trust”

This seems to imply there are two ‘sides’. A statement by P3 seems to agree with this. Talking about her action learning facilitator, she said:

“it was nice having her, she understood the realities…she was very neutral”

The use of the word ‘neutral’ again implies a sense of ‘us and them’.

One participant who had had a bad experience and not felt supported had actually considering leaving the Trust because of it. P4 also considered moving at least from her area to somewhere she perceived as less stressful. She said that the preceptorship programme helped her keep her sanity in the first six months and went on to say:

“I think if I hadn’t had the support through the [preceptorship] programme and through (name of her preceptor), I think I would have moved off from the ward”.

It is evident that some situations are so stressful that the organisation is at risk of losing its newly-qualified nurses.

P5 was clear that colleagues are not unwilling to provide support, but are unable to, due to the pressures of the environment:

“That person who is supporting you has their own 4 or 5 patients, again, time-wise they can’t be there every 5 minutes…..understandably, not because they’re being awkward, but because their priority is their own sick patients”.

The fact that the priority of ward staff is their ‘own’ patients seems to indicate that everyone is busy with their individual workload and that the environment may not always be conducive to learning.

As highlighted earlier, P5 described signing competency assessments as “rushed” and added:

“That’s because they don’t have the time and there’s not an allocated slot where they say ‘OK, you two are not counted in the numbers for the next hour’ – that’s just not going to happen, realistically.”
Again, P1 said:

“I never got the time to actually sit down and properly go through it, you know, it was a very quick process…”

P2 and P4 both said that completing the portfolio and competencies enabled them to see how much they had achieved, which indicates one of the reasons why the portfolio is important. However, P4 noted that she often stayed late to get hers signed. Although she described this as not being a problem, possibly not everyone would agree or even be able to stay late.

4.4 Summary of data analysis process

The use of Colaizzi’s guide proved helpful to me as a novice researcher. It was difficult at times to categorise some statements into themes, as often they seemed to fit with more than one theme. However, I would argue that this is the nature of qualitative research: it is not neat in this way and my supervisor’s guidance was invaluable at this point.

The detailed analysis above represents Colaizzi’s seventh stage: writing an exhaustive description. For me this was the final stage in my analysis as the last two stages refer to returning data to participants for validation - a process which I eliminated, as discussed previously. Therefore, the data presented here represents an exhaustive description of the phenomenon under investigation: the experience of newly-qualified nurses undergoing preceptorship. This does not mean that this study claims to have captured the total essence of the phenomenon, but simply that it represents a full and complete description of these participants’ experience of the phenomenon. It is hoped that this will add to the existing body of knowledge on the subject, which in turn can add credibility to this individual study (Morse, 2006).

4.5 Conclusion

This chapter has outlined the process followed in the data analysis stage of my research and has presented the key findings of the project. These include newly-qualified nurses’ need to know people and not feel alone, the importance of a supportive preceptor plus concerns over the clinical environment and the need for on-going teaching for these nurses. These findings have raised issues which need further exploration, including:

1, the sense of unfair expectations reported by the nurses
2, the learning environment
3, the need for on-going teaching with provision of study time
4. the question of who should be a preceptor and what qualities or training might they require.

These issues are now discussed in Chapter 5.
Chapter 5: Discussion

5.1 Introduction
This study aimed to discover what helped newly-qualified nurses in their preceptorship year and what would have helped, had it been available. It was evident that the nurses’ experiences were variable, but there were common themes that emerged which require further investigation. The data show that these nurses feel a sense of unfair expectations which leads me to consider the environment in which they work and the possible risks to patient safety. Relationships were clearly very important and in particular I want to consider the question of preceptor selection and preparation in the light of the data. Issues relating to learning and teaching such as content of and access to the preceptorship programme also warrant further consideration, as does the clinical area as a learning environment. Figure 1 overleaf shows the issues arising from this study which will now be further explored in this chapter.
Figure 1: Issues arising from the findings to the question “what are newly-qualified nurses’ experiences of preceptorship”?

Code:
NQN = Newly-qualified nurse
PDN = Practice Development Nurse
5.2 Findings and discussion

5.2.1 Unfair expectations

Many authors have written about the different expectations that educators and practitioners have of a newly-qualified nurse (Castledine, 1996; Greenwood, 2000; Maben et al., 2007). Holland (2008) argues that it is only once nurses are qualified and working in practice that fitness for purpose can be developed, whilst Chambers (2007) identifies that there is still a discrepancy between what managers and educators consider the term fit for purpose to mean.

Arguably, the NHS was largely unprepared for the new type of nurse that would be produced by the change in nurse education at the time of Project 2000 and many difficulties arose from this unpreparedness, not least for newly-qualifying nurses themselves (Dunne, 2012). However, bearing in mind that nurse training in the UK has not changed significantly in the last decade, this problem might have been expected to have been resolved, such that practice would now be more aware of what could be expected of a newly-qualified nurse. However two recent studies indicate that this is not the case.

Allan et al. (2011) identified that senior nurses in practice still want newly-qualified nurses to hit the ground running and Maxwell et al. (2011) also found that newly-qualified nurses working in the community reported unfair expectations of them by senior colleagues. This problem does not appear to be unique to the UK. In Australia, pressure on newly-qualified nurses to be “fully-functional as soon as possible” has been identified (Goh & Watt, 2003:17) and another study across two Australian States reported unrealistic expectations on this group (Fox et al., 2005).

These reports concur with the findings of my study and it is disappointing that this issue is still a significant problem for the newly-qualified nurse to contend with. My participants found this stressful, which in itself has implications, but first I want to consider why this might still be the case.

5.2.1.2 Possible reasons for unfair expectations - Clinical environment

The reality shock identified so long ago by Kramer (1974) relates to the contrast between the safe and nurturing environment of the educational institution and the reality of the workplace. So what is this environment like today? Kilstoff and Rochester (2004), in their study exploring the experiences of newly-qualified nurses in Australia, state that the values in the workplace reflect a concern for the timely completion of tasks, and this would resonate with the experiences of some of my study participants. In the UK, Chambers (2007:74) writes that the NHS is now “business-orientated” and Allan et al. (2008) found that this focus on efficiency has consequences for learners.
It is into this environment that our newly-qualified novices are thrown, after - in the case of my organisation – two weeks of supernumerary working. As one of my participants indicated, it cannot be a case of knowing it all after those two weeks. Once the staff nurse is on the roster their workload is rarely very different to that of a more experienced nurse, although two of the nurses in my study did say that, when possible, their ward did try to allocate the least experienced nurses to work with the smallest group of patients. Nevertheless, the rosters themselves do not allow for a reduced patient caseload. Calls for a reduced caseload or a gradual increase in caseload can be found in the literature (Smith & Crawford, 2003; Oermann & Garvin, 2002) as can some examples of this actually taking place (Scholl & Swarts, 2006), however, seemingly not in the UK. This would indicate that practice expects newly-qualified nurses to be able to handle the same caseload as nurses with years of experience. However, to expect them to do so without sufficient support is surely inconsistent with the idea of a transition period and thus the whole ethos of preceptorship which is designed to assist with this transition (DH, 2010).

The question that arises is why this situation persists. An obvious answer may well be the issue of resourcing. There would, of course, be cost implications if nurses were supernumerary for longer or if another trained nurse was needed for every shift to allow for the reduction in workload for newly-qualified nurses. However, it is possible that there are implications of not doing this which I now discuss under the heading of patient safety.

5.2.2 Implications for patient safety

One of the participants in my study expressed just how difficult it was to ask for help when there were few regular staff on duty or when staff were just too busy (see theme 2c). Others talked generally about staff being too busy and some also gave examples of colleagues who they found difficult to approach with a concern (see theme 2b). One participant described her colleagues as being approachable but too busy and her choice of phrase is interesting: “their priority is their own patients”. This seems to indicate that time for the provision of learning and support for colleagues is not a priority on the wards.

This raises concerns about safety on the wards. My research showed that these novice nurses are aware of their need for help and advice, but sometimes have to consider carefully whether or not they should approach someone who they perceive to be either too busy or unhelpful. Whilst their actions in these situations were not explored in depth in this study, it does raise a possible concern and there is literature which seems to support this. In one study, nurses reported not asking questions because they were fearful, as they were expected to know what to do (Maxwell et al.,
2011). This links in with the issue of expectations and seems to indicate that nurses choose to ask for help (or not) according to these perceived expectations. In another study, one nurse admitted to not looking up drugs when a particular sister was on duty, as this sister told her she spent too long on the drug round (Mooney, 2006). Kennedy et al. (2009) looked at how junior doctors made decisions about whether to ask for help managing sick patients and they found that availability and approachability of supervisors was one of three factors that they took into consideration. Consistent with my findings, Myers et al. (2010) found that newly-qualified nurses did not find all their nurse colleagues safe to approach with questions and, furthermore, suggested that lack of feedback caused stress which in turn made them less likely to ask questions.

The decision-making process regarding a request for support is therefore complex and related to what nurses think they should know and by the perceived approachability of colleagues. If hospital Trusts do not wish to invest in supporting newly-qualified nurses by giving them a reduced workload, they may need to consider the possible consequences. There is a focus on quality today with inspections from bodies such as the Care Quality Commission and Trusts should consider some links that have been identified between staff support and the quality of care. For example, a study in the USA found links between nurse:patient ratios and patient mortality (Aiken et al. (2010). These are issues which go beyond preceptorship. However, feeling safe to ask questions is also closely related to relationships in the clinical area and this issue warrants further consideration.

5.2.3 Relationships

The importance of relationships stood out in my research in a number of ways. Nurses pointed out the advantage of having worked in their department as a student or the disadvantage of not having done so and this was always about the people and not the specialty (theme 1a). Fox et al.’s (2005:195) study includes a quote very similar to one in my study: a nurse said that having been on her ward as a student meant that “I got to know the staff and they knew me”. Other authors have noted the benefit of having worked in one’s area as a student, though this may have been for other reasons, such as knowing the layout of the ward (Charnley, 1999) and “continuity” (Burns, 2009:21), which is unfortunately not expanded on to clarify the meaning. Whatever the reasons, this previous experience does seem to be significant and although not every newly-qualified nurse can commence employment on a ward where they have had a student placement, it is worth raising awareness of this issue so that extra effort can be made to support those staff who are totally new to the area.
Participants in my study made it clear that there were positive and negative behaviours that they experienced from preceptors and from colleagues in general. Prior to the study I had been interested in what qualities a preceptor should possess and whether some sort of training for the role might be deemed necessary. I also wanted to consider whether choosing a preceptor for oneself made a difference or not, so that recommendations could be made. Unfortunately, I feel that I did not explore all these issues well with all participants (see table 1), but there were still some useful findings. The literature was also examined to see if this could shed light here.

My data showed that the nurses valued good relationships with their preceptors and wanted them to be approachable and supportive. This is backed up by a number of other studies and practice accounts. Positive preceptor behaviours reported by Schumaker (2007) included being welcoming, being available and making human connections. In this study, some nurses reported over-presence of their preceptor, which made them feel they were not trusted to be left alone. This was not something I found in my study, presumably because the preceptors did not have the luxury of being supernumerary and therefore available. Persaud (2008) reports on an unsuccessful preceptorship programme which she identified as being due to the failure of newly-qualified nurses and preceptors to build effective relationships. The author explains that this was remedied by introducing mentors from outside of the clinical area. Beecroft et al. (2006) also describe a programme in which nurses were given both preceptors in their clinical area and mentors from elsewhere. The success or otherwise of these relationships was noted to be largely down to the attitude of the mentors: nurses could tell whether or not the mentors really wanted to carry out the role. In two separate studies, Olsen (2009) and Winter-Collins & McDaniel (2000) both found that the quality of relationships was seen as more important than the length of orientation and Fox (2010) describes a preceptorship programme where the “buddying” aspect was considered so important that they undertook Myers-Briggs personality testing to ensure compatibility of preceptors and preceptees. This would have resource implications, but it does indicate the importance placed on this relationship by the author. In our Trust, if managers are allocating preceptors rather than giving the preceptee a choice, then this sort of consideration might be important. On the other hand, mentor relations have been found to develop naturally (Thomka, 2007) so perhaps allowing this rather than planning for it might be preferable. Further research into this aspect of preceptorship would be useful.

Myrick and Yonge’s (2004) view is that preceptor behaviour is key to the success or failure of the relationship. Issues they identified as crucial included trust, openness and the need for a safe environment for asking questions. Eraut et al. (2000)
emphasise the influence of relationships in workplace learning and, of course, this relates to everyone with whom staff may have contact, not just preceptors. My data shows that participants did not find all their colleagues supportive and a number of studies report similar findings (Evans et al., 2008; Schumacher, 2007). This brings me to other questions that I had at the start of my research: who should be a preceptor and what preparation for the role should they have, if any?

5.2.4 Preceptor selection and preparation

If nurses simply want a preceptor to be friendly, welcoming, available and approachable, are these not characteristics that all nurses should possess, as another participant in my study stated? If nurses do not possess these attitudes and attributes towards their colleagues then I would argue that there may also be concerns over their delivery of patient care. This concern is unfortunately beyond the scope of this study.

Perhaps then the selection of preceptors should be based on these attitudes. Park et al. (2011) interviewed ten preceptors and noted that all but one enjoyed the role, highlighting that they remembered what it was like to be newly-qualified and wanted to improve the experience for others. If this attitude is an essential qualification for the preceptor role, the question then arises as to whether or not such attitudes can be changed through training.

One innovative study in Australia (Nicol & Young, 2007) took preceptors (who had never sailed before) for sailing lessons. This proved successful as the preceptors reported having gained an experience of being new at something and appreciating how hard it is to absorb a lot of unfamiliar information. One of my participants emphasised the need to remind preceptors of what it was like to be newly-qualified so this sort of approach would arguably be an effective way of addressing the issue.

There are obvious resource implications from this specific example but less costly options could possibly be found. If preceptors could be released for training, perhaps a discussion could be had where each is asked to talk about a skill they have learned recently, either outside nursing or within nursing. Experiences could be shared and a facilitator could encourage participants to link their learning with an appreciation of the experiences of newly-qualified nurses.

Other authors who recommend the preparation of preceptors include Anderson (2008) who is concerned that preceptor selection tends to be based solely on clinical skills, with no consideration of their willingness to teach or an understanding of issues such as learning styles. Sorenson and Yankech (2008) also focus on the need to increase preceptors’ awareness of different learning styles. This is an interesting issue and important for my organisation and quite possibly for many others in the UK.
appreciation of learning styles is part of the curriculum on the Mentor Preparation module at our local university, a mandatory course for those who will mentor student nurses. The university has recently added preceptorship to the content of the module, thus recognising newly-qualified nurses as learners. Two questions then arise for me as the Preceptorship Lead in my Trust:

- Is the content of this module sufficient to produce preceptors who are prepared? and
- Does this mean that only those nurses who have completed the Mentorship module meet the standards required to be a preceptor?

It is interesting that the university have taken this decision as, arguably, preceptorship is not their domain but the responsibility of Trusts. Indeed, preceptorship leads in some Trusts in the south east of England used part of their preceptorship monies to deliver preceptor training, as is recommended in the Preceptorship Framework (DH, 2010). However, I am aware from my preceptorship contacts that the end of SHA (Strategic Health Authority) funding has led to the demise of the Preceptorship Facilitator role in many organisations and preceptor training has generally either ceased or been replaced with an information leaflet. This seems disappointing, but the effectiveness of preceptor preparation is actually hard to judge as Trusts have not been required to evaluate such training.

The data from this study suggest that the main criteria for being a preceptor should be a willingness to undertake the role and an appreciation of what it is like to be newly-qualified. Whilst I need to establish more detail of what exactly is taught on the mentorship course regarding preceptorship, I now think that limiting precepting to those with a mentorship course may rule out some suitable candidates. Furthermore, the responsibility of providing support to student nurses is already an additional to the daily workload of mentors, so to add precepting to that as well may be setting up the process to fail.

Whilst preceptor training could be beneficial, for example in raising awareness of the concerns of newly-qualified nurses, a need highlighted in the data, I would argue that preceptor training may have limited impact if there is no support in practice for preceptors to work with newly-qualified nurses. Indeed, Henderson et al. (2006) reported that preceptors, following training which raised their understanding of newly-qualified nurses’ needs, became frustrated by the lack of support for the role in practice. Therefore, I believe that the issue of the hospital as a learning environment and the question of who is responsible for this still needs addressing.

5.2.5 Learning environment and preceptorship
As identified earlier, caring for patients and making time for supported learning seem to be competing priorities in the acute hospital setting. Learning in practice has been identified as being dependant upon both the availability and the time of other staff (Charnley, 1999). Thus, even when a newly-qualified nurse is assigned an understanding and supportive preceptor and is rostered to work with them (Fox et al., 2005), this does not necessarily result in the provision of learning and support. Although one of my participants did report having her preceptor on the same shifts, it has become evident from my data that the practice setting often does not have the capacity to support on-going learning (Holland & Lauder, 2012).

Of course, this has implications beyond preceptorship. The learning environment has been studied by those interested in the experiences of student nurses, for example Allan et al. (2011) who concluded that the NHS is not a learning-focused organisation. If this is true for students, whose sole purpose for being in the workplace is to learn, then it will surely be even more true of the “workforce”. Researchers who have studied learning in newly-qualified nurses include Eraut et al. (2003) and Clark and Holmes (2007) who both conclude that the conditions in which newly-qualified nurses work are not conducive to thinking and reflecting and therefore to learning in general. I would suggest therefore that the NHS is a long way from promoting lifelong learning for all.

If the reality is that the hospital setting is not an environment that is conducive to learning, perhaps this is why most of the nurses in my study talked about the role of the Practice Development Nurse (PDN). This title may be confusing as many different ones exist with sometimes similar and sometimes differing functions (Holland & Lauder, 2012). However, in my Trust, these are nurses that are employed to work alongside colleagues in a particular area (usually the more specialist areas) for the purpose of education and training. My study revealed that this role seems to be valued by newly-qualified nurses as one which can effectively provide teaching and support.

O’Driscoll et al. (2009) noted that PDNs helped student learning but that they were often only in specialist areas. It would be interesting to investigate why this so often seems to be the case. Another UK study (Mallik & Hunt, 2007) discussed how the PDN role had been introduced initially for the support of student nurses, but that the learning needs of other staff had then been recognised, which led to the introduction of a whole practice development team. Kelly et al. (2002) described how PDNs were introduced into a UK hospital for the purpose of teaching and supporting both newly-qualified staff and healthcare assistants. Ward managers reported appreciating the role because it meant that someone was focusing on teaching – the implication being that they themselves could not do so. It seems clear from my study that I ought to make recommendations to my organisation that the PDN role would be of benefit
Trust-wide. It is possible that this role could take on the preceptor function. This would certainly ease the pressure on clinical staff whose primary role is patient care. Furthermore, it would also hopefully ensure that the preceptor role was being carried out by someone who had a genuine interest in teaching (Anderson, 2008).

5.2.6 On-going, formal teaching outside of the clinical area

It was clear that the nurses in my study found the delivery of the formal preceptorship programme beneficial and these are useful data to justify the on-going provision of this course when posts no longer have external funding. The fact that the teaching sessions were more relevant to the nurses working in general areas than specialist areas needs addressing. Hollywood (2011) actually recommends separate preceptorship programmes for each specialty, but in my organisation these numbers are usually very small so this could prove to be a challenge. Furthermore, the benefit of group support found in the study, which gave nurses reassurance that they were not the only ones struggling, would be lost.

My participants’ explanations about being able to relate this post-registration learning to practice are significant and fit with the findings of Eraut et al. (1995, cited in Eraut et al., 2000:242) where nursing and midwifery students could not link learning in education settings and practice settings “unless they occurred within a fairly short period of time”. Freshwater and Stickley (2004) also argue that nurse education delivers propositional and practical knowledge separately, so that the theory-practice gap remains. Whilst this argument is considerably beyond the scope of this study, the education system from which newly-qualified nurses emerge is highly relevant to the delivery of preceptorship. I would suggest that as long as there remain concerns about newly-qualified nurses’ fitness for practice in the UK (Mallik & Hunt, 2007; Leigh et al., 2005) there is an argument for the continuation of post-registration skills-based training. Interestingly, the Preceptorship Framework (DH, 2010) is silent on the provision of formal teaching, focusing more on learning in the clinical setting. As stated in the literature review chapter, some studies and practice accounts indicate that nurses’ acquisition of skills improved with a preceptorship programme, (Beecroft et al., 2001; Williams et al., 2007; Kingsnorth-Hinrichs, 2009) but I would argue that further research in this area would certainly be worthwhile and even necessary.

5.3 Conclusion

This research study explored newly-qualified nurses’ lived experiences of preceptorship with the aim of uncovering some of the factors that helped or hindered
the transition period. Some clarity has been achieved, with further points also emerging as relevant or as requiring further investigation.

It is clear that seemingly unrealistic expectations of newly-qualified nurses remain an issue in 2012, possibly because the NHS has been seen to be a business-orientated, outcome-focussed organisation, with clinical areas not being resourced to allow new starters to have a reduced workload. It has been argued from the findings of this study and other research that the clinical environment is not a learning environment. Added to this is the concern that not all staff have been found to be approachable to ask questions so there are possible implications for patient safety of which Trusts need to be aware. Relationships have been found to be key in the provision of support for newly-qualified nurses and it is worth noting that those who commence employment in an area where they have not worked as a student may feel particularly vulnerable. The fact that nurses in this study and those in some other studies have not found all their colleagues supportive is an area of concern, which raises the issue that the selection of preceptors could perhaps best be based on their attitude, approachability and willingness to undertake the role.

The importance of the preceptor / preceptee relationship has highlighted for me that some training may be beneficial, notably to ensure that preceptors understand the needs of newly-qualified nurses. This may not need to be lengthy nor too costly financially. However, on-going support for preceptorship is still needed in the clinical areas. One issue that was raised in this study is the provision of PDNs, a role which was seen as being key to the delivery of training and support in the clinical areas. It can be argued that if the substantive staff on any given ward are unable to devote time to teaching and learning, then this role may provide a safety net for both staff and patients. I would suggest that this role is then well-placed to participate in the delivery of preceptorship. The importance of continued post–registration education and training has been highlighted by this study as has the fact that preceptorship programmes can act as a support due to the coming together of nurses with similar concerns and anxieties. Some recommendations for practice are now considered in chapter 6.

Chapter 6: Recommendations, limitations and personal learning
Having looked at the data from my study and relevant literature, I now consider some recommendations for research, for practice and for education - although these are all linked and do overlap - and I then draw some final conclusions. Finally, limitations of the study and my learning from the experience are highlighted.

6.1 Recommendations

6.1.1 Recommendations for research

A number of recommendations for research have come out of my study. Research into the relationship between the teaching content of preceptorship programmes and skills acquisition may be of benefit in highlighting the effectiveness of this particular aspect of such programmes. Preceptees’ views of how the provision of protected study time affects attitudes to learning is worthy of further exploration and is addressed under recommendations for education.

Other issues which would benefit from further investigation are those relating to preceptors. As preceptor preparation is recommended in the Preceptorship Framework (DH, 2010), research into the training of preceptors and any resulting changes would be of interest. The question of what effects might result from the choice of preceptor being made by the newly-qualified nurse versus the manager would also be of interest.

I believe that the function and value of the PDN role requires further investigation. Suggested areas for research are:

- Why is this role often limited to specialist areas?
- What are the benefits of this role and for whom does this person provide teaching and support?

It might be interesting to compare the views of those in management with those in teaching and those in practice. This brings me back to the question of who is responsible for learning in practice and, therefore, who will resource it and this links in with recommendations for practice and education.

6.1.2 Recommendations for practice

There are some actions that I personally need to carry out in my own organisation, though implementation of these recommendations could arguably have benefits beyond my Trust. These actions include highlighting the benefits of the preceptorship programme and seeking support from the Chief Nurse for protected study time for all newly-qualified nurses. This would demonstrate a commitment to their learning by the most senior nurse in the Trust. A Preceptorship policy is in progress which does state these assurances, but I question whether the writing of a policy can guarantee the delivery of its content. Lord Darzi’s (DH, 2008) promise of a three-fold investment in
preceptorship has arguably not yet been realised. I would suggest that we are already witnessing some of the threats to the delivery of preceptorship highlighted by Robinson and Griffiths (2009), notably workloads and staffing shortages. Some recommendations can be implemented by liaising with ward managers, for example to highlight the extra support that may be needed for nurses who have never worked in their area as a student. The importance of supportive relationships can be emphasised, which of course extends beyond preceptorship, but I would suggest that preceptors could best be selected according to their attitude and their willingness to undertake this supportive role. Managers can also be urged to arrange off-duty to enable preceptors and preceptees to work together as much as possible.

The issue of the expectations on newly-qualified nurses has been discussed for some time and needs a resolution, I would argue. Ways to address this in practice have been raised, such as a reduction in the workload of these nurses or perhaps the introduction of more PDNs. However, these solutions require resources so the question remains as to how and whether healthcare organisations will support this. The answer may lie in the provision of evidence as to the consequences of the current system. A study in Taiwan reported that 50% of all medication errors were found to have been made by newly-qualified nurses, but following the introduction of a preceptorship programme this figure was reduced to 0% (Lee et al., 2009). Studies in the United States looking at the cost implications of preceptorship have demonstrated that investment in support and training for newly-qualified nurses can be extremely cost-effective (Bullock et al., 2011; Fox, 2010). I would argue that similar work is needed here in the UK and may help to urge senior managers and budget holders to invest further in learning and education.

6.1.3 Recommendations for education

My role is in education and, as stated above, research is needed into the views of preceptees - and indeed other learners - regarding the impact of protected study time on attitudes to learning. In my organisation I am considering how to investigate the attitudes of those with poor attendance records, which may provide insight into this. It may be difficult to gain engagement from previous non-attendees, but an audit of non attendance on current programmes would be achievable.

Another action that I can take is to link in with tutors at our local university regarding the preceptorship content of the mentorship preparation course. However, education in healthcare cannot be exclusively the remit of Higher Education Institutions; much learning has to take place in practice. In considering recommendations for education, I came to the question, “to whom do I refer here?”
Allan et al. (2008) have raised the question as to who is responsible for learning in practice and concerns over the lack of a learning environment need addressing. Holland and Lauder (2012) state that leadership is needed for the NHS to become a learning organisation, which implies we are not there yet. This is clearly a big issue, but small steps that I can take in my role might include working to improve links between our local university and the Trust, perhaps at a more senior level than currently exists. I can also investigate why there is a limited number of PDNs in the organisation, which represents inconsistency in the educational support provided for different departments.

6.1.4 Conclusions
Recommendations have been made for research, practice and education but it is evident that these are all linked. My personal challenge is to find the best forum to inform the people with the power to make decisions about the realities of the workplace and the existing evidence of the need for supported learning in practice. Further work may be needed to demonstrate the benefits of resourcing learning, for example in employing PDNs, but this will be worthwhile if changes result from it which have a positive impact on the experiences of newly-qualified nurses. Indeed, if newly-qualified nurses are not encouraged to learn in practice then “the nursing profession itself is undermined” (Thomka, 2007:26).

However, I would argue that newly-qualified nurses would not be the only group to benefit if the clinical environment could become a learning environment; the environment affects students, who are there specifically to learn, but also all staff working there. Furthermore, and perhaps most significantly, patient care will benefit from a workforce that is supported to learn (Holland and Lauder, 2012) and we must never lose sight of the fact that it is the patients for whom we ultimately all exist, whether our role be in practice, research or education.

6.2 Limitations
As with any research study, there are limitations and these need to be acknowledged. This study had a small sample size and claims are not made as to the transferability of the results, as they may not necessarily be applicable to other contexts. Nevertheless, this is not the claim of phenomenology; the research represents the world according to these participants and, as such, is valid in itself and adds to the body of knowledge on the subject (Morse, 2006). There will always be other descriptions because it is not possible to limit human experience (Van Manen, 1984). The fact that I was a novice researcher needs to be recognised as a limitation. On reflection, there were times when I could have probed deeper into some issues, which
a more experienced researcher might have done. This could have led to a more in-depth understanding of some issues. The different ways in which I asked some of the questions has also been highlighted and although the impact on the study is difficult to determine, it should be acknowledged. Nevertheless, as seen in table 1 and my general discussion on rigour, I have endeavoured to counter my inexperience with reflexivity and supervision.

6.3 Reflections on the study as a learning experience
The whole process of undertaking a research project had been a positive learning experience for me. I have learned to appreciate the procedures required, which ensure the confidentiality of participants’ stories. In this respect, qualitative data seems infinitely more precious than the numbers dealt with in quantitative studies. Reading Kvale’s (1996) descriptions of the different types of interview one might conduct proved helpful to me prior to beginning my research. I noted that it was possible that some participants would have been part of an action learning set for which I was the facilitator: this would be viewed by Kvale as a therapeutic interview. The research interview is not the same, however, and it was useful for me to reflect on the contrasting purposes of the two types of conversation: my purpose now was to answer my research questions and not to provide support or guidance.

One key area of learning for me arose when listening to the interviews on tape, as I feel that I sometimes lacked curiosity. I wondered why I had not gone on to ask another question in some instances. On reflection, I think that I tend to conclude too quickly that I have understood what is being said and I think that perhaps this is related to preconceptions and previous experience. So I now wonder whether those who argue against bracketing have a valid point: it is perhaps naïve to think that by identifying one’s existing thoughts and knowledge about a phenomenon one can prevent them having any influence. Nevertheless, I feel it was beneficial to carry out this exercise, as it did help me to seek to be open-minded. Clearly, however, I could learn to maintain a more curious frame of mind, which I can apply in many settings such as action learning sessions with newly-qualified nurses.

One regret I have is not spending more time in between the interviews to review and evaluate my interview technique. In particular, two of the interviews took place one immediately after the other, which suited the participants, but did not allow for the process of reflection at all. Furthermore, there was the temptation when listening to the taped interviews to be more interested in the phenomenon being studied than in my technique, good or bad. I perhaps lost focus of my own learning at this point.

That said, there has been much learning from this project, not least from hearing the nurses’ experiences in a one-to-one setting with plenty of time for them to talk and
share. I had expected that I would gain answers to set questions, but I gained more than that. As Van Manen (1984:43) says, “we are now able to grasp the nature and significance of this experience in a hitherto unseen way”. This has, I believe been the result of my study and it does seem fitting as this was certainly the aim; to understand something of these people’s lived experiences that I had not previously known. I now hope to utilise this new knowledge to improve the experiences that future nurses have of preceptorship, which again, was one of the purposes of carrying out this research study.

Reference List


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