An investigation into newly qualified nurses' ability to recontextualise knowledge to allow them to delegate and supervise care (AaRK)

Project Summary Report

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Foreword

The Francis report highlighted the importance of proper support and supervision for health care assistants (HCAs), to ensure they are not just 'left to their own devices', potentially exposing patients to unacceptable risks[1]. The report also indicated a need for more effective delegation by nurses in relation to HCAs. However, despite the increasing relevance of delegation and supervision skills among nurses, these do not form a central component of nurse training or preceptorship programmes. Newly qualified nurses (NQNs) often feel they can be left to 'sink or swim' as they make the transition from student to fully operational qualified nurse. This transitional period is not yet well understood and yet it is a vital stage in the qualified nurse's journey. A central element of it involves being able to delegate and supervise bedside care.

Therefore this research is timely and breaks new ground in several key ways. Firstly, using ethnographic methods, including direct observation, and drawing on a substantial dataset, it tracks the processes involved in NQNs' initial months of transition from student status. Secondly it identifies the pressures and challenges, frustrations and successes, and learning processes which are involved. Finally, it highlights the systemic contexts in which this transition takes place, and which ward and/or organizational cultures are most likely to facilitate this process.

This report focuses in particular on how NQNs develop their delegation and supervision skills, helping to explain the transitional processes and reporting on the piloting of a tool which may support these processes. The pilot study offers rich insights into how NQNs respond to the challenges of delegation and supervision, and which learning styles respond best to use of the tool. The study also highlights the importance of supporting nurses in developing reflective practice skills.

With increasing pressures on NHS resources, there is going to be ever more reliance on streamlining tasks and roles between nurses and healthcare support workers. Maximising clinical microsystem performance via effective working between them, and in particular, appropriate task allocation and completion respectively, will form a crucial component in safe and efficient patient care and outcomes. As such this report is a useful addition to the literature, offering insights into how effective working can be maximised, in order to optimise use of resources as well as minimising potential failures of care and promoting the optimum patient experience.

Professor *Fiona Ross*, August 2014

Director of Research, Leadership Foundation for Higher Education

[1] Francis R (chair) (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.* The Stationery Office.

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Executive Summary

Delegation of care by nurses, patient safety and quality of care are unequivocally linked. Failures in delegation can create fertile ground for errors. Delegation has been proven to be particularly challenging for newly qualified nurses, leading to performance problems associated with time management, inadequate workload distribution, insufficient supervision of delegated tasks, with associated implications for clinical productivity.

This report describes key findings from the Aark project which involved: a) An investigation into newly qualified nurses' (NQNs) ability to recontextualise knowledge to allow them to deliver, organise and supervise care; b) A pilot evaluation of a newly developed delegation tool aimed at supporting newly qualified nurses in the organisation, delegation and supervision of bedside care.

The first phase of the study involved: observations of newly qualified nurses; and semi-structured interviews with NQNs, health care assistants (HCAs) and ward managers, which sought to understand NQNs transition from student to fully operational qualified nurse. From the first phase of our study, we identified that NQNs need support during the transition from student to fully operational qualified nurse in the following areas: developing confidence; understanding role boundaries; accessing knowledge; developing communication skills; setting care priorities; achieving successful care outcomes. This informed the second phase of our study, which involved the piloting of a tool designed to support nurse development in these areas. In the pilot study the nurses who made good use of the tool demonstrated learning by reflection and how that learning process in turn supported recontexualisation of knowledge.

Our research highlighted the significance of the changing roles and worlds of nursing for recontextualisation in the development of skills relating to the prioritisation, delegation and supervision of care by nurses. The nursing curriculum prepares nurses only partially for the many demands of supervision, delegation and accountability in the modern staff nurse role. There is a need for increased focus on learning and support in this important area.

How NQNs delegate to HCAs, and how they learn to supervise HCAs in carrying out those delegated tasks, also tend to be fairly ad hoc and contingent upon ward cultures and staff teams. This suggests the need for more structured educational/training support in development of the necessary skills. This may be in academic, practice or preceptorship contexts and might also involve simulated scenarios.

Our research suggests that NQNs recontextualise theoretical knowledge in the workplace to emerge as competent and safe nurses. We suggest that this process occurs in a liminal space with three phases, pre-liminal (separation), liminal (transition) and post liminal (reincorporation). This liminal space is where recontextualisation takes place. There are support functions within the NHS to both recognise and support this liminal journey, most notably preceptorship courses but also informally in support shown by clinical colleagues towards the NQNs. Both sources of formal and informal support are highly variable across wards and hospitals.

The delegation tool may support this process of recontextualisation. The tool may be optimised by ensuring that there is sufficient organisational space for reflection and that nurses are encouraged to understand the importance of reflective practice for optimum professional performance.

1. Introduction

This summary report presents the background, study design and key findings from the Aark project which aimed to:

a) Investigate newly qualified nurses' ability to recontextualise knowledge to allow them to deliver, organise and supervise care, including consideration as to whether this differs between degree- and diploma-qualified nurses; and

b) Carry out a pilot evaluation of a preceptorship delegation tool developed during this project aimed at supporting newly qualified nurses in the organisation, delegation and supervision of bedside care.

The knowledge from this study will contribute to ensuring the safe and professional delegation and supervision of bedside care, and examine the knowledge that nurses need, in evolving and contemporary academic and healthcare contexts.

2. Background

This section describes the background to the project in terms of:

- Social policy context;
- Research context;
- Theoretical context; and
- Research rationale.

2.1. Social policy context

As a result of the economic downturn and to help meet expected financial targets, NHS trusts require more from their nursing workforce. Nursing is a profession for which demand is predicted to increase due to an ageing population and more people suffering from long-term, manageable conditions (Shin 2006; Worrell 2007).

The UK Government has made it clear that nurses will increasingly take up leadership positions in order to meet these challenges in future healthcare. The Government has tasked the Department of Health (DH) and the nursing and midwifery profession with implementing the nursing leadership agenda through policies such as:

- Modernising Nursing Careers (DH 2006) which aims to develop careers to retain highly skilled nurses in the workforce;
- The Nursing and Midwifery Council's (NMC) review of pre-registration nursing education with the aim to introduce all undergraduate pre-registration programmes by 2011 (NMC 2009);
- The Prime Minister's Commission (DH 2009) which is charged with developing a template and vision for the future of nursing and midwifery.

At the heart of these policy strands (DH 2006; 2009; NMC 2009) is the aspiration for:

- Compassionate, skilled care combined with a sense of service;
- Nurses who respond to patients' stated needs;
- A flexible, competent nursing workforce;
- Nurses who are prepared to lead changes within health services.

2.2. Research context

Nurses are increasingly delegating tasks to unregistered health care staff due to rising healthcare costs, the need to maximise resources, skills-mixes, and the general expansion of health workers' roles (Standing & Anthony 2008; Sikma and Young 2001; Weydt, 2010; Gillen & Graffin, 2010). There is a greater interest in delegation in the United States of America (USA) which may be attributable to a stronger focus on accountability, legal authority and litigation in the USA (Standing and Anthony, 2008, Sikma and Young, 2001).

In the USA, each state has its own legal definition regarding delegation. By contrast,

in the UK there is no legal definition of delegation (Cipriano, 2010). However the United Kingdom's Nursing and Midwifery Council's Code of Conduct (NMC, 2010) states that nurses and midwives must: establish that anyone being delegated to is able to carry out instructions; confirm that outcomes of tasks meet the required standards; and can ensure that delegatees are supervised and supported. The NMC also offers separate guidance which advises nurses and midwives to consider the following in relation to delegation (NMC 2012): the needs of the people in their care; the stability of the people being cared for; the complexity of the delegated task; the expected outcome of the delegated task; the availability of resources to meet those needs; and the judgment of the nurse or midwife.

Delegation is defined as the "transfer of responsibility for the performance of an activity from one individual to another while retaining accountability for the outcome" (ANA, 1997: 4). The term is closely related to other concepts, such as responsibility, accountability and authority (Weydt, 2010). Cipriano (2010) maintains that delegation is an underdeveloped skill among nurses which is difficult to assess as it relies on personality, communication style and mutual respect between the registered nurse and the healthcare assistant.

Munn, Tufanaru, and Aromataris (2013), propose that there is a lack of clarity about the role of healthcare assistants complicates delegation processes. Bradley (2013) in a recent large-scale UK survey, reported that many HCAs feel unsupported in their roles. It has been highlighted that delegation skills are not evaluated in the same way as other clinical skills; this as problematic because of delegation's strong influence on clinical and financial outcomes (Weydt, 2010).

Several authors suggest that nurses urgently need to improve their delegation skills (Curtis & Nicholl, 2004), and that:

> one of the most complex nursing skills is that of delegation ... requir[ing] sophisticated clinical judgement and final accountability for patient care (Weydt, 2010).

Despite this, it has been suggested that "nurse education does not prepare students for the practicalities of this role" (Hasson, McKenna and Keeney 2013: 231). Improvement of delegation may require training and confidence-building at different stages as the newly qualified nurse matures. Multiple, multimodal, teaching strategies may need to be utilised to support this process (Josephsen 2013). The consequence of poor or unsafe delegation is serious as it can lead to poor patient outcomes and concern for patient safety (Francis 2013; Standing and Anthony 2008). According to Anthony and Vidal (2010), delegation, patient safety and quality of care are unequivocally linked and can provide fertile ground for errors. Although delegation was not highlighted in the Mid Staffordshire Report (Francis 2013), clinical leadership was, and delegation is linked inextricably to the flawed leadership which was highlighted by the Inquiry.

Research on delegation has tended to be small scale and focused largely on the attitudes and experiences of the Registered Nurses (RNs). For example, Sikma and Young (2001) explored what it was like to be involved in nurse delegation. The findings demonstrated that RNs enjoyed the freedom of delegating as it allowed them to use professional judgement, develop new models of care, set boundaries and, in essence, define their own practice. However, the authors acknowledged that there were risks, such as the liability for care performed by others and a lack of resources for training and supervision. Standing and Anthony (2008) interviewed

acute care nurses in the USA to examine the nature and significance of delegation. Their findings suggested that many nurses conceptualised delegation as the tasks that go on outside of the ward routine, and a positive working relationship was seen as key to successful delegation. According to Anthony and Vidal (2010), the issue of inadequate delegation in clinical practice is still poorly understood, as are the processes of supervision of HCAs.

Delegation has been proven to be particularly challenging for NQNs (Gillen and Graffin 2010; O'Kane 2012) but is under-addressed in pre- and post-qualifying nurse education (Hasson, McKenna, & Keeney 2013; Whitehead, Owen, et al 2013). This can lead to performance problems associated with time management (Curtis and Nicholl 2004), inadequate workload distribution and insufficient supervision of delegated tasks, with associated implications for clinical productivity, patient safety (Mohr and Batalden 2002) and the patient care experience (Cipriano 2010).

Central to the introduction of all graduate entry to nursing in the UK is the aspiration to educate to graduate level while maintaining care at the heart of nursing. However there can be a belief that being a graduate nurse precludes a caring attitude (Joel 2002). Attitudes to an all-graduate nursing profession vary in England despite its introduction in Wales and Scotland and internationally (Clinton et al 2004; Shin 2006). Additional concerns include:

- The need for the existing nursing workforce to adapt to an all graduate nursing profession and the curriculum changes in the new undergraduate pre-registration programmes;
- The need to ensure the safe and professional delegation and supervision of bedside care to health care assistants (HCAs), when graduate nurses no longer provide as much direct hands-on care.

We do not yet know what effects the move to an all graduate profession in England will make on patient care or what measures we have in place to assess the possible future effects of an all graduate profession.

2.3. Theoretical context: Recontextualisation and liminality

The work of Evans et al. (2010) proposes that knowledge in practice-based disciplines is not merely transferred from theory to practice but recontextualised in different practice settings. This insight is useful for practice disciplines where theoretical knowledge is not always directly transferable to practice (Allan, Smith & O'Driscoll M (2011). In this project we draw upon the concept of liminality. This was originally used to conceptualise life transitions. It has been expanded by Allan et al to understand the Recontextualisation processes involved as NQNs stand at the threshold of their transition from student nurse to registered nurse (Allan et el subm.).

Recontextualisation and liminality are both useful theoretical frameworks to examine nurse learning in practice, as they offer a way of understanding the uncertain, exploratory, changing nature of learning as a newly qualified professional in the world of work/clinical practice. They are also a useful way to encourage a learning organisational approach to professional knowledge-making and practice development.

2.4. Research rationale

Little is known about the experiences of newly qualified nurses and how they learn to delegate and supervise health care assistants' work. Improving nurse delegation and supervision, particularly among newly qualified nurses as they adjust to their new role, will maximise the coordination of bedside care and ensure

safe, effective and efficient patient outcomes (Weydt 2010). Devising a preceptorship toolkit has the potential to support the development of NQNs delegation and supervision skills to improve patient outcomes. It will also provide evidence to support and enhance training (Allan, Smith & Lorentzon 2008), improve the patient experience and contribute towards safer, more cost-effective care (Steven et al 2014). Understanding the effects of academic award on registered nurses' ability to recontextualise knowledge to allow them to deliver, organise and supervise care, will inform the development, delivery and effectiveness of nurse training and practice.

3. Methodology

This section describes the research methodologies used in two aspects of the research project: the study of NQNs' recontextualised knowledge and the piloting of a preceptorship tool.

3.1. NQN's Recontextualised Knowledge

3.1.1. Research aims

The primary research aim was to understand how newly qualified nurses (NQNs) use the knowledge learnt in university to allow them to organise, delegate and supervise care on the wards when working with and supervising healthcare assistants. A secondary research aim was to determine whether there was a difference between degree or diploma qualified nurses in their delegation and supervision of bedside care.

3.1.2. Research objectives

- Observe and describe the organisation, delegation and supervision of nursing care by newly qualified nurses to HCAs;
- Explore how newly qualified nurses recontextualise knowledge to allow them to organise, delegate and supervise nursing care.
- Ascertain whether there are differences between degree and diploma qualified nurses in terms of the way they are able to organise and delegate care

3.1.3. Data collection

Three ethnographic case studies (Burawoy 1994) were undertaken in three hospital sites, using mixed methods including:

1. Participant observations: n=230 hours;
2. Interviews with NQNs: n=28;
3. Interviews with Healthcare Assistants: n=10;
4. Interviews with Ward Managers: n=10.

Observational research is acknowledged to be an effective way of learning about what happens in the clinical workplace (Pope, Van Royen and Baker 2002). See Appendix One for full details of data collection from the three hospital sites, and for profiles of each hospital site.

3.1.4. Data analysis

Data were analysed using thematic analysis aided by the qualitative software NVivo. Summary findings are presented in Section Four.

3.2. Pilot of Preceptorship tool

Drawing on the findings from phase one, an evidence-based preceptorship tool for organizing, delegating and supervising care was developed focusing on the specific areas where NQNs needed support. The tool was designed to be in addition to other learning, teaching and assessment approaches used within the local Hospital NQN preceptorship programme.

The tool (see Appendix Two) comprises six areas for reflexive and supportive conversations relating to organizing, delegating and supervising care of patients:

1. Confidence
2. Role Boundaries
3. Knowledge
4. Communication
5. Care Priorities
6. Care Outcomes

Each area contains trigger questions to direct and support reflective processes and conversations. The tool has been produced in two formats (pocket-sized booklet, A4 sheet) so that the NQN can select the format best suited to that individual and organisational context.

The pilot aims and objectives, as well as evaluation methodology, are described below.

3.2.1. Research aims

The aim of the pilot was to evaluate the usefulness of the tool in supporting NQNs' development of skills in organizing, delegating and supervising HCAs in the provision of bedside care.

3.2.2. Research objectives: Tool development

The research objectives for the development of the tool are as follows:

- Describe the use of the tool by newly qualified nurses;
- Explore how newly qualified nurses use the tool;
- Explore reasons for non-use of the tool;
- Identify ways in which the tool might be refined and/or improved;
- Identify organisational contexts which best promote effective use of the tool.

3.2.3. Intervention procedure

An initial three month pilot (October 2013 to January 2014) of the preceptorship tool was conducted with NQNs recruited from the three hospital sites. Each was provided with an explanation of the tool and its purpose by one of the research team members, and was given the tool in a choice of formats (A4 and/or booklet). It was envisaged that use of the tool would be supported within preceptorship meetings. The aim was that through use of this tool as part of reflective practice, the NQN would find the tool useful in a) developing, organizing, delegating and supervising knowledge and skills that are meaningful based upon their own experiences and b) in recognizing their own strengths and areas for further development. This would in turn expose the NQNs to opportunities to identify strategies for improved performance that would positively impact upon the quality of patient care provision.

After three months NQNs were individually interviewed, using semi-structured interviews, to explore their experiences of using the tool and individual NQN's personal development in organizing, delegating and supervising bedside care.

3.2.4 Data collection

Data were collected via telephone interviews with the NQNs who had been given the pilot tool. Out of the original participants, thirteen were interviewed. Reasons for non-interview of the remaining included: left the hospital Trust; on long-term sick leave; on maternity leave; unavailable; withdrew from study (one individual).

3.2.5. Data analysis

Data were analysed using qualitative methodology and simple quantitative (statistical) analysis. The findings are described in Section Four.

4. Findings

This section summarises the findings from the respective data sets and analyses as outlined in Section Three.

4.1. NQNs' Recontextualised Knowledge

The findings are presented according to the project conceptual framework for NQNs' knowledge recontexualisation (see Appendix Three). This framework involves three inter-related areas of development:

1. Organisational learning contexts: the context within which NQNs develop, recontextualise and use their knowledge.
2. Delegation in context: how the NQNs supervise and delegate care to HCAs and how the role boundaries are negotiated between NQNs and HCAs.
3. Learning processes: NQN knowledge development 'in action' and factors that support/hinder learning.

4.1.1. Organisational learning contexts

Each ward and each hospital organisation has its own unique set-up and culture and this was found to have a strong influence on how the NQNs were able to recontextualise their knowledge.

The *care contexts* within which nurses work every day were found to have a strong influence on how the NQNs learn. In particular, NQNs spent considerable time:

- Documenting care and assuring accountability;
- Reassuring relatives;
- Being repeatedly interrupted and facing competing priorities;
- Completing discharges;
- Being 'held up' due to having to wait for medication from pharmacy, late test results or trying to get hold of other organisations, such as social services, the police or care homes.

Ward managers commented on *the constantly changing nursing environment*, and the pressures on both themselves and on NQNs in this context. Healthcare assistants and NQNs observed how much time NQNs were required to spend on the computer, and how this in turn left much of the direct patient contact with the HCAs. In this way, NQNs were very reliant on HCAs to keep them informed about patients, and in particular about any changes in a patient's condition.

The *pace of nursing*, particularly on certain wards, added to the pressures as NQNs sought to adjust and become competent in their new role. The transition process for the NQN was often contingent upon *ward culture and skill mix.* Some wards had higher staffing levels, and a greater number of qualified nurses, which involved greater sub-division of tasks and sharing of responsibilities. At the same time wards with higher staffing levels were often also very fast paced. Availability and support for continuing professional development for the NQNs, and the HCAs was found to be critical.

Clarification of role boundaries and communication about tasks and patient issues was essential for effective NQN-HCA team working.

4.1.2. Delegation in context

In this section, we explore how the NQNs supervised and delegated care to HCAs. In summary, this section sets the scene for how knowledge was recontextualised and explores key findings in relation to:

- Delegation contingencies;
- Care priorities and care outcomes;
- Ensuring safe and good quality care;
- Manifested delegation styles.

Delegation of tasks between NQNs and HCAs was found to be *contingent* on several factors including ward culture and the skill level of HCAs. On wards with well-established routines and experienced HCAs, there was a sense of a minimal need/opportunity for delegation.

One of the most important aspects of NQNs being able to delegate care *was the ability to prioritise tasks*. This prioritisation often involved a steep learning curve for NQNs. NQNs in the study had adopted a range of different strategies to help them to prioritise care, such as:

- Prioritising according to early warning scores;
- Determining which patient(s) were in most pain;
- Relying upon the structure of the medication round;
- Making lists.

Another important aspect of delegation relates to how the NQNs were able to *ensure that the care which HCAs provided was of good quality and safe*.

As we observed and interviewed the NQNs delegating and organising care on the wards a number of *different approaches* to how nurses' practiced delegation emerged. The most common type was the *'Do-It-All nurse.'* The findings suggested that many of the NQNs did not have the skill or confidence to delegate care and so tried to complete all the tasks on their own. In effect, nurses and HCAs worked largely in parallel.

As a consequence these nurses often struggled to finish their shifts on time and frequently felt overwhelmed, stressed, tired and even on occasions forgot some important work. In addition, the HCAs often felt undermined and mistrusted to do their jobs and felt that they had to prove their competence to each new NQN.

The second approach to delegation which emerged was nurses who felt it necessary to justify every single decision and explain to the HCA why they needed their help. We have called this nurse the *'Justifier.'* This delegation approach seemed to be linked to a degree of defensive practice, where NQNs felt the need to defend their authority and newly acquired senior position. The NQN's felt uncomfortable doing this and often linked needing to justify delegation with a lack of confidence, or a worry that they might be perceived as not working hard enough and/or being lazy. For nurses who over-justified, one of the consequences was an undermining of their personal authority, and HCAs also feeling undermined by being given information they already know or understood.

Another strong emergent finding suggested that many NQNs were worried about being 'bossy' and preferred to try to be everybody's friend. This suggested a third, *'Buddy,'* approach. The consequence of this approach was that often HCAs did not respect the NQNs who took this approach as somebody senior to them. The NQNs frequently realised this through learning by 'trial and error' and tried to change their approach. There was also evidence that NQNs not wanting to be bossy was reflected in the views among HCAs experiences of concerns with nurses who 'bossed them around', so it is possible that NQNs views also stemmed, at least in part, from attitudes and prevailing cultures.

The fourth approach to delegation among NQNs involved the *'Role-Model'* nurse. These nurses tried to act as good role-models in front of HCAs in order to show them how to deliver good care. This might have seemed a productive approach but it frequently stemmed from NQNs not being able to verbalise their plans or desired standards of care. Instead, they hoped that HCA's would 'pick up' on good models of care, but they often did not know if any learning had actually occurred. The obvious consequence of this type of approach is

that 'hoping' HCAs will pick-up certain skills are a somewhat haphazard way of working. It also does not give the HCAs themselves clarity about what is required of them by the NQN.

The fifth approach to delegation involved nurses who repeatedly wanted to check on the work of the HCAs. These nurses were very aware of their accountability for care and were worried that mistakes could be made. Their method of delegation was acting as a '*Reviewer'* or an *'Inspector.'*

The consequences of this approach was that it both negated the time saving advantages of delegation, if delegated tasks have to be checked all the time, and also left the HCA feeling not trusted by the NQN. This is not to say there should not be monitoring of delegated tasks at all, but rather this should be done in a balanced way.

There has to be, then, a balancing of approaches in supervising delegated tasks.

4.1.3. Learning processes

We identified the following significant factors in learning processes:

- Three 'liminal' learning phases;
- Developing confidence;
- Learning from negative experiences and mistakes;
- Gaining knowledge and support from mentors and ward leadership.

We identified *three 'liminal' learning phases* as NQNs' struggled for mastery over their transition to competence as NQNs: the separation or preliminal state; the liminal or transition state; and the reincorporation or postliminal state. The separation or preliminal phase started at the point of registration on qualifying; this is when the NQNs were no longer students and had received their personal identification number (PIN) yet they were not working as fully competent registered nurses. The liminal or transition phase covered the period when the NQN was working at the same time as being allocated a preceptor. This state was a period of struggle as the NQNs tried to gain mastery over what was a stressful experience. The reincorporation or post liminal state was encompassed when the NQN finished the preceptor course, and felt themselves to be, and were perceived by others as, competent nurses.

The empirical findings support a strong relationship between the NQNs' ability to apply previous knowledge in new practice contexts with *levels of confidence*. This was found to always be in relation to a specific skill or area of practice. For example, NQNs described confidence in their ability, knowledge and skills. But their levels of confidence were also dependent upon what shifts they were working, on what type of ward, and with which patients and colleagues.

The data suggest that often the NQN's had to *learn from negative experiences*, trial and error, and using untested strategies. Our evidence found that the NQN's were making mistakes ranging from minor to at times more severe (leading to serious untoward incident reports having to be completed). The risk of making mistakes was frequently on the NQNs' minds as they were charged with taking on increasing responsibility. This created an emotional burden so great for some NQNs that it blocked their learning.

How the NQNs were able to re-use their knowledge was found to be strongly linked to the *quality of support, mentors or preceptors and leadership,* primarily at ward level. Paradoxically though, the observations of NQNs in practice provided very few opportunities to see how this support and leadership was enacted. During this study we carried out sixty-six observation and we only observed a handful of occasions when the NQNs were

effectively supported (structured or unstructured) in their learning and development of knowledge and confidence.

4.2. Degree vs diploma pathways

We found that there were no observable and/or reported differences between how degree and diploma qualified nurses delegated and supervised care.

We analysed observations and interviews, in relation to whether recontextualisation differed between diploma and degree qualified. We concluded that there were *no observable and/or reported differences* between nurses who qualified via the different routes.

4.3. Preceptorship tool

In this section we summarise the findings from the pilot evaluation of the preceptorship tool. Experiences and feedback from those nurses who used the tool, and from those nurses who were not able to use the tool, are described. Non-use of the tool was often located in the context of such systemic factors as heavy workloads, insufficient time on the ward, and a perceived lack of a supportive infrastructure at ward and/or hospital level.

We concluded that those NQNs who are more orientated towards reflective practice, and who are in working environments which support reflective practice, may benefit from using the tool, particularly in the early months of transition from student to qualified nurse.

Participants who had used the tool and found it helpful reflected that it had been of particular use during the early period of their transition from student to qualified nurse, especially in relation to delegation. Those participants who had been unable to make use of the tool attributed this to heavy workloads, insufficient time on the ward, and a lack of a supportive infrastructure at ward and/or hospital level. A significant number of nurses described their non-use of the tool within the context of a preceptorship programme which they did not experience as meeting their needs.

Different nurses had different attitudes to reflective practice and this will also have impacted their use of the tool. Several nurses were moving wards, planning on leaving the trust and/or knew of friends who had given up nursing. Their observations offered insights into how inadequate preceptorship and support may contribute to loss of NQNs either from specific wards/hospitals or from the nursing profession as a whole.

Conclusion and Recommendations

Our research has highlighted the significance of the changing roles and worlds of nursing for recontextualisation in general and, more specifically, the development of skills relating to the prioritisation, delegation and supervision of care by nurses. Increasing emphasis on documentation, mostly on computers, is in particular a time consuming priority for qualified nurses in a highly accountable culture, and many nurses feel this takes them away from bedside care of patients. This in turn means that they increasingly turn to HCAs for more of the frontline care of patients, which in turn calls upon them to deploy effective prioritisation, delegation and supervision skills. The nursing curriculum prepares nurses only partially for the many demands of supervision, delegation and accountability in the modern staff nurse role. There is a need for increased focus on learning in these important areas.

Recommendation One:

Nurse academics and practice educators should consider how to update nursing curricula to include both theoretical and practical opportunities for nurses to learn how to effectively delegate and supervise care.

The teaching of how to prioritise care would appear to be learnt in a fairly ad hoc way, according to our study. This raises questions about how the prioritisation of care should be taught, what essential skills and strategies should be included in that teaching, and whether it might be taught more formal, in student nurse training, Preceptorship programmes, or both. If it should be included, the next question is, how, and whether the use of simulated scenarios might be useful in this process. Similarly how NQNs delegate to HCAs, and how they learn to supervise HCAs in carrying out delegated tasks, would also appear to be fairly ad hoc and contingent upon ward cultures and staff teams. This again would imply the need for more formal educational/training support in the development of the necessary skills. Again, this might be in the academic and practice contexts, or both, and could also involve simulated scenarios.

Recommendation Two:

Newly qualified nurses need structured support in learning how to prioritise care in different context, and how to navigate different ward cultures and policy contexts.

Our research would suggest that being able to exercise and/or develop personal authority is fundamental to NQNs becoming competent nurses, both in their own eyes, and in the eyes of others. Being able to be assertive, both in giving instructions, offering constructive challenging to colleagues, and being able to say no in the face of competing time pressures and demands is essential to that authority. Again, some of this assertiveness is contingent upon an individual nurse's personality style, and some nurses may find it easier than others to be assertive. But assertiveness can also be taught, and given its central significance to nurse competence, the teaching of assertiveness skills, and provision of safe spaces within which to practice them, would enhance nurse development in this area.

Recommendation Three:

Newly qualified nurses will benefit from continuous assertiveness training both during pre-registration education and continuing professional development. This should include development of communication skills, self- and emotional-awareness.

From a theoretical perspective, the reality shock for NQNs has been described before (Kramer 1974) and previous theories given for the phases of adjustment or indeed non-adjustment to the responsibilities of newly registered nursing roles. However our findings suggest that a more nuanced explanation of these transitional stages is possible and necessary, one which illuminates the learning points for NQNs. We suggest that recontextualisation and liminal spaces are useful concepts to understand the process leading up to adjustment, i.e. emergence into a post liminal phase. Our research suggests that NQNs recontextualise theoretical knowledge in the workplace to emerge as competent and safe nurses. We have suggested that this process occurs in a liminal space with three phases, pre-liminal (separation), liminal (transition) and post liminal (reincorporation). These different types of liminal spaces are where recontextualisation takes place. There are support functions within the NHS to both recognise and support this liminal journey, most notably the preceptorship course, but also informally in support shown by clinical colleagues towards NQNs. However this support can be variable according to context.

Phases of liminality are characterised by uncertainty and anxiety as NQNs assume authority while not yet feeling recognised by themselves of others as fully competent. The ways in which these liminal spaces are used by NQNs to learn to manage their authority suggest that this is where professional identity is played out safely (Allan 2007; Bruce et al. 2013). Knowledge acquired during this transitional period particularly involves the prioritisation, delegation and supervision of care. The ability to exercise these skills mark a NQNs emergence as a competent nurse, both to colleagues, patients and, perhaps most importantly, to themselves.

The idea of learning spaces as transformative is perhaps an obvious one but we stress that it is important to recognise this in an increasingly busy NHS in which opportunities for learning are squeezed, but which are inherently important for good patient care (Francis 2013). We have suggested that the preceptorship course for NQNs is one such protected space in which recontextualisation of knowledge occurs for the most part productively. NQNs emerge from this period of liminality and learning as competent nurses, confident in their ability to manage the staff with whom they work. However less formal social learning also plays an important part in NQNs transitions to competency and this informal social learning is less well reflected in the literature.

Recommendation Four:

Healthcare organisations need to recognise the transition of NQNs towards developing confidence, competence and a professional identity and provide them with safe learning spaces.

Our work not only raises further questions about the nature of learning in the NHS but also about the nature of recontextualisation and liminality. These include: why certain learners seem better able to negotiate the liminal space and others to find difficulty in doing so; how far these differences are internal to the learner, inherent to the learning relationships in practice or shaped by the context of learning in a rapidly changing and busier NHS context.

From the first phase of our study, we have identified that newly qualified nurses need support during the transition from student to fully operational qualified nurse in the following areas: developing confidence; understanding role boundaries; accessing knowledge; developing communication skills; setting care priorities; achieving successful care outcomes. This informed

the second phase of our study, which involved the piloting of a tool designed to guide, assist and support nurse development in these areas.

In the pilot study the nurses who made good use of the tool demonstrated learning by reflection and how that learning process in turn informed recontexualisation of knowledge. Organisational barriers to successfully using the tool included a lack of reflective space and/or time at work. Personal barriers to successfully using the tool might be a reluctance to deploy reflective practices, which in turn might be a defence against dealing with difficult emotions.

Use of the tool, then, might be optimised, both by ensuring that there is sufficient organisational space for reflection and that nurses are encouraged to understand the importance of reflective practise and be supported in developing the necessary skills and processes within, and for, themselves. It is important that this reflection is followed by deliberation and action, which supports safe and effective clinical judgement.

Recommendation Five:

Learning how to supervise and delegate care seem particularly suitable for reflective learning. Hence, organisations should consider providing structured opportunities for reflection. This may take the form of peer, group or individual reflection.

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Appendix One: Data Collection

Data collection method	Site A	Site B	Site C	Total
Observation of nurses (twice/nurse)	17 nurses 34 obs.	6 nurses 12 obs.	10 nurses 20 obs.	33 nurses 66 obs. (approximately 230 hours)
Nurse Interviews	16	4	8	28
HCA Interviews	6	2	2	10
Ward Manager / Matron Interviews	5	3	4	12
TOTAL (Interviews and Observations)	61	21	34	116

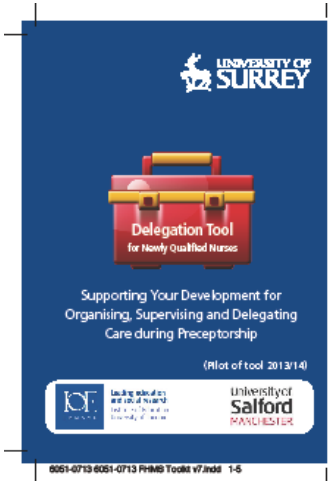
Table 1. Summary of data collected (November 2011 to May 2012)

Appendix One: Data Collection contd.,

	Site A	Site B	Site C
Ward specialities where participants worked	• EAU • Elderly • Medicine • Trauma • HDU • Surgical • Adult • General • EAU	• Medical • ADU • Surgical • Adult • General	• Surgical • Respiratory • Medicine • Gastro • Adult • General
Approximate number of beds	700	700	450
Preceptorship programme	Yes	Yes	Yes

Table 2 Overview of the three hospital sites which participated in the study

Appendix Two: Preceptorship Tool



Using this tool, please schedule a 20-30 minute reflective conversation with your preceptor or somebody responsible for your development. This should take place during the first 2 weeks of preceptorship, then again during your second month, and again at 3 months. The tool should be used in conjunction with other components of your preceptorship programme.

Following the 3 month trial you are encouraged to continue to use this tool with on-going supportive discussions at 6 months and at the end of preceptorship.

CONFIDENCE

Discuss a situation where you **lacked confidence** in your knowledge to organise and supervise care given by other in the team such as healthcare assistants.

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

ROLE BOUNDARIES

Discuss a situation where you **checked your understanding** of the roles and responsibilities of members in your team (e.g. your own, healthcare assistants and student nurses).

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

ROLE BOUNDARIES

Discuss a situation where you **set expectations** in relation to different roles and responsibilities in the team at the start of a shift.

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

23/08/2013 15:05

DELE

This pocket-sized evidence-based tool has been designed to support reflective conversations with your preceptor regarding 6 areas of organising, delegating and supervising care as a newly qualified nurse.

According to The NMC Code (2008) you should be able to delegate effectively. Delegation can include any member of the team; such as Health Care Assistants, RNs and student nurses.

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KNOWLEDGE

Using an example from your experience, discuss how you have learned about delegation, including how the expectations from The NMC Code (2008), **matched with the reality you experienced**.

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

COMMUNICATION

Discuss a situation where communication with another member of the care team such as a healthcare assistant **created a challenge** for you in subsequent delegation activity.

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

CARE PRIORITIES

Using an example from your experience, discuss how you **identified and communicated priorities** of care to the team you work with.

What went well?

What was most troubling?

What have you done or what have you seen others do that you can learn from?

CARE OUTCOMES

Using an example from your experience, discuss how you ensured that what you delegated to a healthcare assistant or student nurse was **delivered to your expectations.**

What went well?

What was most troubling?

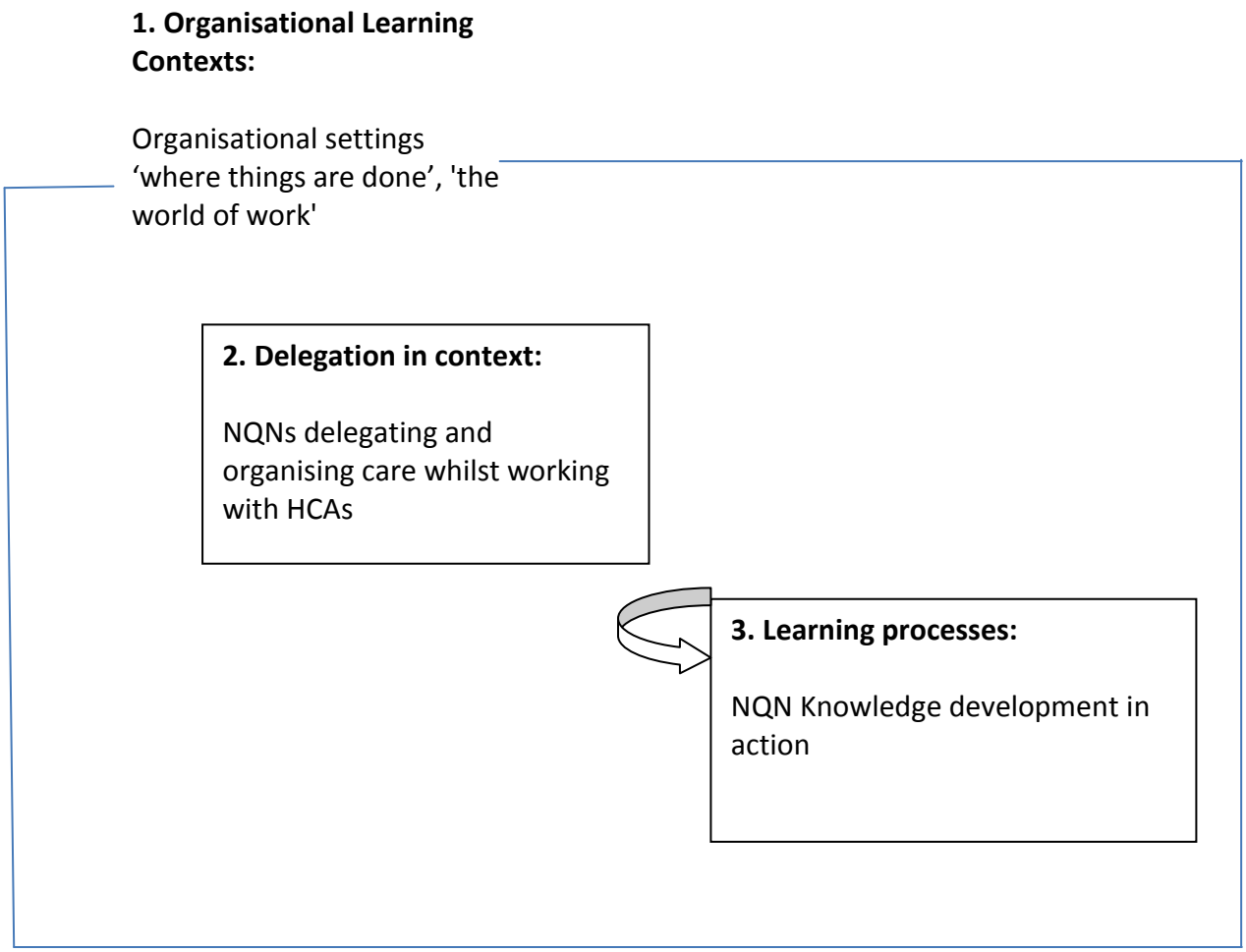
What have you done or what have you seen others do that you can learn from?

23/08/2013 15:05

GATE

Appendix Three: Outline of project conceptual framework

The conceptualisation of the delegation and organisation of care to HCAs by NQNs is outlined below. Note that the NQNs' individual progression between these knowledge domains is seldom linear, but depends on personal, organisational and contextual factors.



Model 1. Outline of project conceptual framework

Appendix Four: Outputs and dissemination

Publications

The project team has so far (August 2014) submitted the following papers to peer-reviewed journals:

Allan, H. et al (submitted a). 'Newly Qualified Nurses and the Delegation of Care: A literature study of current policy and practice.' Journal Nursing Studies

Allan, H. et al (submitted b). 'People, liminal spaces and experience: understanding recontextualisation for newly qualified nurses' Nursing Inquiry

Johnson, M. et al (accepted for publication) '"Doing the writing"' and working in parallel: issues with learning delegation and supervision in the emerging role of the newly qualified nurse.' Nurse Education Today

Conferences

The project team has so far (August 2014) presented findings at the following conferences:

FHMS Festival of Research, July 2012, University of Surrey

Helen Allan, Carin Magnusson, Khim Horton

'The AaRK project*:* Academic Award and Recontextualising/Re-using Knowledge'

RCN Research Conference, Belfast, March 2013

Carin Magnusson, Helen Allan, Elaine Ball, Karen Evans, Martin Johnson & Khim Horton:

Symposium: **'**Organisation and delegation of care: competencies for safe performance.'

Researching Work and Learning: The visible and invisible in work and learning', University of Stirling, June 2013

Carin Magnusson, Helen Allan, Elaine Ball, Karen Evans, Martin Johnson & Khim Horton:

'Work based learning for newly qualified nurses in the UK: Visible and invisible.'

NET Conference, Cambridge, September 2013

Carin Magnusson, Helen Allan, Elaine Ball, Karen Evans, Martin Johnson, Khim Horton (core paper).

'"Doing my writing": What is the modern role of the newly qualified nurse?'

BSA Sociology Medical Group Annual Conference, September 2013

Carin Magnusson, Helen Allan, Elaine Ball, Karen Evans, Martin Johnson, Khim Horton:

'Messy learning or incompetence? The experiences of newly qualified nurses.'

University of York Practice Learning Conference. 2013.

Helen Allan:

'The Challenges of practice learning in the light of Francis.'

European Academy of Nursing Sciences. Rennes, France, 2014

Helen Allan:

'Developing an intervention tool for clinical learning: Evaluating a reflective tool for newly qualified nurses.'

RCN conference, UK 2014

Helen Allan, Elaine Ball, Cathy Curtis, Karen Evans, Martin Johnson, Khim Horton, Carin Magnusson:

'Delegation as a Newly Qualified Nurse: Early findings from an intervention study'