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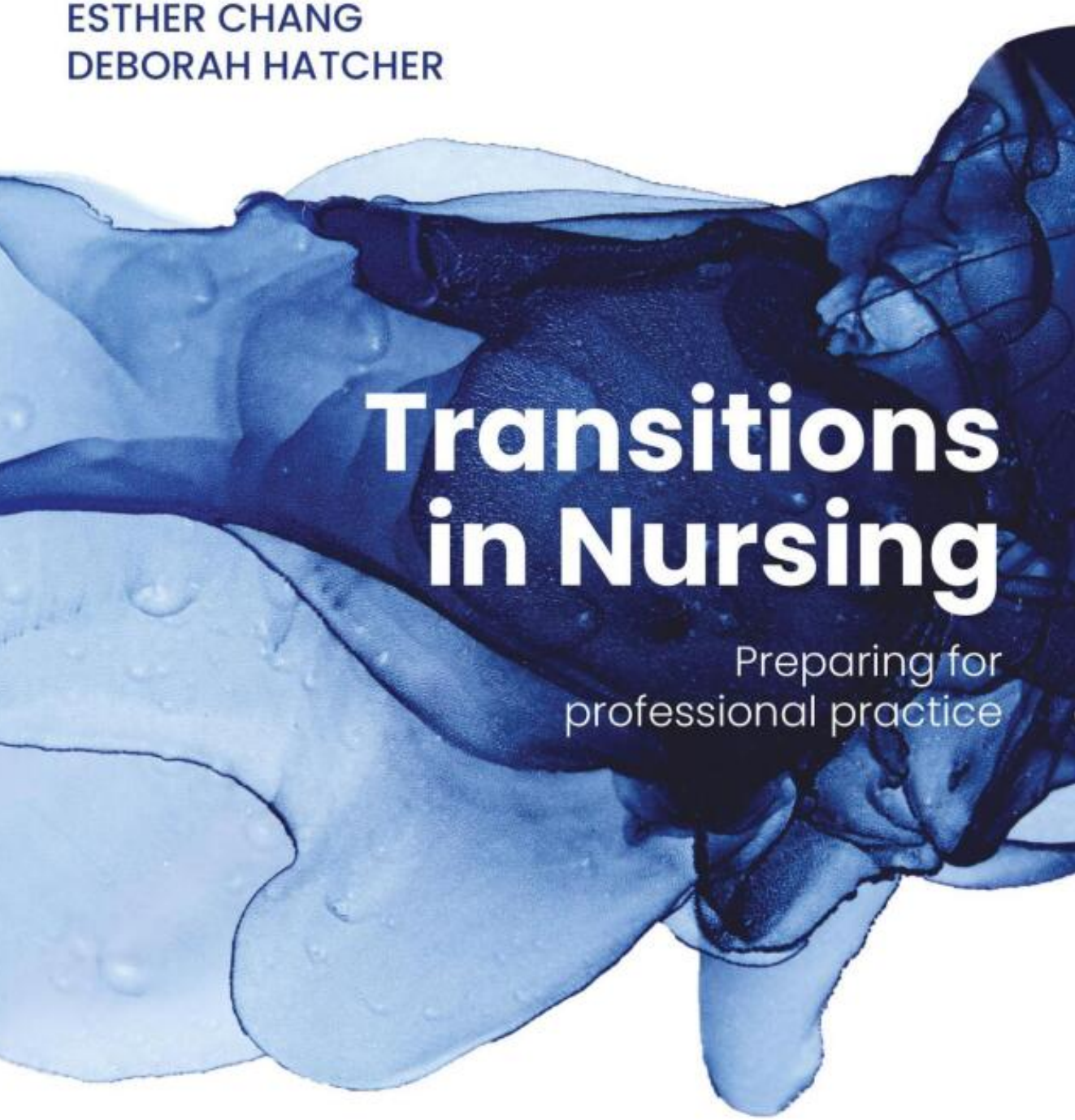

Transitions in Nursing

Preparing for professional practice

SIXTH EDITION

ELSEVIER

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PREFACE

Welcome to the sixth edition of *Transitions in Nursing: preparing for professional practice*. This book has been developed to assist preregistration students, new registered nurses and other professionals interested in issues and challenges associated with the transition from higher education to practice in various health environments. For most new graduates, this rite of passage is associated with a degree of stress, strain and culture shock. These are issues that have existed in nursing for decades. The literature continues to show that this transition is a multidimensional and complex process. Intensive socialisation brings to the surface many challenges and opportunities for new registered nurses as they assimilate into their professional work roles. Research through the years has shed much light on the issues associated with transition, including strategies that can be useful in negotiating the process.

The book provides comprehensive information on the key issues associated with transition. You will find viewpoints that are challenging and sometimes disconcerting, but at the same time motivating and thought-provoking. The sixth edition is divided into three sections. Section 1 examines issues relating to the transition from student to graduate nurse. Section 2 looks at skills for dealing with the world of work. Section 3 discusses the organisational environments that we work in. This edition also includes new contributors and two new and important chapters: chapters 13 and 18. Chapter 13 examines infection prevention and control in the healthcare setting. It helps you to understand your nursing and public health role in the prevention and control of infectious disease, especially in the climate of the COVID-19 pandemic. It also encourages the importance of patient participation and empowerment in infectious disease prevention and control. Chapter 18 discusses the challenge of bullying in nursing. It describes the features and different categories of bullying. It further explores the consequences of bullying on the nurse, bystanders, the organisation and patient care, as well as strategies that can be employed following an incident.

Transitions in Nursing: preparing for professional practice shows you how to be a successful graduate and at the same time how to care for yourself. The exercises and learning activities that appear throughout the book offer you a range of helpful suggestions for understanding the nursing context, managing stress and caring for yourself. In addition, each chapter includes recommended reading, case studies and reflective questions for further exploration. In this new edition, most of the chapters have new and/or updated case studies, and additional case studies and media can be accessed on Evolve.

importantly, it is a resource that every student, practising nurse, educator and administrator can use to understand the issues that transition raises for new registered nurses. By reading the book, reflecting on the issues and proposing possible answers, you should be able to gain a comprehensive view of the issues, challenges and opportunities that lie ahead of you. The journey during this period can be rewarding, with implications for a long-term and hopefully enjoyable career for you, particularly when educators, administrators and clinicians collaboratively anticipate and manage the socialisation process.

We extend our most sincere appreciation to all the contributors to the book for their shared interest in and concern for the issues and challenges of transitioning from student to registered nurse. **This book would not be possible without them.** They have stood by us (Professor Daly and Professor Chang) for more than 20 years. We would especially like to thank and acknowledge Emeritus Professor John Daly for his substantial contribution to previous editions of the book. We would like to express our gratitude to the late Emeritus Professor Judith Lumby for her commitment to this book through the years. Our thanks also go to Natalie Hunt, Kritika Kaushik and the rest of the team at Elsevier for their encouragement and support, as well as to Carol Natsis for her careful editing of the text of this edition. Elsevier Australia joins us in thanking the reviewers for their feedback on the manuscript. This book is dedicated to all our amazing students through the years.

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SECTION 1

FROM STUDENT TO GRADUATE

CHAPTER 1

Managing the transition from student to graduate nurse

Esther Chang

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- describe the process of transition from student to graduate nurse
- appreciate a range of factors and issues that influence the transition from student to graduate nurse
- consider strategies to ease the tension associated with adjustment to the realities of nursing practice for new registered nurses
- recognise the importance of a positive, proactive approach to managing transition on an individual level
- identify and access resources which have been shown to facilitate adjustment to nursing practice for new registered nurses.

KEYWORDS: transition, role stress, strategies, students, new graduate nurse

INTRODUCTION

Nursing attracts people from many walks of life, motivated largely by a concern and a desire to understand and help people who are confronted by a range of actual or potential health problems and challenges. Many of these experiences cause major disruption in people's lives – for example, illness, suffering, loss, grief and trauma. According to Englert,[1] 'such experiences are both the privilege and burden of nurses and of others who share the drama, the humor, and the tragedy of other people's lives' (p 1). Englert, a leader in the administration of nursing services, encouraged members of the nursing profession to 'reflect for a moment … to recall some of those high and low points of the beginning years as a registered nurse' (p 1). She went on:

> *that they will be found wanting when the crisis occurs, a certain awkwardness in accepting advice, however kindly given, and an admiration for those whom they see as epitomising the best of nursing.* (p 1)[1]

At the time of writing this chapter, the COVID-19 pandemic continues. Many of those in Australia's healthcare workforce are on the front line and continue to be impacted in many ways.[2] COVID-19 requires graduates to be ready to participate in the workforce and assist in the increased demands on healthcare delivery.[3]

The nursing profession in Australia and elsewhere continues to be concerned with the process of transition for graduates of undergraduate nursing courses upon their entry into the world of clinical practice.[2–7] This concern exists for several reasons: (1) it has remained an issue of concern in nurse education in Australia because of ongoing changes in the clinical practice environment; (2) research data continue to show that this period of transition can be stressful; [4] (3) professional, service and economic issues can impact recruitment and retention; and (4) there are related questions about adequate preparation of new graduate nurses.

One continuing key issue here is the relevance and quality of clinical education in undergraduate courses. Indeed, in recent times, access to an adequate number of quality clinical placements has become a serious challenge to educators in nursing, medicine and allied health. This has fostered several innovations, including the development of effective simulation-based nursing education for clinical simulation teaching and learning environments.[8] The impact of such innovations on the clinical competence of graduates in the health professions will require ongoing research and evaluation.

These challenges are international, particularly in developed countries that are struggling with health sector reforms, cost containment challenges, the growing burden of chronic disease, ageing populations and human resources for health issues. It is imperative to develop transformative healthcare changes for which nurses can play an important role in contributing, driving and taking a lead. In the United States, a provocative and scholarly report for the Carnegie Foundation for the Advancement of Teaching and several research studies have called for a reinvention of preregistration nursing education.[9–11] The author's argument is based on several factors, one dimension being the relevance of current models of undergraduate nursing education in the present-day context of health system re-engineering. In 2010 the Council of Australian Governments established Health Workforce Australia (HWA), which had a role to play in creating solutions to clinical education challenges.[12] However, the Australian Federal Government closed HWA in 2014 and transferred its role and functions to the Commonwealth Department of Health. Undoubtedly, challenges will persist with supply of and access to quality clinical placements across health professional education, including undergraduate nursing.

In addition, recruitment and retention of new graduates are issues from time to time, both nationally and internationally. Demand for, and supply of, registered nurses is cyclical, and occasionally healthcare systems are confronted by a shortage of nurses. Such shortages can reach crisis proportions, a global challenge and phenomenon that is occasionally seen because of an ageing nursing workforce and the undersupply of graduates.[13] HWA predictions pointed to a likely workforce shortage of 109,225 registered nurses by 2025 as a result of demographic changes in

Other reasons for this concern with the experience of transition include changing attitudes in society towards nursing as a career, a decline in the number of people choosing to enter undergraduate nursing courses and the need to create sustainable nursing. It also appears that healthcare system reform has created an environment that has a negative impact on the quality of work life for nurses and other health professionals and on the quality of patient care.

There is a large amount of literature on the process of transition from senior student to graduate nurse. It is clear from this literature that transition is multifaceted and complex, and that problems often described and discussed in relation to the process are not new[7,11,16] and continue to evolve.[4] In Australia, nursing education has undergone rapid transformation since the late 1980s. The system of basic nurse education (BNE) is now university-based, with three-year degree programs leading to eligibility to register as a nurse. In addition, the national healthcare system has undergone radical change in the last two decades. Much of this system change has been driven by the shift to an economic model for designing and managing health services. This has led to changes in the nursing practice environment that have implications for new graduates entering employment.

Preregistration nursing courses today need to prepare graduates for a work environment that has undergone enormous change in the last two decades. The practice environment is constantly changing, as has been seen with the COVID-19 pandemic, and this has implications for the type of knowledge and skills that new graduates will require.[3] University schools of nursing are constantly challenged to ensure their courses are designed to give graduates the best possible preparation for entry to nursing practice as new registered nurses, and to optimise their ability to move through the transition process confidently and successfully. Experience has shown that this is best done in cooperation with nursing service leaders and providers. Preparation of new graduates in nursing is best viewed as a shared responsibility between the university and nursing service sectors;[11,17] universities should act as facilitators of learning in collaboration with healthcare service partners.[18]

University schools of nursing aim to prepare flexible, critical thinkers for the practice of professional nursing. They emphasise individual client- or person-centred holistic care and lifelong learning as key values. All preregistration nursing courses are required to provide a clinical education component to ensure that course graduates meet the clinical competency expectations of beginning registered nurses. However, in many surveys, new graduates report that the clinical practice and clinical education components of their undergraduate course were too short and that the course was too theoretical.[16] Other research work has found that, on entry to the workforce, graduates perceive that employers do not understand what they know and can do.[19]

Nursing service providers often report that new graduates 'are inadequately prepared for clinical practice in that they are deficient in certain skills' (p 17).[17] This reflects a clear mismatch in expectations of new graduate nurses between the education and service sectors. Preregistration nursing courses do not aim to produce expert practitioners on graduation. Research has demonstrated that development of clinical expertise requires some years of constant immersion in clinical experience following entry to nursing practice as a registered nurse.[20] It would be ideal if newly registered nurses could meet all expectations required by the healthcare settings immediately following entry to the workforce. Experience has shown that few individuals are able

It is important that new graduates are patiently provided with support, tolerance and encouragement as they learn to assimilate the values, beliefs and practices acquired in their undergraduate education with the practice values and beliefs that are dominant in the clinical working environment. It is no surprise that, in this context, the transition process presents many challenges and potential rewards for the new graduate in nursing. The first 3–6 months as a new registered nurse have been identified as potentially the most challenging and stressful period in their professional adjustment.[11,21,22] This period is 'crucial in determining new graduates' commitment to nursing as well as their acquisition of technical, clinical and patient management skills' (p 20).[17] Perhaps the keys to successful negotiation of this phase are anticipation and psychological preparation. This requires you to be adequately informed of what is known about the process and what you can do to ease your transition into practice as a new registered nurse. In addition, nurses in service need to realise the increasing importance of learning as a lifelong process in healthcare.[23]

A survey of the table of contents of this book will show that component chapters are concerned with preparation for entry into the nursing workforce and the development of a successful, sustainable and rewarding career in nursing. Chapter topics can be classified according to several themes: managing self in clinical practice; caring for self; understanding the forces that shape the practice environment and infection; learning to manage different approaches to nursing care delivery; collaborating and working with colleagues and patients/clients; and professional development strategies.

TRANSITION: A PROCESS

The transition from student to graduate nurse is characterised by a period of intense socialisation into the culture of the clinical work world. Socialisation, in this context, may be defined as 'a complex process directed at the acquisition of appropriate attitudes, cognition, values, motivations, skills, knowledge, and social patterns necessary to cope with physical, cultural and social environment' (p 30).[24] Corwin[25] believes there is a 'turning point' between graduating from a nursing school and induction into employment for students. This turning point in a career produces role conflict between professional (idealised) role conceptions and bureaucratic (actualised) role conceptions in the working environment. Consequently, a sense of conflicting loyalties towards bureaucratic and professional systems of work organisation emerges.

The gap between what students are taught to expect and what is actually experienced in the early stages of work has been termed 'reality shock'.[26] Marlene Kramer, a nurse researcher, first recognised the problem in 1966. Although the phenomenon of reality shock has been substantiated as part of the new graduate nurse transition for decades, there is confirmation to indicate that the problems with the transition into practice are more serious today.[26] The difference between professional and bureaucratic role conceptions is a source of conflict for the nurse.[21,25,26] The strong dissimilarity in the expectations of these two systems often gives rise to nursing role conflicts.

classroom does not match the theory said to be required in clinical practice),[27] limited proficiency in managing and executing technical procedures, time management, drug administration, patient assessment and report-writing skills.[1] Other issues include:

- managing nursing care responsibilities for a number of patients simultaneously
- working in teams
- coping with a beginning level of skill as a new registered nurse relative to job demands and workload
- the acceptance of accountability
- independently taking action and making decisions
- coping with unexpected events
- supervising other nurses
- shift work
- learning how to collaborate with other nurses and health professionals, including liaison and discussion about the total care of patients
- developing competence in planning and organising
- impact of COVID-19 on new graduate nurses as they transition to practice.[4,11,27–30]

In some research studies, heavy patient loads were found to create excessive tiredness in many new graduate nurses because they were often allocated high-dependency patient loads. This was further affected by low staffing ratios, which resulted in additional stress for the graduates as they attempted to adjust to their new culture.[31] A common issue for new graduates in many studies was having inadequate staff and time to complete all client care.[11,30,32] Many new registered nurses were also having to adjust not only to their own role, but also to the health service organisation. New nurses today often work in specialty settings with complex patients whose care requires high-level decision-making skills.[22] Because of the pressures in hospitals, many new nurses felt they lacked a receptive climate in which to enact many of the aspects of what they perceived should comprise a professional nurse's role, such as having autonomy and more responsibility to assess and plan care. As Dyes and Sherman[22] explain the role, 'new graduate nurses want visibility and transparency from their nursing leadership' (p 7).

Role Ambiguity and Role Overload

Role ambiguity and role overload have also been identified as sources of stress during role transition and have been linked to organisational dynamics and subsequent job dissatisfaction and turnover. Many research studies, as far back as the 1970s, show a relationship between role ambiguity and voluntary turnover.[32–35] According to some authors, role ambiguity was more influential than role conflict in an individual leaving the organisation. In general, 'role ambiguity occurs when people are unclear or uncertain about their expectations with their role in a job or workplace or lack of clear, consistent information about the behaviour expected in a role' (p 23).[36]

There are two types of role ambiguity in relation to the uncertainty felt by the individual: (1) objective ambiguity, which arises from lack of the information needed for

goals.[35] Studies with registered nurses have shown, in all relationships, that role conflict or role ambiguity was a basis of negative influence, causing decreased job satisfaction.[11,32,34,36]

Role ambiguity is often increased by the fact that each ward is a specialty unit in an organisation and has different personnel and unique patient management. New graduates not only have to adjust to the nursing role, but also adapt to the transition within complicated social networks. Role ambiguity can be further compounded by role overload, when graduates lack skills in handling role demands, establishing priorities and allocating their time wisely.[11,32,35]

The author of this chapter conducted two longitudinal surveys on role stress in her dissertation.[11] The first survey showed that role overload and ambiguity were negatively related to job satisfaction in the first few months of employment. However, in the second survey, role overload was not significantly related to job satisfaction. Despite the overload prevalent in the role of registered nurses, many of the graduates did not relate this to job satisfaction after 11–12 months of employment. It appears to be easier for graduates to deal with role overload after the first year of employment. This may be a reflection of the graduates' coping abilities and experience gained in their role, which can ultimately make a difference in dealing with problems in the work environment.[11,37]

Factors Affecting Role Transition

According to a major Australian study undertaken by Madjar and colleagues[28] in 1997, but which is still relevant today:

> *how well and how quickly newly graduated nurses are able to demonstrate mastery of their new role, acting in a safe, competent, sensitive, and confident manner, depends on a range of factors. In broad terms these may include:*
>
> - *personal qualities of each beginning registered nurse, including age, maturity, previous work experiences, motivation, aspirations, and availability of personal supports;*
> - *the quality and extent of the educational preparation, including the nature and duration of structured clinical experiences during the pre-registration course, and the quality and rigour of formative and summative assessments within the course;*
> - *the quality and duration of orientation/transition programs for new graduates provided by employing institutions;*
> - *the expectations, attitudes, reactions, and behaviour of more experienced clinical nurses, nurse managers and other staff toward new graduates, the role modelling of expected behaviour by more senior nurses, and the prevailing ethos of the institution;*
> - *the exigencies of clinical situations, staffing levels, and other demands placed on the registered nurse.* (p 3)

The complexity of the process of transition is illustrated by the many factors that

to nursing. However, it is reassuring to note that the majority of participants in a study by Kramer[27] reported that the transition process was worthwhile and culminated in 'a sense of satisfaction and personal achievement' (p 79).[27]

NEW GRADUATES: SKILLS AND STRENGTHS

Against this background of challenges and difficulties, it is important to acknowledge the skills and strengths that new graduates have on entry to the workforce.[11,36] In a major longitudinal study of new graduates this author[11] conducted in New South Wales, Australia, both nursing unit managers and graduates believed that the graduates were well prepared in three main areas: (1) communication skills with patients; (2) psychosocial assessment skills; and (3) accountability for their actions.

These areas of strength were consistent with the findings of several other researchers, who found that graduates excelled in identifying patients' psychological needs and in communicating with them. Even though greater competency was thought to be needed in the development of technical and clinical skills, both graduates and their managers considered the overall performance to be adequate and felt that their education had been quite sufficient in preparing them for the job. Over time, graduates felt more confident and demonstrated significant improvement in performance. This may well have been expected, but strong significant improvement was observed across all areas of their role. In addition, nursing unit managers rated the overall performance of the graduates more positively compared with hospital-trained nurses. The graduates had mostly positive feelings about their tertiary program and perceived that it had provided them with a theoretical background to care for the multidimensional needs of their patients – not only physical needs, but economic, spiritual and psychosocial needs as well.[11,31,36,37]

Other research studies[11,29] show that, over a period of time, graduates were working more autonomously, establishing relationships with their clients, and coping with their new role. They saw the importance of their professional role, including as a health teacher, a provider of care, a communicator, an advocate, a coordinator of care and a decision maker as well as being able to make suggestions for changes in practice. These values are consistent with findings from studies in Australia and overseas that have examined the professional or value systems of graduates.[11,31,36,38,39] Skill acquisition was an important issue for many graduates as they progressed from novice to advanced beginner.[20]

STRATEGIES TO FACILITATE TRANSITION

Several strategies have been shown to be of use in easing the transition from student to new registered nurse. Cooperation between service and education plays a key role in the success or otherwise of many of these strategies. Many experts in nursing believe that:

> *the key to bringing respective expectations [i.e. those of providers of BNE and clinical nursing services] into line with each other ... [is] the establishment of a more cooperative framework in which higher education and health agencies*

In relation to specific strategies, a positive preceptor relationship, adequate support systems and assignment congruence have been shown to have positive outcomes in the first 6 months of employment as a new registered nurse.[40,41] Preceptorship programs are one practical strategy offered to reduce culture shock and to assist new registered nurses in the integration of theory and practice. There is extensive literature on preceptorship programs.[40,41] One version of this strategy is called the professional nurturance preceptorship program, which can be jointly sponsored by healthcare and tertiary institutions. Reports of graduate nurse preceptorship programs have demonstrated that these programs are an effective means of facilitating the transition process for new graduates, including clinical learning. Such programs could also be incorporated as a subject in the final year of undergraduate nursing courses. During the preceptorship experience, the student is guided by the registered nurse preceptor in caring for appropriate patients. Initially, preceptor and student work closely together; as students develop greater confidence and competence, they are given more autonomy in patient care. A similar approach can be used with the experienced nurse preceptor and the new registered nurse.

Many important variables make the work environment either positive or negative for graduates. The key factors that appear to facilitate successful transition include a supportive environment that accommodates incremental development in clinical skill acquisition and patient management skills.[5,22] A graduate nurse who is assigned too many patients within a short timeframe may not be proficient enough to provide for patients' physical and psychosocial care. It is crucial that the workload is structured to provide opportunities for newly registered nurses to see the effective outcomes of their work.[11]

In the practice environments that accept new graduates in nursing, there needs to be ready recognition of, and support for, the fact that learning, especially clinical learning, is a lifelong process. Another positive influence on transition is preparedness and commitment by experienced registered nurses to value and nurture new registered nurses as they move through the transition process.

The first national Review of Nurse Education carried out in Australia (in 1994) made specific recommendations about transition support for beginning graduates of nursing. Relevant recommendations include that:

> *graduates be provided with employer-funded assistance for transition to employment, including appropriate induction and orientation activities, peer support and mentoring as appropriate, and introduction to specific clinical requirements ... [and] where relevant infrastructure is not available (for example in rural and remote areas), funds be made available to provide appropriate levels of support.* (p 21)[40]

Some employers appear to be high performers in the way they manage new graduates entering employment. Consequently, several hospitals and community

Knowing how to provide patient care is not enough for new graduates, although this is a complex process requiring appropriate exposure and clinical learning. It is important that nurses can manage job stressors successfully. Health professionals, including nurses, need to learn how to care for themselves in order to care effectively for their patients. This requires a balanced approach to all facets of life and stress management skills.[2,11,37]

It is important to raise issues of concern during transition with appropriate colleagues and support systems. Discussion of these issues will lead to the identification of appropriate ways of managing problems early. This approach can be invaluable in reducing anxiety and stress and facilitating successful adjustment to nursing practice.

Quality of work life is a concept that is gaining currency, and health service providers need to address it to ensure adequate recruitment and retention of nursing staff. Sources of dissatisfaction in clinical nursing have been found to include inadequate staffing patterns, conflict with other healthcare providers, lack of support in dealing with death and dying, unresponsiveness in leadership, poor communication among staff and poor administration.[44–47] There is a clear need for leaders in nursing education to work with leaders in nursing service to develop short- and long-term strategies to promote and ensure sustainable nursing. This will require attention to a number of factors and processes that influence commitment to nursing; for example, socialisation programs affect the general satisfaction of staff and their feelings of autonomy and personal influence.[11]

It is important that senior students in undergraduate nursing courses and new registered nurses anticipate the issues and challenges associated with transition. By building knowledge and understanding of these phenomena, it is possible to plan to manage the transition period.[27] Managing involves the selection of a range of strategies designed to facilitate positive adjustment to the professional registered nurse role.

CONCLUSION

All graduates of nursing courses will experience a degree of culture shock on entry to the world of clinical practice. This experience is complex and multidimensional. Research has uncovered several issues and challenges that confront new graduates on entry to the workforce as registered nurses. In addition, several strategies have been found to be useful in easing the stress and strain associated with transition. Careful planning and use of resources in the practice environment can also facilitate positive adjustment to employment as a registered nurse. Nursing education and nursing service need to monitor the transition process continually to optimise the number of new registered nurses who manage this phenomenon successfully and go on to enjoy fulfilling, rewarding careers in their chosen profession.

ACKNOWLEDGMENT

CASE STUDY 1.1

William Michaels, who just completed his Bachelor of Nursing program, has been accepted to undertake a graduate program in a public teaching hospital in a few weeks' time. He has been informed that his first placement will be in a respiratory medical ward. He is very excited, but at the same time apprehensive and anxious, about starting his new role as a registered nurse. He knows he could draw on his tutorial notes at university as well as the literature and other resources available to him. In this situation, William considers the following questions in preparing to develop his plan for transition to registered nurse.

REFLECTIVE QUESTIONS

1. What do we know and understand from the literature about factors influencing transition?
2. What strategies have been found to be successful in assisting a new registered nurse to adjust to practice?
3. What types of resources can be accessed to facilitate individual transition?

CASE STUDY 1.2

Alannah Bella, a clinical specialist in a surgical ward, has two new registered nurses starting work in her clinical area. She was asked by her nursing unit manager to develop an orientation program that will assist them in adjusting to their new roles and responsibilities.

REFLECTIVE QUESTIONS

1. What advice could you give Alannah Bella to assist the new registered nurses regarding their overall needs?
2. What topics would be helpful to the new registered nurses in the orientation program? What is the rationale for your choice?
3. How could Alannah Bella prepare her senior and junior registered nurse colleagues to meet the support needs of these new registered nurses?

CASE STUDY 1.3

Geraldine Lynn is a new registered nurse who has worked in aged care for over a year. She is keen to extend her learning in the dementia care unit. She wants to have a better understanding of dementia in aged care facilities and there are many residents diagnosed with mild and moderate dementia.

REFLECTIVE QUESTIONS

1. With whom should she discuss her possible change of placement to the dementia care unit?
2. What skills and competence does she need in this area?

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CHAPTER 2

Becoming a competent, confident, professional registered nurse

Jill White

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- develop an understanding of the complexity of the development of practice knowledge
- appreciate the deeply contextual nature of professional practice knowledge
- understand the transformation in skill acquisition from novice to expert
- construct a personal plan for reflective practice
- develop a positive perception of yourself as being on a career-long journey of your understanding of nursing practice.

KEYWORDS: competent, confidence, reflection, professional development, unconscious bias

INTRODUCTION

On graduation, one of the hardest things to come to terms with is the apparent discrepancy between the way you, as a new graduate, see a clinical situation and the way an expert nurse might see it. At university, the focus seemed to be on understanding the signs, symptoms and diagnoses, and making decisions through the exercise of 'clinical judgment'. This usually involves breaking the situation down into understandable, 'bite-sized' pieces and then reintegrating them. Experienced nurses rarely seem to do this in their practice. 'How do I get from where I am now to that sort of confidence and competence?' is a question that, as a new graduate, you may sometimes find yourself asking. 'Why didn't my university studies prepare me properly for the real world?', 'And what is this competent/competence/competency anyway?'

COMPETENCE IN NURSING PRACTICE

the university will have assessed you in the classroom and in clinical practice against the Registered Nurse Standards for Practice.[1] These standards are the benchmark of the minimum level of competence necessary for registration with the Nursing and Midwifery Board of Australia. There are seven standards:

1. *Thinks critically and analyses nursing practice.*
2. *Engages in therapeutic and professional relationships.*
3. *Maintains the capability for practice.*
4. *Comprehensively conducts assessments.*
5. *Develops a plan for nursing practice.*
6. *Provides safe, appropriate and responsive quality nursing practice.*
7. *Evaluates outcomes to inform nursing practice.* (pp 1–2)[1]

However, university can do only part of the job of preparing a confident, competent professional nurse. It is in the nature of the acquisition of practice understanding that it takes layer upon layer of personal clinical experiences to move towards competence in the practice reality of nursing, as opposed to assessment of 'competence' following graduation from university and the beginning of practice as a registered nurse.

The complex conditions of the early 2020s have disrupted the normal transition from university to registered nurse practice for many. New graduates have been called upon to enter the turmoil of the clinical world without supervised graduate programs and without the staffing levels commensurate with the best early learning experiences. You did it, you coped, and you saved lives, but it took a toll on your learning and processing. You became highly skilled in working quickly but you also recognised that the care you gave might have been different had you had more time and more resources. It is with the refreshing of the health services that the nursing voice must demand what we know from evidence to be necessary, not only for safe and effective patient care, but also to foster the development of the next generation of confident, competent registered nurses. Hopefully the worst crises are over, and it is now time to explore what this transition should entail and to assess what has been missing. By reflecting on this experience, you can identify and remediate any gaps in learning you may have as you progress on your path to expert clinical nursing practice.

SKILL ACQUISITION

The cardinal work of Patricia Benner,[2] despite its age, still provides us with the most useful map for understanding the notion of skill acquisition within practice. Benner's work was a refinement and application of the work on skill development by Dreyfus and Dreyfus,[3] who developed this schema by studying airline pilots and chess players. From this study, Dreyfus and Dreyfus came up with five levels of skill acquisition: (1) novice; (2) advanced beginner; (3) competent; (4) proficient; and (5) expert. (Yes, there is that word again. It is very confusing when the word 'competent' is used by so many to mean so many different things.)

approached your first few clinical practice experiences?

The advanced beginner has coped with sufficient clinical situations to have grasped what to do in a global sense and can demonstrate what Benner[2] describes as 'marginally acceptable performance'. It is still difficult for advanced beginners to be really sure of what is important in a situation, and rapidly changing situations or subtle changes often elude them. This time the question is not 'Do you remember this?', but 'Do you recognise this?'. Benner suggests that new graduates are advanced beginners and that they remain so until they have spent upwards of a year-and-a-half in one type of clinical setting, at which time they reach Benner's level of skill acquisition of 'competent'.[4] She further states that transferring to a very different clinical environment brings the nurse quickly back to advanced beginner status, despite expertise in another field of nursing.

The biggest jump in practice skill development occurs between the competent nurse and the proficient one, as this represents a move in cognitive grasp from perceiving aspects of a situation to perceiving the situation as a whole. It is at this stage that it becomes easier to tell whether a patient is moving along an expected path or subtly into difficulties.

The movement through the levels of skill acquisition is characterised by

> *a movement from reliance on abstract principles to the use of past concrete experiences; a change in the learner's perception of the demand of the situation, in which the situation is seen as less and less a compilation of equally relevant bits, and more and more as a complete whole in which certain parts are more relevant; and a passage from detached observer to involved performer.*[2]

The expert involved performer is defined by Benner as one who

> *no longer relies on an analytic principle to connect her or his understanding of the situation to an appropriate action. The expert – with an enormous background of experience – now has an intuitive grasp of each situation.*[2]

But hang on, isn't intuition the thing that we have without formal education – the 'just knowing' that is demonstrated so well by adolescents?

INTUITION

Two of the most confusing words that are constants in the new environment of work are 'competence' and 'intuition', and trying to gain a sense of shared understanding about them seems difficult.

'Intuition' is an often used, frequently misunderstood word – we use it colloquially to mean 'undifferentiated gut feeling' and at other times very specifically to mean 'expert clinical judgment'. One of the main confusions in looking at this concept is that we do not often stop to explore and ensure that our use of the word is received with shared meaning.

within nursing by Benner and others.

The key aspects that Dreyfus and Dreyfus[3] saw as representing this intuitive judgment were:

- pattern recognition – similarities and links with previous experiences
- similarity recognition – 'fuzzy' resemblances, similarities despite differences
- common-sense understanding – knowing the practice setting and its patterns
- skilled know-how – mastery of the job
- sense of salience – recognition of some events as more important than others
- deliberative rationality – exploring what might stand out as significant if one's perspective were changed.

It is obvious when we look at these aspects of intuitive judgment that they are predicated on deep contextual knowing of a practice situation. So, it is time to be kind to yourself, and to think of this as an opportunity to look at how you can best take advantage of your new clinical access to begin to gather and mentally file your repertoire of pictures of clinical situations, rather than being harsh with yourself about what you do not know.

If we accept that there is an important component of expert practice that has, for good or ill, been called intuition, we return to the question of how we differentiate this from the more colloquial use of the term. The work of Belenky and colleagues, in *Women's Ways of Knowing*,[6] may be helpful here. This research was influenced by the work of Kohlberg[7] and Perry,[8] two key figures in our understanding of psychological development, and by Gilligan's[9] critique of these works as gender-distorted, as they were developed studying only men.

As a result of their extensive research with women, Belenky and colleagues[6] found that the women's positions were better represented as five – rather than Perry's four – ways of knowing, and that women have a position previous to Perry's first level. The researchers called this level 'silence', where women perceive themselves as having no voice at all. The five ways of knowing are:

1. Silence: nothing worth saying.
2. Received knowledge: listening to the voices of others and holding them as 'true' – 'black-and-white' thinking.
3. Subjective knowledge: the inner voice – personal opinion.
4. Procedural knowledge: the voice of reason, of what is known.
5. Constructed knowledge: integrating the voices. Here it is possible to hold a personal opinion, having considered the available literature and being aware of the multiple other positions that might be held on the subject.

The reason for introducing this work here is that it provides us with a strong point of differentiation between the various ways in which the word 'intuition' is used. The chapter in *Women's Ways of Knowing* on subjective knowledge begins with the words of a young mother, Inez:

There's part of that I didn't know I had until recently instinct, intuition,

In this stage of subjective knowledge things cease to be clear-cut, and personal freedom and personal opinions are asserted. Inez continues:

> *I can only know with my gut. I've got it tuned to a point where I think and feel at the same time and I know what is right. My gut is my best friend – the one thing in the world that won't let me down or lie to me or back away from me.*[6]

We do not wish to denigrate this powerful personal knowing. It is a deep point of inner strength on a journey of knowing, but it is a private knowing and, as such, has the limitations of 'small sample size and limited generalisability'; it also suffers the inevitable influences of potency of an experience and recency of experience. First-hand experience and the intergenerational stories of those in close private spaces are critical to the development of this knowing. It is the 'feel-right' component of knowing, for example, one's children. It seems not dissimilar to the knowing described by Tanner and colleagues[10] in their early work on 'knowing the patient', with its in-depth knowledge of the patterns of responses and the knowing of the patient as a person. (We return to knowing the patient later.)

Such personal knowing is the agency of maternal authority and is therefore not to be ignored. It is the unwise nurse or doctor who does not listen to the mother's report on her child's condition and, particularly, on subtle changes in condition. The mother knows her own child but would not be in a position to make a judgment on the child of another mother. The knowing needs to be understood and responded to as highly contextually confined.

In moving to procedural knowledge, there is a profound shift – a shift to appreciating the fallibility of gut feelings and the importance of shared knowledge and understanding that can be gained without direct experience of an event. Seeing outside our own frame of reference characterises this stage – setting personal experience within the context of extant knowledge of an informed community.

How, then, do we gain access to understanding something that we have not or could not experience directly? This is the research and theory base of the procedural knowledge of Belenky and colleagues[6] and represents the theoretical and research base provided by formal education. It includes work such as the meta-analyses being undertaken by groups like the Cochrane Collaboration, with their user-friendly outcome summaries detailing those practices that reduce negative outcomes, those that appear promising, those that have unknown effects and, most importantly, those that should be abandoned.

The issue here for practice and practitioners is not necessarily the lack of research and theory but that of having practitioners incorporate the research findings into practice, particularly those identified as 'should be abandoned'. Procedural knowledge gives the novice-to-competent nurse a basis for determining what can be wrong, what can go wrong and what can be done. This then allows the nurse to enter the clinical

at this time, in this circumstance? Inherent in this is an element that we might call 'knowing the patient'. This, importantly, is where you find yourself now.

KNOWING THE PATIENT

In later refinements of the concept of expert practice, Tanner and colleagues[10] took Benner's notion of 'involved performer' and explored it further through what they called 'knowing the patient'. They saw this as a precursor to the exercise of intuitive judgments and therefore to moving from the stage of competent to that of proficient or expert nurse. Two specific elements to 'knowing the patient' were found: 'in-depth knowledge of the patient's responses' and 'knowing the patient as a person'.

In-depth knowledge of the patient's patterns of responses included responses to therapeutic measures, routines and habits, coping resources, physical capacities and endurance, and body typology and characteristics. This was illustrated by the following clinical exemplar:

> *you look at this kid, because you know this kid and you know what he looked like two hours ago. It's a dramatic difference to you but [it] is hard to describe that to someone in words.*[10]

Knowing the patient as a person, on the other hand, was seen as the need to be able to know the person outside his or her present situation, particularly where the patient was a baby or an unconscious adult:

> *I had never ever spoken to this man, but I grew to know him because of the family, because I became real close to his wife and son and knew what he was like before.*[10]

An extension of this work, by Liaschenko and Fisher,[11] gave even greater clarity to this notion. They suggested there are three types of knowledge, which they call 'case', 'patient' and 'person' knowledge. Case knowledge is that generalised knowledge that we were just discussing. The two types of particular interest here are patient and person knowledge. These are differentiated as follows.

Patient knowledge includes knowledge of how the individual is identified as a patient, how the individual responds to therapeutics, how to get things done for the person within and between institutions and what other providers are involved in the care of the person. This places the person in the context of healthcare and treatment as an individual.

Person knowledge is knowledge of personal biography. Person knowledge is a potent reminder that the life lived is the life of the recipient of care. Nurses use their person knowledge to defend their arguments for an alternative management of disease trajectories and to justify their actions when those actions support an individual's agency, even though this can conflict with established biomedical or institutional courses of action.

interprofessional collaboration broke down. They found that 'collaboration broke down when doctors dismissed nurses' concerns because they did not fit into a schema of case knowledge'. Managing the confused patient was seen as a problem to be solved by nurses, as it requires 'knowing the patient' in order to be able to respond to the person's particular behaviour, and 'making sense' of behaviour is made possible when one could put it in the context of the specific person – that is, through having patient knowledge.

Liaschenko and Fisher[11] elaborated on the importance of social knowledge that links patient knowledge to person knowledge. They stressed the importance of understanding illness trajectories that go beyond the health system and into the world of the person who is the patient. This includes knowledge of:

- the social conditions in which the recipient lives
- the impact of the particular disease on the individual's ability to function and manage his or her disease in a variety of contexts
- the stigma attached to a given disease
- the degree to which the individual takes up the dominant cultural discourse about his or her particular disease.

This type of knowing is helped by providing opportunities to walk in the shoes of the other, and can be accessed through storytelling, by novels or books with accounts of illness experience, through poetry and in movies. These sources provide us with profound glimpses into the experiences of others, and increase our personal repertoire of knowing and therefore our readiness to interact appropriately with others. This knowing can be elaborated by narrative analysis and by research using a variety of interpretive methodologies.

Understanding culture and its relationship to power, politics, language, identity, family and land connection is an essential part of knowing the person. It includes exploration of whose voices are privileged and whose voices are silenced. It seeks to expose and explore alternative conceptions of reality. Ramsden's[13] ground-breaking work on cultural safety developed in New Zealand (*kawa whakaruruhau*) offers nursing the opportunity to explore its practice in relation to cultural recognition, respect and nurture. This dimension of our nursing knowledge is now being developed in Australia and presents a considerable challenge.[14,15] This challenge is posed to all nurses by the Council for Aboriginal and Torres Strait Islander Nurses and Midwives (CATSNaM). We can enhance our cultural/political understandings through research grounded in critical theory such as action research, by critical ethnography, by feminist studies or by discourse analyses, but the fundamental element of cultural understanding is knowing oneself and challenging 'taken-for-granteds'. Brookfield,[16] although writing over three decades ago now, made the point in a way we have not seen bettered when he stated that 'coming to realise that every belief we hold, every behaviour we cherish as normal, every social or economic arrangement we perceive as fixed and unalterable can be and is regarded by others as bizarre, inexplicable, and wholly irrational'. Much has now been written about unconscious bias, a concept critical to nursing practice. Recognising our unconscious biases enables us to work towards mitigating them and thus to provide a more equitable healthcare experience for our patients.[17 18]

enable the nurse to have a body of experience on which to draw 'intuitively' when faced with any of Dreyfus and Dreyfus's aspects of intuition – pattern recognition, similarity recognition, common-sense understanding, skilled know-how, sense of salience and deliberative rationality.

This is the experience described by Benner[2] and Schon.[5] It is experience that incorporates reflective practice. They both speak of experience as not simply being time spent in a situation, but rather as new understandings that come when taken-for-granted and expected happenings are disturbed through reflection during action or reflection on action. In Benner's words,[2] experience results when 'preconceived notions and expectations are challenged, refined, or disconfirmed in the actual situation' or, as she and her colleagues elaborate in a later text:

> *Experience, as defined here, is not the mere passage of time but rather is an active transformation and refinement of expectations and perceptions in evolving situations. The nurse shifts from exclusive use of objective characteristics and quantitative measures as guides to understanding and action with particular patients. Clinical reasoning is based on understanding patient changes through time – that is reasoning through transitions.*[4]

This work has clear implications for organisational work practices of relevance to new graduates, particularly in terms of consistency of work environment and stable ward staffing to facilitate the development of collegial trust and the authority that comes with trust. It holds implications, too, for the introduction of models of care delivery that enhance opportunities for continuity of care and carer, a continuity that enables a very thorough 'knowing [of] the person'.

Work environment stability has been severely challenged in recent years by fires, floods and a pandemic. Health services have been stretched to near breaking point, and nurses have been the backbone of the ability of those services to continue to offer care, albeit in ways we never imagined. New graduates and even final-year students have, as acknowledged earlier, become part of the workforce in ways that challenge any notion of 'being thrown in at the deep end', and it is critical that those of you experiencing this have opportunities to process what you have experienced, intellectually and emotionally.

In refashioning health systems nursing has much to offer. Our deep research into what enables the person who is the patient to be placed at the centre of care and into the ratios of nursing staffing that enable this care to be provided should form the basis for new directions in healthcare reform.

Professor Brendan McCormack and his colleagues[19] have developed a theoretical framework for understanding person-centred care. This framework is predicated on the work of Benner, Tanner and colleagues, Liaschenko and others, and captures organisational and staffing issues as well as those of nursing skill acquisition. The framework has four central constructs:

3. person-centred processes, which focus on the activities through which care is delivered
4. expected outcomes, which come from effective person-centred nursing.

The attributes of the nurse that form the prerequisites of McCormack and colleagues[19] include 'being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; and knowing self'.

The care environment elements that affect person-centred nursing include 'appropriate skill mix; systems that facilitate shared decision-making; the sharing of power; effective staff relationships; organisational systems that are supportive; the potential for innovation and risk-taking; and the physical environment'.[19] These elements are heavily dependent on skilled nursing leadership and an open and inquiring organisational culture. They influence the nurse's ability to know the patient and to observe and gain feedback from skilled colleagues.

Person-centred processes require working with the person's beliefs and values, sharing decision making and providing holistic care. The outcome of these processes should be the creation of a therapeutic environment within which the patient and family are satisfied with their care.

It is clear, then, that if the goal of nursing is the creation of a therapeutic environment in which patients receive safe, appropriate and quality care with which they are satisfied, developing the attributes described above is an essential step – that is, becoming a competent, confident, professional registered nurse.

REFLECTIVE PRACTICE

This brings us to perhaps the most potent of all aspects of your continued learning: reflective practice – the key to learning from experience. Much has been written about the importance of reflection for the developing practitioner, most notably by Schon,[5] but it has been elaborated on within nursing by many. Reflective practice is the subject of Chapter 18 but is referred to briefly here, as it is critical for acquiring practice skills and moving towards expert practice. Johns[20] provides an excellent example of the transformation from novice to expert learning through reflective practice by using Belenky and colleagues'[6] ways of knowing, as described earlier. This will give you a clear exemplar of this movement in thinking to the constructed voice or, as Johns calls it, 'whole brain stuff using both hemispheres to marry logic, reason [and] analysis with creativity, curiosity and perception'.[20] Johns and his colleagues provide models of reflective practice and examples from practice to guide you in developing these skills. Reflective practice has never been more important, given the relative and sometimes real chaos of clinical environments recently. These tools will be extraordinarily useful in helping you look back critically on what you did and how you did it, on how it may have affected people and on what else could have been done, on what you would do differently next time and what you have learnt from the experience.

Belenky and colleagues[6] call 'constructed knowledge'. *Constructed knowledge* is the integration of the voices, obliterating the spaces between private and public knowing: 'weaving together the strands of rational and emotive thought and of integrating objective and subjective knowing'.[6] The real learning of artful practice is gained through intelligently watching our own practice and that of others, and reflecting during and on that practice. This highest level of knowing, necessary for the development of expert practice, makes possible the very difficult work of the experienced, expert nurse, who is often called upon to make judgments with imperfect and often contradictory information and to do so in a time-bound manner.

CONCLUSION

Bringing together intuition from our private life experiences (subjective knowing) and theoretical understanding through research undertaken in the public domain (procedural knowing) in their fullness through practice-based experience allows us to gain the other type of intuition – expert clinical practice, but let us call it what it is, the best of constructed knowledge in action – practice wisdom.

Bring forward the best of your theoretical learning as it has been modified and tested through your clinical experiences to date. Combine it with the layer upon layer of clinical pictures you are beginning to collect and collate, enrich these through reflection on what you have learnt and are learning, deeply engage with your patients and colleagues and be open to changing your current understandings of the meaning of illness, pain and suffering. You are ready. You are at the beginning of the rest of your journey towards being a competent, confident, professional registered nurse. Here is the best bit: the journey can last for as long as you choose to practise. The gaining of wisdom is a never-ending journey. Go well.

CASE STUDY 2.1

Astrid is the senior nurse on the general medical surgical ward to which Hamed has been allocated for his second new graduate rotation. After dinner one evening, Mr Falter in bed 1 appears unwell and is complaining of epigastric pain but says it is just his heartburn playing up again. Hamed reports this to Astrid, who moves quickly into assessment action and appears to be taking the situation very seriously. And indeed, within a matter of minutes Mr Falter has suffered a heart attack. When the team have time to debrief later during the shift, they discuss the differences in what they saw, what it may have signalled and what action they would have planned.

REFLECTIVE QUESTIONS

1. Take a few minutes at the end of a shift to write a brief account of a critical incident in which you were involved that day, one in which an experienced nurse also took part.
2. When you have finished your account, ask the experienced registered nurse to recount his or her recollection of the event and what he or she saw as the most significant aspects. How did your accounts differ? Why might this be so?

CASE STUDY 2.2

Harriet Preacher is a 35-year-old woman from Roseville in Sydney. She was admitted to your hospital last night and is currently in the intensive care unit. She was admitted via ambulance after an episode of lack of consciousness, followed on arousal by complaints of severe neck and head pain. On scan, she was diagnosed as having had a small bleed from an aneurysm, which was clipped in theatre prior to admission to the ward. Mrs Preacher has a picture of two children beside her bed and they appear to be a boy and girl in their early teens. She is currently being visited by her husband Sean, who tells you that she is very upset at missing the children's school drama production this evening and that she has asked Sean to bring her in some food to replace the hospital food, which she says is flavourless.

REFLECTIVE QUESTIONS

1. Which pieces of the above information are examples of 'knowing the patient' using Liaschenko and Fisher's topology: case knowledge, patient knowledge and person knowledge?
2. Explore your clinical work on your next shift and note examples of case knowledge, patient knowledge and person knowledge.
3. In what ways do these different ways of 'knowing the patient' help you to determine the basis for your care?

CASE STUDY 2.3

Asham has been a registered nurse for 4 years and loves his job. He consistently volunteers to help mentor new graduates and staff who are new to the area. Patients respond really well to him, and the feedback the nursing unit manager receives is always that Asham is a nice person and an excellent communicator. He leads the 'essentials of care' team in the values clarification exercises, having already completed the facilitator's course, of which introspection and personal values clarification are inherent parts.

REFLECTIVE QUESTIONS

1. Assess Asham in terms of his attributes for engaging in person-centred nursing. What other information would you want to know before completing this assessment?
2. In McCormack and colleagues'[19] person-centred nursing framework, give yourself a score out of five for the 'prerequisites' or 'attributes' of the nurse:
   - professional competence
   - interpersonal skills
   - commitment to the job
   - clarity of beliefs and values
   - self-knowledge.
3. Studying these results, what actions might you take to increase your score so that it is closer to five out of five?

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CHAPTER 3

Becoming part of a team

Tracy Levett-Jones and Lorinda Palmer

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- identify the different teams in healthcare and the attributes of well-functioning teams
- describe effective strategies for becoming a part of the healthcare team
- outline how well-functioning teams impact patient safety and how dysfunctional teams can cause harm
- reflect on the importance of belonging to the healthcare team
- discuss the positive and negative implications of striving to belong to a healthcare team.

KEYWORDS: team, belonging, patient safety, communication, collaboration

INTRODUCTION

In this chapter, we explore the strategies that graduate nurses can use to become effective members of the healthcare team. The importance of teams and teamwork – both to you as a graduate nurse and for the patients you care for – is discussed, and we share some practical strategies that you can use to develop your communication and collaboration skills.

For newcomers to a clinical setting, a feeling of belonging to the team does not happen overnight. It gradually develops as you become increasingly familiar with your role and the roles of other team members, and when you experience a sense of alignment between your own professional and personal values and those of the team. This chapter discusses the phenomenon of belonging and explores how a judicious approach must be used when weighing up what you will and will not do to 'fit into' the team.

TEAMS IN HEALTHCARE

ESTHER CHANG
DEBORAH HATCHER

Transitions in Nursing

Preparing for professional practice

SIXTH EDITION

ELSEVIER

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SIXTH EDITION

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PREFACE

Welcome to the sixth edition of *Transitions in Nursing: preparing for professional practice*. This book has been developed to assist preregistration students, new registered nurses and other professionals interested in issues and challenges associated with the transition from higher education to practice in various health environments. For most new graduates, this rite of passage is associated with a degree of stress, strain and culture shock. These are issues that have existed in nursing for decades. The literature continues to show that this transition is a multidimensional and complex process. Intensive socialisation brings to the surface many challenges and opportunities for new registered nurses as they assimilate into their professional work roles. Research through the years has shed much light on the issues associated with transition, including strategies that can be useful in negotiating the process.

The book provides comprehensive information on the key issues associated with transition. You will find viewpoints that are challenging and sometimes disconcerting, but at the same time motivating and thought-provoking. The sixth edition is divided into three sections. Section 1 examines issues relating to the transition from student to graduate nurse. Section 2 looks at skills for dealing with the world of work. Section 3 discusses the organisational environments that we work in. This edition also includes new contributors and two new and important chapters: chapters 13 and 18. Chapter 13 examines infection prevention and control in the healthcare setting. It helps you to understand your nursing and public health role in the prevention and control of infectious disease, especially in the climate of the COVID-19 pandemic. It also encourages the importance of patient participation and empowerment in infectious disease prevention and control. Chapter 18 discusses the challenge of bullying in nursing. It describes the features and different categories of bullying. It further explores the consequences of bullying on the nurse, bystanders, the organisation and patient care, as well as strategies that can be employed following an incident.

Transitions in Nursing: preparing for professional practice shows you how to be a successful graduate and at the same time how to care for yourself. The exercises and learning activities that appear throughout the book offer you a range of helpful suggestions for understanding the nursing context, managing stress and caring for yourself. In addition, each chapter includes recommended reading, case studies and reflective questions for further exploration. In this new edition, most of the chapters have new and/or updated case studies, and additional case studies and media can be accessed on Evolve.

importantly, it is a resource that every student, practising nurse, educator and administrator can use to understand the issues that transition raises for new registered nurses. By reading the book, reflecting on the issues and proposing possible answers, you should be able to gain a comprehensive view of the issues, challenges and opportunities that lie ahead of you. The journey during this period can be rewarding, with implications for a long-term and hopefully enjoyable career for you, particularly when educators, administrators and clinicians collaboratively anticipate and manage the socialisation process.

We extend our most sincere appreciation to all the contributors to the book for their shared interest in and concern for the issues and challenges of transitioning from student to registered nurse. **This book would not be possible without them.** They have stood by us (Professor Daly and Professor Chang) for more than 20 years. We would especially like to thank and acknowledge Emeritus Professor John Daly for his substantial contribution to previous editions of the book. We would like to express our gratitude to the late Emeritus Professor Judith Lumby for her commitment to this book through the years. Our thanks also go to Natalie Hunt, Kritika Kaushik and the rest of the team at Elsevier for their encouragement and support, as well as to Carol Natsis for her careful editing of the text of this edition. Elsevier Australia joins us in thanking the reviewers for their feedback on the manuscript. This book is dedicated to all our amazing students through the years.

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SECTION 1

FROM STUDENT TO GRADUATE

CHAPTER 1

Managing the transition from student to graduate nurse

Esther Chang

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- describe the process of transition from student to graduate nurse
- appreciate a range of factors and issues that influence the transition from student to graduate nurse
- consider strategies to ease the tension associated with adjustment to the realities of nursing practice for new registered nurses
- recognise the importance of a positive, proactive approach to managing transition on an individual level
- identify and access resources which have been shown to facilitate adjustment to nursing practice for new registered nurses.

KEYWORDS: transition, role stress, strategies, students, new graduate nurse

INTRODUCTION

Nursing attracts people from many walks of life, motivated largely by a concern and a desire to understand and help people who are confronted by a range of actual or potential health problems and challenges. Many of these experiences cause major disruption in people's lives – for example, illness, suffering, loss, grief and trauma. According to Englert,[1] 'such experiences are both the privilege and burden of nurses and of others who share the drama, the humor, and the tragedy of other people's lives' (p 1). Englert, a leader in the administration of nursing services, encouraged members of the nursing profession to 'reflect for a moment … to recall some of those high and low points of the beginning years as a registered nurse' (p 1). She went on:

> *that they will be found wanting when the crisis occurs, a certain awkwardness in accepting advice, however kindly given, and an admiration for those whom they see as epitomising the best of nursing.* (p 1)[1]

At the time of writing this chapter, the COVID-19 pandemic continues. Many of those in Australia's healthcare workforce are on the front line and continue to be impacted in many ways.[2] COVID-19 requires graduates to be ready to participate in the workforce and assist in the increased demands on healthcare delivery.[3]

The nursing profession in Australia and elsewhere continues to be concerned with the process of transition for graduates of undergraduate nursing courses upon their entry into the world of clinical practice.[2–7] This concern exists for several reasons: (1) it has remained an issue of concern in nurse education in Australia because of ongoing changes in the clinical practice environment; (2) research data continue to show that this period of transition can be stressful; [4] (3) professional, service and economic issues can impact recruitment and retention; and (4) there are related questions about adequate preparation of new graduate nurses.

One continuing key issue here is the relevance and quality of clinical education in undergraduate courses. Indeed, in recent times, access to an adequate number of quality clinical placements has become a serious challenge to educators in nursing, medicine and allied health. This has fostered several innovations, including the development of effective simulation-based nursing education for clinical simulation teaching and learning environments.[8] The impact of such innovations on the clinical competence of graduates in the health professions will require ongoing research and evaluation.

These challenges are international, particularly in developed countries that are struggling with health sector reforms, cost containment challenges, the growing burden of chronic disease, ageing populations and human resources for health issues. It is imperative to develop transformative healthcare changes for which nurses can play an important role in contributing, driving and taking a lead. In the United States, a provocative and scholarly report for the Carnegie Foundation for the Advancement of Teaching and several research studies have called for a reinvention of preregistration nursing education.[9–11] The author's argument is based on several factors, one dimension being the relevance of current models of undergraduate nursing education in the present-day context of health system re-engineering. In 2010 the Council of Australian Governments established Health Workforce Australia (HWA), which had a role to play in creating solutions to clinical education challenges.[12] However, the Australian Federal Government closed HWA in 2014 and transferred its role and functions to the Commonwealth Department of Health. Undoubtedly, challenges will persist with supply of and access to quality clinical placements across health professional education, including undergraduate nursing.

In addition, recruitment and retention of new graduates are issues from time to time, both nationally and internationally. Demand for, and supply of, registered nurses is cyclical, and occasionally healthcare systems are confronted by a shortage of nurses. Such shortages can reach crisis proportions, a global challenge and phenomenon that is occasionally seen because of an ageing nursing workforce and the undersupply of graduates.[13] HWA predictions pointed to a likely workforce shortage of 109,225 registered nurses by 2025 as a result of demographic changes in

Other reasons for this concern with the experience of transition include changing attitudes in society towards nursing as a career, a decline in the number of people choosing to enter undergraduate nursing courses and the need to create sustainable nursing. It also appears that healthcare system reform has created an environment that has a negative impact on the quality of work life for nurses and other health professionals and on the quality of patient care.

There is a large amount of literature on the process of transition from senior student to graduate nurse. It is clear from this literature that transition is multifaceted and complex, and that problems often described and discussed in relation to the process are not new[7,11,16] and continue to evolve.[4] In Australia, nursing education has undergone rapid transformation since the late 1980s. The system of basic nurse education (BNE) is now university-based, with three-year degree programs leading to eligibility to register as a nurse. In addition, the national healthcare system has undergone radical change in the last two decades. Much of this system change has been driven by the shift to an economic model for designing and managing health services. This has led to changes in the nursing practice environment that have implications for new graduates entering employment.

Preregistration nursing courses today need to prepare graduates for a work environment that has undergone enormous change in the last two decades. The practice environment is constantly changing, as has been seen with the COVID-19 pandemic, and this has implications for the type of knowledge and skills that new graduates will require.[3] University schools of nursing are constantly challenged to ensure their courses are designed to give graduates the best possible preparation for entry to nursing practice as new registered nurses, and to optimise their ability to move through the transition process confidently and successfully. Experience has shown that this is best done in cooperation with nursing service leaders and providers. Preparation of new graduates in nursing is best viewed as a shared responsibility between the university and nursing service sectors;[11,17] universities should act as facilitators of learning in collaboration with healthcare service partners.[18]

University schools of nursing aim to prepare flexible, critical thinkers for the practice of professional nursing. They emphasise individual client- or person-centred holistic care and lifelong learning as key values. All preregistration nursing courses are required to provide a clinical education component to ensure that course graduates meet the clinical competency expectations of beginning registered nurses. However, in many surveys, new graduates report that the clinical practice and clinical education components of their undergraduate course were too short and that the course was too theoretical.[16] Other research work has found that, on entry to the workforce, graduates perceive that employers do not understand what they know and can do.[19]

Nursing service providers often report that new graduates 'are inadequately prepared for clinical practice in that they are deficient in certain skills' (p 17).[17] This reflects a clear mismatch in expectations of new graduate nurses between the education and service sectors. Preregistration nursing courses do not aim to produce expert practitioners on graduation. Research has demonstrated that development of clinical expertise requires some years of constant immersion in clinical experience following entry to nursing practice as a registered nurse.[20] It would be ideal if newly registered nurses could meet all expectations required by the healthcare settings immediately following entry to the workforce. Experience has shown that few individuals are able

It is important that new graduates are patiently provided with support, tolerance and encouragement as they learn to assimilate the values, beliefs and practices acquired in their undergraduate education with the practice values and beliefs that are dominant in the clinical working environment. It is no surprise that, in this context, the transition process presents many challenges and potential rewards for the new graduate in nursing. The first 3–6 months as a new registered nurse have been identified as potentially the most challenging and stressful period in their professional adjustment.[11,21,22] This period is 'crucial in determining new graduates' commitment to nursing as well as their acquisition of technical, clinical and patient management skills' (p 20).[17] Perhaps the keys to successful negotiation of this phase are anticipation and psychological preparation. This requires you to be adequately informed of what is known about the process and what you can do to ease your transition into practice as a new registered nurse. In addition, nurses in service need to realise the increasing importance of learning as a lifelong process in healthcare.[23]

A survey of the table of contents of this book will show that component chapters are concerned with preparation for entry into the nursing workforce and the development of a successful, sustainable and rewarding career in nursing. Chapter topics can be classified according to several themes: managing self in clinical practice; caring for self; understanding the forces that shape the practice environment and infection; learning to manage different approaches to nursing care delivery; collaborating and working with colleagues and patients/clients; and professional development strategies.

TRANSITION: A PROCESS

The transition from student to graduate nurse is characterised by a period of intense socialisation into the culture of the clinical work world. Socialisation, in this context, may be defined as 'a complex process directed at the acquisition of appropriate attitudes, cognition, values, motivations, skills, knowledge, and social patterns necessary to cope with physical, cultural and social environment' (p 30).[24] Corwin[25] believes there is a 'turning point' between graduating from a nursing school and induction into employment for students. This turning point in a career produces role conflict between professional (idealised) role conceptions and bureaucratic (actualised) role conceptions in the working environment. Consequently, a sense of conflicting loyalties towards bureaucratic and professional systems of work organisation emerges.

The gap between what students are taught to expect and what is actually experienced in the early stages of work has been termed 'reality shock'.[26] Marlene Kramer, a nurse researcher, first recognised the problem in 1966. Although the phenomenon of reality shock has been substantiated as part of the new graduate nurse transition for decades, there is confirmation to indicate that the problems with the transition into practice are more serious today.[26] The difference between professional and bureaucratic role conceptions is a source of conflict for the nurse.[21,25,26] The strong dissimilarity in the expectations of these two systems often gives rise to nursing role conflicts.

classroom does not match the theory said to be required in clinical practice),[27] limited proficiency in managing and executing technical procedures, time management, drug administration, patient assessment and report-writing skills.[1] Other issues include:

- managing nursing care responsibilities for a number of patients simultaneously
- working in teams
- coping with a beginning level of skill as a new registered nurse relative to job demands and workload
- the acceptance of accountability
- independently taking action and making decisions
- coping with unexpected events
- supervising other nurses
- shift work
- learning how to collaborate with other nurses and health professionals, including liaison and discussion about the total care of patients
- developing competence in planning and organising
- impact of COVID-19 on new graduate nurses as they transition to practice.[4,11,27–30]

In some research studies, heavy patient loads were found to create excessive tiredness in many new graduate nurses because they were often allocated high-dependency patient loads. This was further affected by low staffing ratios, which resulted in additional stress for the graduates as they attempted to adjust to their new culture.[31] A common issue for new graduates in many studies was having inadequate staff and time to complete all client care.[11,30,32] Many new registered nurses were also having to adjust not only to their own role, but also to the health service organisation. New nurses today often work in specialty settings with complex patients whose care requires high-level decision-making skills.[22] Because of the pressures in hospitals, many new nurses felt they lacked a receptive climate in which to enact many of the aspects of what they perceived should comprise a professional nurse's role, such as having autonomy and more responsibility to assess and plan care. As Dyes and Sherman[22] explain the role, 'new graduate nurses want visibility and transparency from their nursing leadership' (p 7).

Role Ambiguity and Role Overload

Role ambiguity and role overload have also been identified as sources of stress during role transition and have been linked to organisational dynamics and subsequent job dissatisfaction and turnover. Many research studies, as far back as the 1970s, show a relationship between role ambiguity and voluntary turnover.[32–35] According to some authors, role ambiguity was more influential than role conflict in an individual leaving the organisation. In general, 'role ambiguity occurs when people are unclear or uncertain about their expectations with their role in a job or workplace or lack of clear, consistent information about the behaviour expected in a role' (p 23).[36]

There are two types of role ambiguity in relation to the uncertainty felt by the individual: (1) objective ambiguity, which arises from lack of the information needed for

goals.[35] Studies with registered nurses have shown, in all relationships, that role conflict or role ambiguity was a basis of negative influence, causing decreased job satisfaction.[11,32,34,36]

Role ambiguity is often increased by the fact that each ward is a specialty unit in an organisation and has different personnel and unique patient management. New graduates not only have to adjust to the nursing role, but also adapt to the transition within complicated social networks. Role ambiguity can be further compounded by role overload, when graduates lack skills in handling role demands, establishing priorities and allocating their time wisely.[11,32,35]

The author of this chapter conducted two longitudinal surveys on role stress in her dissertation.[11] The first survey showed that role overload and ambiguity were negatively related to job satisfaction in the first few months of employment. However, in the second survey, role overload was not significantly related to job satisfaction. Despite the overload prevalent in the role of registered nurses, many of the graduates did not relate this to job satisfaction after 11–12 months of employment. It appears to be easier for graduates to deal with role overload after the first year of employment. This may be a reflection of the graduates' coping abilities and experience gained in their role, which can ultimately make a difference in dealing with problems in the work environment.[11,37]

Factors Affecting Role Transition

According to a major Australian study undertaken by Madjar and colleagues[28] in 1997, but which is still relevant today:

> *how well and how quickly newly graduated nurses are able to demonstrate mastery of their new role, acting in a safe, competent, sensitive, and confident manner, depends on a range of factors. In broad terms these may include:*
>
> - *personal qualities of each beginning registered nurse, including age, maturity, previous work experiences, motivation, aspirations, and availability of personal supports;*
> - *the quality and extent of the educational preparation, including the nature and duration of structured clinical experiences during the pre-registration course, and the quality and rigour of formative and summative assessments within the course;*
> - *the quality and duration of orientation/transition programs for new graduates provided by employing institutions;*
> - *the expectations, attitudes, reactions, and behaviour of more experienced clinical nurses, nurse managers and other staff toward new graduates, the role modelling of expected behaviour by more senior nurses, and the prevailing ethos of the institution;*
> - *the exigencies of clinical situations, staffing levels, and other demands placed on the registered nurse.* (p 3)

The complexity of the process of transition is illustrated by the many factors that

to nursing. However, it is reassuring to note that the majority of participants in a study by Kramer[27] reported that the transition process was worthwhile and culminated in 'a sense of satisfaction and personal achievement' (p 79).[27]

NEW GRADUATES: SKILLS AND STRENGTHS

Against this background of challenges and difficulties, it is important to acknowledge the skills and strengths that new graduates have on entry to the workforce.[11,36] In a major longitudinal study of new graduates this author[11] conducted in New South Wales, Australia, both nursing unit managers and graduates believed that the graduates were well prepared in three main areas: (1) communication skills with patients; (2) psychosocial assessment skills; and (3) accountability for their actions.

These areas of strength were consistent with the findings of several other researchers, who found that graduates excelled in identifying patients' psychological needs and in communicating with them. Even though greater competency was thought to be needed in the development of technical and clinical skills, both graduates and their managers considered the overall performance to be adequate and felt that their education had been quite sufficient in preparing them for the job. Over time, graduates felt more confident and demonstrated significant improvement in performance. This may well have been expected, but strong significant improvement was observed across all areas of their role. In addition, nursing unit managers rated the overall performance of the graduates more positively compared with hospital-trained nurses. The graduates had mostly positive feelings about their tertiary program and perceived that it had provided them with a theoretical background to care for the multidimensional needs of their patients – not only physical needs, but economic, spiritual and psychosocial needs as well.[11,31,36,37]

Other research studies[11,29] show that, over a period of time, graduates were working more autonomously, establishing relationships with their clients, and coping with their new role. They saw the importance of their professional role, including as a health teacher, a provider of care, a communicator, an advocate, a coordinator of care and a decision maker as well as being able to make suggestions for changes in practice. These values are consistent with findings from studies in Australia and overseas that have examined the professional or value systems of graduates.[11,31,36,38,39] Skill acquisition was an important issue for many graduates as they progressed from novice to advanced beginner.[20]

STRATEGIES TO FACILITATE TRANSITION

Several strategies have been shown to be of use in easing the transition from student to new registered nurse. Cooperation between service and education plays a key role in the success or otherwise of many of these strategies. Many experts in nursing believe that:

> *the key to bringing respective expectations [i.e. those of providers of BNE and clinical nursing services] into line with each other ... [is] the establishment of a more cooperative framework in which higher education and health agencies*

In relation to specific strategies, a positive preceptor relationship, adequate support systems and assignment congruence have been shown to have positive outcomes in the first 6 months of employment as a new registered nurse.[40,41] Preceptorship programs are one practical strategy offered to reduce culture shock and to assist new registered nurses in the integration of theory and practice. There is extensive literature on preceptorship programs.[40,41] One version of this strategy is called the professional nurturance preceptorship program, which can be jointly sponsored by healthcare and tertiary institutions. Reports of graduate nurse preceptorship programs have demonstrated that these programs are an effective means of facilitating the transition process for new graduates, including clinical learning. Such programs could also be incorporated as a subject in the final year of undergraduate nursing courses. During the preceptorship experience, the student is guided by the registered nurse preceptor in caring for appropriate patients. Initially, preceptor and student work closely together; as students develop greater confidence and competence, they are given more autonomy in patient care. A similar approach can be used with the experienced nurse preceptor and the new registered nurse.

Many important variables make the work environment either positive or negative for graduates. The key factors that appear to facilitate successful transition include a supportive environment that accommodates incremental development in clinical skill acquisition and patient management skills.[5,22] A graduate nurse who is assigned too many patients within a short timeframe may not be proficient enough to provide for patients' physical and psychosocial care. It is crucial that the workload is structured to provide opportunities for newly registered nurses to see the effective outcomes of their work.[11]

In the practice environments that accept new graduates in nursing, there needs to be ready recognition of, and support for, the fact that learning, especially clinical learning, is a lifelong process. Another positive influence on transition is preparedness and commitment by experienced registered nurses to value and nurture new registered nurses as they move through the transition process.

The first national Review of Nurse Education carried out in Australia (in 1994) made specific recommendations about transition support for beginning graduates of nursing. Relevant recommendations include that:

> *graduates be provided with employer-funded assistance for transition to employment, including appropriate induction and orientation activities, peer support and mentoring as appropriate, and introduction to specific clinical requirements ... [and] where relevant infrastructure is not available (for example in rural and remote areas), funds be made available to provide appropriate levels of support.* (p 21)[40]

Some employers appear to be high performers in the way they manage new graduates entering employment. Consequently, several hospitals and community

Knowing how to provide patient care is not enough for new graduates, although this is a complex process requiring appropriate exposure and clinical learning. It is important that nurses can manage job stressors successfully. Health professionals, including nurses, need to learn how to care for themselves in order to care effectively for their patients. This requires a balanced approach to all facets of life and stress management skills.[2,11,37]

It is important to raise issues of concern during transition with appropriate colleagues and support systems. Discussion of these issues will lead to the identification of appropriate ways of managing problems early. This approach can be invaluable in reducing anxiety and stress and facilitating successful adjustment to nursing practice.

Quality of work life is a concept that is gaining currency, and health service providers need to address it to ensure adequate recruitment and retention of nursing staff. Sources of dissatisfaction in clinical nursing have been found to include inadequate staffing patterns, conflict with other healthcare providers, lack of support in dealing with death and dying, unresponsiveness in leadership, poor communication among staff and poor administration.[44–47] There is a clear need for leaders in nursing education to work with leaders in nursing service to develop short- and long-term strategies to promote and ensure sustainable nursing. This will require attention to a number of factors and processes that influence commitment to nursing; for example, socialisation programs affect the general satisfaction of staff and their feelings of autonomy and personal influence.[11]

It is important that senior students in undergraduate nursing courses and new registered nurses anticipate the issues and challenges associated with transition. By building knowledge and understanding of these phenomena, it is possible to plan to manage the transition period.[27] Managing involves the selection of a range of strategies designed to facilitate positive adjustment to the professional registered nurse role.

CONCLUSION

All graduates of nursing courses will experience a degree of culture shock on entry to the world of clinical practice. This experience is complex and multidimensional. Research has uncovered several issues and challenges that confront new graduates on entry to the workforce as registered nurses. In addition, several strategies have been found to be useful in easing the stress and strain associated with transition. Careful planning and use of resources in the practice environment can also facilitate positive adjustment to employment as a registered nurse. Nursing education and nursing service need to monitor the transition process continually to optimise the number of new registered nurses who manage this phenomenon successfully and go on to enjoy fulfilling, rewarding careers in their chosen profession.

ACKNOWLEDGMENT

CASE STUDY 1.1

William Michaels, who just completed his Bachelor of Nursing program, has been accepted to undertake a graduate program in a public teaching hospital in a few weeks' time. He has been informed that his first placement will be in a respiratory medical ward. He is very excited, but at the same time apprehensive and anxious, about starting his new role as a registered nurse. He knows he could draw on his tutorial notes at university as well as the literature and other resources available to him. In this situation, William considers the following questions in preparing to develop his plan for transition to registered nurse.

REFLECTIVE QUESTIONS

1. What do we know and understand from the literature about factors influencing transition?
2. What strategies have been found to be successful in assisting a new registered nurse to adjust to practice?
3. What types of resources can be accessed to facilitate individual transition?

CASE STUDY 1.2

Alannah Bella, a clinical specialist in a surgical ward, has two new registered nurses starting work in her clinical area. She was asked by her nursing unit manager to develop an orientation program that will assist them in adjusting to their new roles and responsibilities.

REFLECTIVE QUESTIONS

1. What advice could you give Alannah Bella to assist the new registered nurses regarding their overall needs?
2. What topics would be helpful to the new registered nurses in the orientation program? What is the rationale for your choice?
3. How could Alannah Bella prepare her senior and junior registered nurse colleagues to meet the support needs of these new registered nurses?

CASE STUDY 1.3

Geraldine Lynn is a new registered nurse who has worked in aged care for over a year. She is keen to extend her learning in the dementia care unit. She wants to have a better understanding of dementia in aged care facilities and there are many residents diagnosed with mild and moderate dementia.

REFLECTIVE QUESTIONS

1. With whom should she discuss her possible change of placement to the dementia care unit?
2. What skills and competence does she need in this area?

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CHAPTER 2

Becoming a competent, confident, professional registered nurse

Jill White

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- develop an understanding of the complexity of the development of practice knowledge
- appreciate the deeply contextual nature of professional practice knowledge
- understand the transformation in skill acquisition from novice to expert
- construct a personal plan for reflective practice
- develop a positive perception of yourself as being on a career-long journey of your understanding of nursing practice.

KEYWORDS: competent, confidence, reflection, professional development, unconscious bias

INTRODUCTION

On graduation, one of the hardest things to come to terms with is the apparent discrepancy between the way you, as a new graduate, see a clinical situation and the way an expert nurse might see it. At university, the focus seemed to be on understanding the signs, symptoms and diagnoses, and making decisions through the exercise of 'clinical judgment'. This usually involves breaking the situation down into understandable, 'bite-sized' pieces and then reintegrating them. Experienced nurses rarely seem to do this in their practice. 'How do I get from where I am now to that sort of confidence and competence?' is a question that, as a new graduate, you may sometimes find yourself asking. 'Why didn't my university studies prepare me properly for the real world?', 'And what is this competent/competence/competency anyway?'

COMPETENCE IN NURSING PRACTICE

the university will have assessed you in the classroom and in clinical practice against the Registered Nurse Standards for Practice.[1] These standards are the benchmark of the minimum level of competence necessary for registration with the Nursing and Midwifery Board of Australia. There are seven standards:

1. *Thinks critically and analyses nursing practice.*
2. *Engages in therapeutic and professional relationships.*
3. *Maintains the capability for practice.*
4. *Comprehensively conducts assessments.*
5. *Develops a plan for nursing practice.*
6. *Provides safe, appropriate and responsive quality nursing practice.*
7. *Evaluates outcomes to inform nursing practice.* (pp 1–2)[1]

However, university can do only part of the job of preparing a confident, competent professional nurse. It is in the nature of the acquisition of practice understanding that it takes layer upon layer of personal clinical experiences to move towards competence in the practice reality of nursing, as opposed to assessment of 'competence' following graduation from university and the beginning of practice as a registered nurse.

The complex conditions of the early 2020s have disrupted the normal transition from university to registered nurse practice for many. New graduates have been called upon to enter the turmoil of the clinical world without supervised graduate programs and without the staffing levels commensurate with the best early learning experiences. You did it, you coped, and you saved lives, but it took a toll on your learning and processing. You became highly skilled in working quickly but you also recognised that the care you gave might have been different had you had more time and more resources. It is with the refreshing of the health services that the nursing voice must demand what we know from evidence to be necessary, not only for safe and effective patient care, but also to foster the development of the next generation of confident, competent registered nurses. Hopefully the worst crises are over, and it is now time to explore what this transition should entail and to assess what has been missing. By reflecting on this experience, you can identify and remediate any gaps in learning you may have as you progress on your path to expert clinical nursing practice.

SKILL ACQUISITION

The cardinal work of Patricia Benner,[2] despite its age, still provides us with the most useful map for understanding the notion of skill acquisition within practice. Benner's work was a refinement and application of the work on skill development by Dreyfus and Dreyfus,[3] who developed this schema by studying airline pilots and chess players. From this study, Dreyfus and Dreyfus came up with five levels of skill acquisition: (1) novice; (2) advanced beginner; (3) competent; (4) proficient; and (5) expert. (Yes, there is that word again. It is very confusing when the word 'competent' is used by so many to mean so many different things.)

approached your first few clinical practice experiences?

The advanced beginner has coped with sufficient clinical situations to have grasped what to do in a global sense and can demonstrate what Benner[2] describes as 'marginally acceptable performance'. It is still difficult for advanced beginners to be really sure of what is important in a situation, and rapidly changing situations or subtle changes often elude them. This time the question is not 'Do you remember this?', but 'Do you recognise this?'. Benner suggests that new graduates are advanced beginners and that they remain so until they have spent upwards of a year-and-a-half in one type of clinical setting, at which time they reach Benner's level of skill acquisition of 'competent'.[4] She further states that transferring to a very different clinical environment brings the nurse quickly back to advanced beginner status, despite expertise in another field of nursing.

The biggest jump in practice skill development occurs between the competent nurse and the proficient one, as this represents a move in cognitive grasp from perceiving aspects of a situation to perceiving the situation as a whole. It is at this stage that it becomes easier to tell whether a patient is moving along an expected path or subtly into difficulties.

The movement through the levels of skill acquisition is characterised by

> *a movement from reliance on abstract principles to the use of past concrete experiences; a change in the learner's perception of the demand of the situation, in which the situation is seen as less and less a compilation of equally relevant bits, and more and more as a complete whole in which certain parts are more relevant; and a passage from detached observer to involved performer.*[2]

The expert involved performer is defined by Benner as one who

> *no longer relies on an analytic principle to connect her or his understanding of the situation to an appropriate action. The expert – with an enormous background of experience – now has an intuitive grasp of each situation.*[2]

But hang on, isn't intuition the thing that we have without formal education – the 'just knowing' that is demonstrated so well by adolescents?

INTUITION

Two of the most confusing words that are constants in the new environment of work are 'competence' and 'intuition', and trying to gain a sense of shared understanding about them seems difficult.

'Intuition' is an often used, frequently misunderstood word – we use it colloquially to mean 'undifferentiated gut feeling' and at other times very specifically to mean 'expert clinical judgment'. One of the main confusions in looking at this concept is that we do not often stop to explore and ensure that our use of the word is received with shared meaning.

within nursing by Benner and others.

The key aspects that Dreyfus and Dreyfus[3] saw as representing this intuitive judgment were:

- pattern recognition – similarities and links with previous experiences
- similarity recognition – 'fuzzy' resemblances, similarities despite differences
- common-sense understanding – knowing the practice setting and its patterns
- skilled know-how – mastery of the job
- sense of salience – recognition of some events as more important than others
- deliberative rationality – exploring what might stand out as significant if one's perspective were changed.

It is obvious when we look at these aspects of intuitive judgment that they are predicated on deep contextual knowing of a practice situation. So, it is time to be kind to yourself, and to think of this as an opportunity to look at how you can best take advantage of your new clinical access to begin to gather and mentally file your repertoire of pictures of clinical situations, rather than being harsh with yourself about what you do not know.

If we accept that there is an important component of expert practice that has, for good or ill, been called intuition, we return to the question of how we differentiate this from the more colloquial use of the term. The work of Belenky and colleagues, in *Women's Ways of Knowing*,[6] may be helpful here. This research was influenced by the work of Kohlberg[7] and Perry,[8] two key figures in our understanding of psychological development, and by Gilligan's[9] critique of these works as gender-distorted, as they were developed studying only men.

As a result of their extensive research with women, Belenky and colleagues[6] found that the women's positions were better represented as five – rather than Perry's four – ways of knowing, and that women have a position previous to Perry's first level. The researchers called this level 'silence', where women perceive themselves as having no voice at all. The five ways of knowing are:

1. Silence: nothing worth saying.
2. Received knowledge: listening to the voices of others and holding them as 'true' – 'black-and-white' thinking.
3. Subjective knowledge: the inner voice – personal opinion.
4. Procedural knowledge: the voice of reason, of what is known.
5. Constructed knowledge: integrating the voices. Here it is possible to hold a personal opinion, having considered the available literature and being aware of the multiple other positions that might be held on the subject.

The reason for introducing this work here is that it provides us with a strong point of differentiation between the various ways in which the word 'intuition' is used. The chapter in *Women's Ways of Knowing* on subjective knowledge begins with the words of a young mother, Inez:

There's part of that I didn't know I had until recently instinct, intuition,

In this stage of subjective knowledge things cease to be clear-cut, and personal freedom and personal opinions are asserted. Inez continues:

> *I can only know with my gut. I've got it tuned to a point where I think and feel at the same time and I know what is right. My gut is my best friend – the one thing in the world that won't let me down or lie to me or back away from me.*[6]

We do not wish to denigrate this powerful personal knowing. It is a deep point of inner strength on a journey of knowing, but it is a private knowing and, as such, has the limitations of 'small sample size and limited generalisability'; it also suffers the inevitable influences of potency of an experience and recency of experience. First-hand experience and the intergenerational stories of those in close private spaces are critical to the development of this knowing. It is the 'feel-right' component of knowing, for example, one's children. It seems not dissimilar to the knowing described by Tanner and colleagues[10] in their early work on 'knowing the patient', with its in-depth knowledge of the patterns of responses and the knowing of the patient as a person. (We return to knowing the patient later.)

Such personal knowing is the agency of maternal authority and is therefore not to be ignored. It is the unwise nurse or doctor who does not listen to the mother's report on her child's condition and, particularly, on subtle changes in condition. The mother knows her own child but would not be in a position to make a judgment on the child of another mother. The knowing needs to be understood and responded to as highly contextually confined.

In moving to procedural knowledge, there is a profound shift – a shift to appreciating the fallibility of gut feelings and the importance of shared knowledge and understanding that can be gained without direct experience of an event. Seeing outside our own frame of reference characterises this stage – setting personal experience within the context of extant knowledge of an informed community.

How, then, do we gain access to understanding something that we have not or could not experience directly? This is the research and theory base of the procedural knowledge of Belenky and colleagues[6] and represents the theoretical and research base provided by formal education. It includes work such as the meta-analyses being undertaken by groups like the Cochrane Collaboration, with their user-friendly outcome summaries detailing those practices that reduce negative outcomes, those that appear promising, those that have unknown effects and, most importantly, those that should be abandoned.

The issue here for practice and practitioners is not necessarily the lack of research and theory but that of having practitioners incorporate the research findings into practice, particularly those identified as 'should be abandoned'. Procedural knowledge gives the novice-to-competent nurse a basis for determining what can be wrong, what can go wrong and what can be done. This then allows the nurse to enter the clinical

at this time, in this circumstance? Inherent in this is an element that we might call 'knowing the patient'. This, importantly, is where you find yourself now.

KNOWING THE PATIENT

In later refinements of the concept of expert practice, Tanner and colleagues[10] took Benner's notion of 'involved performer' and explored it further through what they called 'knowing the patient'. They saw this as a precursor to the exercise of intuitive judgments and therefore to moving from the stage of competent to that of proficient or expert nurse. Two specific elements to 'knowing the patient' were found: 'in-depth knowledge of the patient's responses' and 'knowing the patient as a person'.

In-depth knowledge of the patient's patterns of responses included responses to therapeutic measures, routines and habits, coping resources, physical capacities and endurance, and body typology and characteristics. This was illustrated by the following clinical exemplar:

> *you look at this kid, because you know this kid and you know what he looked like two hours ago. It's a dramatic difference to you but [it] is hard to describe that to someone in words.*[10]

Knowing the patient as a person, on the other hand, was seen as the need to be able to know the person outside his or her present situation, particularly where the patient was a baby or an unconscious adult:

> *I had never ever spoken to this man, but I grew to know him because of the family, because I became real close to his wife and son and knew what he was like before.*[10]

An extension of this work, by Liaschenko and Fisher,[11] gave even greater clarity to this notion. They suggested there are three types of knowledge, which they call 'case', 'patient' and 'person' knowledge. Case knowledge is that generalised knowledge that we were just discussing. The two types of particular interest here are patient and person knowledge. These are differentiated as follows.

Patient knowledge includes knowledge of how the individual is identified as a patient, how the individual responds to therapeutics, how to get things done for the person within and between institutions and what other providers are involved in the care of the person. This places the person in the context of healthcare and treatment as an individual.

Person knowledge is knowledge of personal biography. Person knowledge is a potent reminder that the life lived is the life of the recipient of care. Nurses use their person knowledge to defend their arguments for an alternative management of disease trajectories and to justify their actions when those actions support an individual's agency, even though this can conflict with established biomedical or institutional courses of action.

interprofessional collaboration broke down. They found that 'collaboration broke down when doctors dismissed nurses' concerns because they did not fit into a schema of case knowledge'. Managing the confused patient was seen as a problem to be solved by nurses, as it requires 'knowing the patient' in order to be able to respond to the person's particular behaviour, and 'making sense' of behaviour is made possible when one could put it in the context of the specific person – that is, through having patient knowledge.

Liaschenko and Fisher[11] elaborated on the importance of social knowledge that links patient knowledge to person knowledge. They stressed the importance of understanding illness trajectories that go beyond the health system and into the world of the person who is the patient. This includes knowledge of:

- the social conditions in which the recipient lives
- the impact of the particular disease on the individual's ability to function and manage his or her disease in a variety of contexts
- the stigma attached to a given disease
- the degree to which the individual takes up the dominant cultural discourse about his or her particular disease.

This type of knowing is helped by providing opportunities to walk in the shoes of the other, and can be accessed through storytelling, by novels or books with accounts of illness experience, through poetry and in movies. These sources provide us with profound glimpses into the experiences of others, and increase our personal repertoire of knowing and therefore our readiness to interact appropriately with others. This knowing can be elaborated by narrative analysis and by research using a variety of interpretive methodologies.

Understanding culture and its relationship to power, politics, language, identity, family and land connection is an essential part of knowing the person. It includes exploration of whose voices are privileged and whose voices are silenced. It seeks to expose and explore alternative conceptions of reality. Ramsden's[13] ground-breaking work on cultural safety developed in New Zealand (*kawa whakaruruhau*) offers nursing the opportunity to explore its practice in relation to cultural recognition, respect and nurture. This dimension of our nursing knowledge is now being developed in Australia and presents a considerable challenge.[14,15] This challenge is posed to all nurses by the Council for Aboriginal and Torres Strait Islander Nurses and Midwives (CATSNaM). We can enhance our cultural/political understandings through research grounded in critical theory such as action research, by critical ethnography, by feminist studies or by discourse analyses, but the fundamental element of cultural understanding is knowing oneself and challenging 'taken-for-granteds'. Brookfield,[16] although writing over three decades ago now, made the point in a way we have not seen bettered when he stated that 'coming to realise that every belief we hold, every behaviour we cherish as normal, every social or economic arrangement we perceive as fixed and unalterable can be and is regarded by others as bizarre, inexplicable, and wholly irrational'. Much has now been written about unconscious bias, a concept critical to nursing practice. Recognising our unconscious biases enables us to work towards mitigating them and thus to provide a more equitable healthcare experience for our patients.[17 18]

enable the nurse to have a body of experience on which to draw 'intuitively' when faced with any of Dreyfus and Dreyfus's aspects of intuition – pattern recognition, similarity recognition, common-sense understanding, skilled know-how, sense of salience and deliberative rationality.

This is the experience described by Benner[2] and Schon.[5] It is experience that incorporates reflective practice. They both speak of experience as not simply being time spent in a situation, but rather as new understandings that come when taken-for-granted and expected happenings are disturbed through reflection during action or reflection on action. In Benner's words,[2] experience results when 'preconceived notions and expectations are challenged, refined, or disconfirmed in the actual situation' or, as she and her colleagues elaborate in a later text:

> *Experience, as defined here, is not the mere passage of time but rather is an active transformation and refinement of expectations and perceptions in evolving situations. The nurse shifts from exclusive use of objective characteristics and quantitative measures as guides to understanding and action with particular patients. Clinical reasoning is based on understanding patient changes through time – that is reasoning through transitions.*[4]

This work has clear implications for organisational work practices of relevance to new graduates, particularly in terms of consistency of work environment and stable ward staffing to facilitate the development of collegial trust and the authority that comes with trust. It holds implications, too, for the introduction of models of care delivery that enhance opportunities for continuity of care and carer, a continuity that enables a very thorough 'knowing [of] the person'.

Work environment stability has been severely challenged in recent years by fires, floods and a pandemic. Health services have been stretched to near breaking point, and nurses have been the backbone of the ability of those services to continue to offer care, albeit in ways we never imagined. New graduates and even final-year students have, as acknowledged earlier, become part of the workforce in ways that challenge any notion of 'being thrown in at the deep end', and it is critical that those of you experiencing this have opportunities to process what you have experienced, intellectually and emotionally.

In refashioning health systems nursing has much to offer. Our deep research into what enables the person who is the patient to be placed at the centre of care and into the ratios of nursing staffing that enable this care to be provided should form the basis for new directions in healthcare reform.

Professor Brendan McCormack and his colleagues[19] have developed a theoretical framework for understanding person-centred care. This framework is predicated on the work of Benner, Tanner and colleagues, Liaschenko and others, and captures organisational and staffing issues as well as those of nursing skill acquisition. The framework has four central constructs:

3. person-centred processes, which focus on the activities through which care is delivered
4. expected outcomes, which come from effective person-centred nursing.

The attributes of the nurse that form the prerequisites of McCormack and colleagues[19] include 'being professionally competent; having developed interpersonal skills; being committed to the job; being able to demonstrate clarity of beliefs and values; and knowing self'.

The care environment elements that affect person-centred nursing include 'appropriate skill mix; systems that facilitate shared decision-making; the sharing of power; effective staff relationships; organisational systems that are supportive; the potential for innovation and risk-taking; and the physical environment'.[19] These elements are heavily dependent on skilled nursing leadership and an open and inquiring organisational culture. They influence the nurse's ability to know the patient and to observe and gain feedback from skilled colleagues.

Person-centred processes require working with the person's beliefs and values, sharing decision making and providing holistic care. The outcome of these processes should be the creation of a therapeutic environment within which the patient and family are satisfied with their care.

It is clear, then, that if the goal of nursing is the creation of a therapeutic environment in which patients receive safe, appropriate and quality care with which they are satisfied, developing the attributes described above is an essential step – that is, becoming a competent, confident, professional registered nurse.

REFLECTIVE PRACTICE

This brings us to perhaps the most potent of all aspects of your continued learning: reflective practice – the key to learning from experience. Much has been written about the importance of reflection for the developing practitioner, most notably by Schon,[5] but it has been elaborated on within nursing by many. Reflective practice is the subject of Chapter 18 but is referred to briefly here, as it is critical for acquiring practice skills and moving towards expert practice. Johns[20] provides an excellent example of the transformation from novice to expert learning through reflective practice by using Belenky and colleagues'[6] ways of knowing, as described earlier. This will give you a clear exemplar of this movement in thinking to the constructed voice or, as Johns calls it, 'whole brain stuff using both hemispheres to marry logic, reason [and] analysis with creativity, curiosity and perception'.[20] Johns and his colleagues provide models of reflective practice and examples from practice to guide you in developing these skills. Reflective practice has never been more important, given the relative and sometimes real chaos of clinical environments recently. These tools will be extraordinarily useful in helping you look back critically on what you did and how you did it, on how it may have affected people and on what else could have been done, on what you would do differently next time and what you have learnt from the experience.

Belenky and colleagues[6] call 'constructed knowledge'. *Constructed knowledge* is the integration of the voices, obliterating the spaces between private and public knowing: 'weaving together the strands of rational and emotive thought and of integrating objective and subjective knowing'.[6] The real learning of artful practice is gained through intelligently watching our own practice and that of others, and reflecting during and on that practice. This highest level of knowing, necessary for the development of expert practice, makes possible the very difficult work of the experienced, expert nurse, who is often called upon to make judgments with imperfect and often contradictory information and to do so in a time-bound manner.

CONCLUSION

Bringing together intuition from our private life experiences (subjective knowing) and theoretical understanding through research undertaken in the public domain (procedural knowing) in their fullness through practice-based experience allows us to gain the other type of intuition – expert clinical practice, but let us call it what it is, the best of constructed knowledge in action – practice wisdom.

Bring forward the best of your theoretical learning as it has been modified and tested through your clinical experiences to date. Combine it with the layer upon layer of clinical pictures you are beginning to collect and collate, enrich these through reflection on what you have learnt and are learning, deeply engage with your patients and colleagues and be open to changing your current understandings of the meaning of illness, pain and suffering. You are ready. You are at the beginning of the rest of your journey towards being a competent, confident, professional registered nurse. Here is the best bit: the journey can last for as long as you choose to practise. The gaining of wisdom is a never-ending journey. Go well.

CASE STUDY 2.1

Astrid is the senior nurse on the general medical surgical ward to which Hamed has been allocated for his second new graduate rotation. After dinner one evening, Mr Falter in bed 1 appears unwell and is complaining of epigastric pain but says it is just his heartburn playing up again. Hamed reports this to Astrid, who moves quickly into assessment action and appears to be taking the situation very seriously. And indeed, within a matter of minutes Mr Falter has suffered a heart attack. When the team have time to debrief later during the shift, they discuss the differences in what they saw, what it may have signalled and what action they would have planned.

REFLECTIVE QUESTIONS

1. Take a few minutes at the end of a shift to write a brief account of a critical incident in which you were involved that day, one in which an experienced nurse also took part.
2. When you have finished your account, ask the experienced registered nurse to recount his or her recollection of the event and what he or she saw as the most significant aspects. How did your accounts differ? Why might this be so?

CASE STUDY 2.2

Harriet Preacher is a 35-year-old woman from Roseville in Sydney. She was admitted to your hospital last night and is currently in the intensive care unit. She was admitted via ambulance after an episode of lack of consciousness, followed on arousal by complaints of severe neck and head pain. On scan, she was diagnosed as having had a small bleed from an aneurysm, which was clipped in theatre prior to admission to the ward. Mrs Preacher has a picture of two children beside her bed and they appear to be a boy and girl in their early teens. She is currently being visited by her husband Sean, who tells you that she is very upset at missing the children's school drama production this evening and that she has asked Sean to bring her in some food to replace the hospital food, which she says is flavourless.

REFLECTIVE QUESTIONS

1. Which pieces of the above information are examples of 'knowing the patient' using Liaschenko and Fisher's topology: case knowledge, patient knowledge and person knowledge?
2. Explore your clinical work on your next shift and note examples of case knowledge, patient knowledge and person knowledge.
3. In what ways do these different ways of 'knowing the patient' help you to determine the basis for your care?

CASE STUDY 2.3

Asham has been a registered nurse for 4 years and loves his job. He consistently volunteers to help mentor new graduates and staff who are new to the area. Patients respond really well to him, and the feedback the nursing unit manager receives is always that Asham is a nice person and an excellent communicator. He leads the 'essentials of care' team in the values clarification exercises, having already completed the facilitator's course, of which introspection and personal values clarification are inherent parts.

REFLECTIVE QUESTIONS

1. Assess Asham in terms of his attributes for engaging in person-centred nursing. What other information would you want to know before completing this assessment?
2. In McCormack and colleagues'[19] person-centred nursing framework, give yourself a score out of five for the 'prerequisites' or 'attributes' of the nurse:
   - professional competence
   - interpersonal skills
   - commitment to the job
   - clarity of beliefs and values
   - self-knowledge.
3. Studying these results, what actions might you take to increase your score so that it is closer to five out of five?

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CHAPTER 3

Becoming part of a team

Tracy Levett-Jones and Lorinda Palmer

LEARNING OBJECTIVES

When you have completed this chapter, you will be able to:

- identify the different teams in healthcare and the attributes of well-functioning teams
- describe effective strategies for becoming a part of the healthcare team
- outline how well-functioning teams impact patient safety and how dysfunctional teams can cause harm
- reflect on the importance of belonging to the healthcare team
- discuss the positive and negative implications of striving to belong to a healthcare team.

KEYWORDS: team, belonging, patient safety, communication, collaboration

INTRODUCTION

In this chapter, we explore the strategies that graduate nurses can use to become effective members of the healthcare team. The importance of teams and teamwork – both to you as a graduate nurse and for the patients you care for – is discussed, and we share some practical strategies that you can use to develop your communication and collaboration skills.

For newcomers to a clinical setting, a feeling of belonging to the team does not happen overnight. It gradually develops as you become increasingly familiar with your role and the roles of other team members, and when you experience a sense of alignment between your own professional and personal values and those of the team. This chapter discusses the phenomenon of belonging and explores how a judicious approach must be used when weighing up what you will and will not do to 'fit into' the team.

TEAMS IN HEALTHCARE