Transitions in Nursing continues to offer motivating discussion and insight into the issues and challenges faced by senior students when making the transition to nursing practice. This highly respected text brings together a team of academics and clinical practitioners of the highest calibre.

Two new chapters, Clinical Leadership and Continuing competence for practice, strengthen the text and reflect recent changes in clinical practice, policies, procedures and National Registration requirements — all other chapters have been fully revised and updated. Themes covered include learning to work in teams, understanding organisational structure, stress management, communication with patients and families, and professional development strategies.

Transitions in Nursing will stimulate interest in theory and concepts while providing the reader with strategies that can be tested and applied in practice.

NEW TO THIS EDITION
- key issues of reflection, resilience, preventative care and safety are emphasised throughout
- new chapters: Clinical leadership and Continuing competence for practice
- restructured into three sections:
  - Section 1: From Student to Graduate
  - Section 2: Skills for Dealing with the World of Work
  - Section 3: Organisational Environments

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Welcome to the third edition of Transitions in Nursing: Preparing for professional practice. As with the first and second editions, this book has been developed to assist undergraduate students, new registered nurses and other professionals interested in issues and challenges associated with the transition from higher education to practice. For the majority of 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, internationally, for decades. The literature shows 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 has shed much light on the issues associated with transition and has uncovered knowledge and strategies that can be useful in managing the process.

The book has been designed to provide comprehensive information on key issues associated with transition. Readers will find viewpoints that are challenging and sometimes disconcerting, but at the same time motivating and thought-provoking. The third edition is divided into three sections. Section 1 examines issues from student to graduate nurse. Section 2 looks at skills for dealing with the world of work. Section 3 discusses the organisational environment. This edition also includes two new chapters in the area of clinical leadership and continuing competence for practice.

Understanding the context in which we work is crucial to effective functioning in the workplace. Knowing how to provide care for patients and their families in the health system is not sufficient: we need to learn how to care for ourselves in order to care for our patients effectively. The exercises and learning activities that appear throughout the book offer readers a range of helpful suggestions in understanding the nursing context, managing stress and caring for themselves. In addition, each chapter includes recommended readings, case studies and reflective questions for further exploration.

Our intention was to involve clinicians and academics in producing a resource which is scholarly, accessible, reality-based and practical. More importantly, it is a resource for every student, practising nurse, educator and administrator in understanding the issues of transition for new registered nurses. By reading the book, reflecting on the issues and posing possible answers, readers should be able to gain a comprehensive view of the issues, challenges and opportunities ahead of them. The journey during this period can be rewarding with implications of a long-term career for new nurses, particularly when educators, administrators and clinicians collaboratively anticipate and manage the socialisation process.

We extend our sincere appreciation to the contributors to the work for their shared interest and concern with the issues and challenges of transition from student to registered nurse. This book would not be possible without them. We are thankful.
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Chapter 1

Managing the transition from student to graduate nurse

Esther Chang and John Daly

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, education, 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 humour and the tragedy of other people’s

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TRANSITIONS IN NURSING

lives’ (p 1). Englert, a leader in 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:

I believe that the situation of our nursing students and new graduates today is not so very different. Their motivations in entering nursing are much the same as were ours. They too share an idealism based on the desire to help their fellow human beings, an apprehension 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.1

The nursing profession in Australia and elsewhere continues to be concerned with the process of transition for graduates of undergraduate nursing courses on entry to the world of clinical practice.2–6 This concern exists for several reasons. It has remained an issue of concern in nurse education in Australia because of ongoing changes in the clinical practice environment; research data which continue to show that it is a period which can be stressful5; and related questions about adequate preparation of new graduate nurses.

One 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 a number of innovations, including the development of more sophisticated clinical simulation teaching and learning environments.7 The impact of such innovations on clinical competence of graduates in the health professions will require ongoing research and evaluation.

These challenges are international, particularly in developed countries which are struggling with health sector reforms, cost containment challenges, the growing burden of chronic disease, ageing populations and human resources for health issues. In the USA, a provocative and scholarly report for the Carnegie Foundation for the Advancement of Teaching called recently for a reinvention of preregistration nursing education.8 The authors’ argument is based on a number of factors, one dimension being the relevance of current models of undergraduate nursing education in the present-day context of health system re-engineering. The Council of Australian Governments recently established Health Workforce Australia which has a role to play in creating solutions to clinical education challenges (www.hwa.gov.au). It has a concern with ‘improving and expanding access to quality clinical training for health professionals in training across the public and private and non-government sectors. This will be achieved through funding programs which expand capacity, improve quality, reform delivery systems and offer diversity in learning opportunities’ (p 2).9

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 phenomenon that we are currently witnessing in Australia and overseas. In Australia and New Zealand supply will continue to be a problem because of our ageing workforce and ongoing undersupply of graduates in many areas.10 It is important to note that this supply and demand imbalance is an international problem.
Managing the transition from student to graduate nurse

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 worklife for nurses and other health professionals, and on the quality of patient care. Nursing leaders are currently investigating these issues and searching for strategies to enhance the quality of undergraduate clinical education, the image of nursing as a career, transition for new graduates, quality of worklife and the recruitment and retention of qualified staff in the nursing workforce.

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. In Australia nursing education has undergone rapid transformation since the late 1980s. The system of basic nurse education (BNE) is now university-based with 3-year degree programs leading to eligibility to register as a nurse. In addition, the national healthcare system has undergone radical change in the last decade in particular. 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.

To date, the Australian government has commissioned two national reviews of undergraduate nurse education since the national shift of BNE from hospital schools of nursing to the higher-education sector. The second review (the Heath report) was published in 2002. Two major matters of concern uncovered by the first national review committee were ‘the adequacy of clinical education provided during pre-registration nursing courses and the best means of facilitating the transition from higher education to work’ (p 4). The first national review of BNE made a number of recommendations designed to enhance the quality of educational endeavours in both these areas and outcomes for course graduates and nursing services providers. These concerns remain and were also considered by the second national review and the Australian Senate inquiry into nursing. The National Nursing and Nursing Education Taskforce, which was established to implement the recommendations of the Heath report, and which concluded its work in 2006, also considered the issue of transition. In the Heath report, transition was addressed through recommendation 14, standards for transition programs. It was recommended that:

- to ensure consistency and quality in the development and delivery of transition programs a national framework be developed for transition to provide guidelines and standards for institutions. State and territory nursing registration boards should accredit transition programs; employing institutions should be responsible for meeting the standards (p 22).

Preregistration nursing courses today need to prepare graduates for a work environment that has undergone enormous change in the last decade. The practice environment is constantly changing and this has implications for the type of knowledge and skills that new graduates will require. University schools of nursing are constantly
challenged to ensure that 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 universities and nursing service sectors.14

University schools of nursing aim to prepare flexible, critical thinkers for the practice of professional nursing. They emphasise individual client- or patient-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. In many surveys, however, 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.12 Nursing service providers often report that new graduates ‘are inadequately prepared for clinical practice in that they are deficient in certain skills’ (p 17).14 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.15 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 to perform at this level, and for the majority of new graduates this is an unrealistic and difficult expectation.

Nursing has a long history of anti-intellectualism,16 and at one time it was believed that nurses who are too academic tend to be hamstrung when it comes to clinical practice. Paradoxically, many authorities argue that contemporary nursing requires intelligent, flexible, critical thinkers and problem solvers who are able to demonstrate the ability to deliver safe, competent care in a range of environments. Many of the environments in which nurses work are highly complex and demand higher-order cognitive skills. The ability to ‘do’ is prized in clinical nursing – this is understandable to a large degree but there has to be acceptance of some middle ground in debates about these issues. Nursing requires adequate theoretical preparation and competence in clinical practice. Conway and McMillan17 argue that the transition from student to graduate and practitioner requires the development of the ability to examine critically our own and others’ practice and be accountable for our own actions. These abilities are often linked to the idea of being a lifelong learner and are seen as increasingly important to professional nursing practice in the 21st century.

It is important, therefore, that new graduates are provided with support, tolerance, patience and encouragement as they learn to assimilate values, beliefs and practices acquired in their undergraduate education with the practice values and beliefs that are dominant in the clinical work world. 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 professional
Managing the transition from student to graduate nurse

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). Perhaps the key to successful negotiation of this phase is 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 place greater emphasis on the clinical area as a place where learning is ongoing and a lifelong process.

A survey of the table of contents in 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 a number of themes: managing self in clinical practice; caring for self; understanding the forces that shape the practice environment; 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 reciprocal process by which the neophyte nurses learn what others will demand of them in a specific role and, in turn, learn to exert control over their new environments’ (p 1). Myers and Arbor describe this process as one of ‘give and take’, a process through which new registered nurses ‘learn to behave as nurses in the hospital setting’. It is through this process that the new nurse learns to behave ‘according to the culturally prescribed rules and standards’ of the clinical work world (pp 120–1). Corwin 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’. Marlene Kramer, a nurse researcher, first recognised the problem in 1966. The difference between professional and bureaucratic role conceptions is a source of conflict for the nurse. The strong dissimilarity in the expectations of these two systems often gives rise to nursing role conflicts.

Most studies of transition for new registered nurses have shown that there are challenges and difficulties associated with the process. Common reactions to initial employment as a registered nurse include:

- physical and emotional exhaustion;
- a sense of inadequacy;
- frustration;
- loss of ideals and, at the extreme, the abandonment of nursing as a career. In other cases, where they have received support and encouragement and advice from more experienced nurses and from their own peers and families, initiation into the world of nursing is reported to be less stressful.
Common problems that surface during transition include the theory–practice gap, limited proficiency in managing and executing technical procedures, time management, drug administration, patient assessment and report-writing skills. 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.

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. A common issue for new graduates in many studies was having inadequate staff and time to complete all client care. What also appears to be operating for many new registered nurses is the fact that they are having to adjust not only to the registered nurse’s role, but also to the health service organisation. 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. This need to care for others well has been found to be related to personal satisfaction, as has appreciation for one’s efforts.

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. According to some authors, role ambiguity was more influential in an individual leaving the organisation than role conflict. In general, role ambiguity is defined as the lack of clear, consistent information about the behaviour expected in a role.

There are two types of role ambiguity in relation to the uncertainty felt by the individual: the first type is known as objective ambiguity, which arises from lack of the information needed for role definition and role performance; the second type is subjective ambiguity, which is related to the social–psychological aspects of role performance. This occurs where individuals are concerned about how others perceive them in relation to attainment of their personal goals.
have shown, in all relationships, that role conflict or role ambiguity was a basis of negative influence, causing decreased job satisfaction.\textsuperscript{11,44,49}

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 time wisely.\textsuperscript{11,50,51}

Chang\textsuperscript{11} conducted two longitudinal surveys on role stress. 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. In spite of 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 1 year of employment. This may be a reflection of the graduates’ coping abilities and experience gained in their role that can ultimately make a difference in dealing with problems in the work environment (p 140).\textsuperscript{52}

Factors affecting role transition

According to a major Australian study undertaken by Madjar and colleagues in 1997\textsuperscript{12}:

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).\textsuperscript{12}

The complexity of the process of transition is illustrated by the many factors that can influence individual experience. For most new graduates this is a time of stress and strain, learning and assimilation. It is also a time of upheaval and adjustment affecting all aspects of life (p 79).\textsuperscript{12} During this time decisions are made about a long-term commitment to nursing. It is reassuring to note, however, that the majority of participants in the study reported that the transition process was worthwhile and culminated in ‘a sense of satisfaction and personal achievement’ (p 79).\textsuperscript{12}
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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. In a major longitudinal study of new graduates by Chang 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 more 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 adequate 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.

Other research studies 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 being a health teacher, a provider of care, a communicator, an advocate, a coordinator of care, a decision maker and making suggestions for change in practice. These values are consistent with findings from studies in Australia and overseas which have examined the professional or value systems of graduates. There is also evidence of greater skill acquisition in relation to assessing clients more quickly and in giving advice to other staff. Skill acquisition was an important issue for many graduates as they progressed from novice to advanced beginner.

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 both contribute to improvements in clinical practice and in the graduate’s transition to work (p. 5).

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. Preceptorship programs are one practical strategy offered to reduce culture shock and to assist new registered
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nurses in the integration of theory and practice. There is extensive literature on preceptorship programs.29,58–62 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 which accommodates incremental development in clinical skill acquisition and patient management skills.14 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.

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).13

Some employers appear to be high performers in the way they manage new graduates entering employment. Consequently, a number of hospitals and community settings appear to function as ‘magnets’ for new registered nurses on the basis of the reputation they have built up for supporting and developing new graduate nurses. Other research has found that the attitudes of staff and a welcoming and positive environment also encourage graduates to adjust to the workplace.63,64

Knowing how to provide patient care is not enough for new graduates, although this, in itself, is a complex process requiring appropriate exposure and clinical learning. It is important that nurses are able to 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
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 worklife 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.65,66 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.

Other factors known to facilitate transition include:
- formal unit orientation programs that incorporate realistic goals13,64
- a unit climate of open communication and timely provision of constructive feedback on performance64,67,68
- assignment congruence, i.e. not being given tasks beyond the new graduate’s sphere of competence60
- participative, democratic governance69,70
- appropriate guidance from senior staff71,72
- continuing staff development opportunities73
- the provision of support and counselling for new employees68
- using personal strategies such as exercise or recreational activity to reduce stress levels.52

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.12 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 a number of issues and challenges that confront new graduates on entry to the workforce as registered nurses. In addition, a number of 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.
CASE STUDY 1.1
Jane, a final-year third-year student in a Bachelor of Nursing program is preparing a plan to assist her in moving into a registered nurse role. She is apprehensive and anxious to excel in her new role. She knows that she can prepare for transition by drawing on the literature and other resources available to her. In this situation Jane considers the following questions in preparing to develop her transition plan.

REFLECTIVE QUESTIONS
• What do we know and understand from the literature about factors influencing transition?
• What strategies have been found to be successful in enhancing transition to practice?
• What types of resources can be accessed to facilitate individual transition?

CASE STUDY 1.2
Geoff, a nursing unit manager in a cardiac step-down unit, has a number of new graduate registered nurses starting work in his clinical area. He needs to develop an orientation program that will assist them in adjusting to their new roles and responsibilities. What advice could you give him regarding the needs of the new graduates?

REFLECTIVE QUESTIONS
• What specific topics could be covered in the program and why?
• How could Geoff prepare his senior registered nurse colleagues to meet the support needs of the new graduates?

CASE STUDY 1.3
Mary Anne is a new graduate registered nurse, who has worked in an aged care unit for 6 months. She is keen to enhance and extend her level of competence in the area of dementia care.

REFLECTIVE QUESTIONS
• What professional competency frameworks can she access to meet her needs?
• How can she document and validate her learning needs and develop competence for this area of practice?

RECOMMENDED READING
TRANSITIONS IN NURSING


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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 on a career-long journey of refining understandings of nursing practice.

Keywords: competent, competencies, confidence, reflection, professional development

INTRODUCTION
On graduation one of the hardest things to come to terms with is the apparent discrepancy between the ways you, as a new graduate, see a clinical situation and the way it seems from the outside to be apprehended by an expert nurse. At university the concentration 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 at times as a new graduate you ask yourself with anguish. Why didn’t the university prepare me properly for the real world? And what is this competent/competence/competency anyway?

COMPETENCE IN NURSING PRACTICE

At university, nursing programs focus on the development of competence as meaning the ‘skills, knowledge, attitudes, values and abilities that underpin effective … performance in a profession/occupational area’ as defined in the Nursing and Midwifery Board of Australia competencies document National Competency Standards for the Registered Nurse, commonly referred to as the Australian Nursing and Midwifery Council competencies. These are a set of minimum competencies accepted by the national registration authority in Australia as core standards for registration. They are a means by which expectations of standards of nursing practice can be communicated within the profession, across health professions and to consumers.

There are currently 10 competency standards involving responsibilities related to four domains. These domains are: (1) professional practice (including practising ethically and within the law); (2) critical thinking and analysis (including professional development, and valuing and using evidence and research); (3) provision and coordination of care (including coordination, organisation, comprehensive assessment and the provision and evaluation of care); and (4) collaborative and therapeutic practice (including professional relationships with individuals and groups, and communication and collaboration within interdisciplinary healthcare teams). By now you will be familiar with these as they will have been the benchmarks against which you will be or will have been assessed in the clinical environment to be competent prior to graduation.

University, however, can only do 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.

SKILL ACQUISITION

The cardinal work of Patricia Benner provides us with a 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, 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’s that word again. It’s very confusing when the word ‘competent’ is used by so many to mean so many different things.)

The novice in Benner’s work has no experience of a situation and requires context-free rules to be available in order to make sense of what would otherwise be an impenetrably messy, undifferentiated situation. Remember what it felt like when you approached your first few clinical practice experiences?
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The advanced beginner has coped with sufficient clinical situations to have grasped what to do in a global sense and can demonstrate what Benner 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’. 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 is moving 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.

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.

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 of 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 major confusions in looking at this concept is that we don’t often stop to explore and ensure that our use of the word is received with shared meaning.

In a systematic review of the literature on intuition within the discipline of nursing from 1981 to 2006, Rew and Barrow devised the following definition from the literature:

A way of knowing something immediately as a whole that improves with experience, informs their judgements and decisions, and leads them to take action within the caring relationship.

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We have all heard people say they ‘just knew’ something, that they had a ‘gut feeling’, but what is it that distinguishes the type of intuition ascribed to the expert practitioner and that ‘knowing’ that we refer to as naive, mystical thinking or simple prejudice? Intuition is not something commonly regarded as descriptive of expert behaviour and yet in the clinical literature it is often seen as the hallmark of expert practice. Perhaps if we look at the practice-focused literature on intuition we may find a clue.

The term ‘intuition’ appears to have entered the clinical literature in the 1980s with the work on skill development in practice by Dreyfus and Dreyfus and within nursing by Benner and others.

The key aspects that Dreyfus and Dreyfus 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 think of this as an opportunity to look at how you can take best 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 don’t know.

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

As a result of their extensive research with women, Belenky et al. 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. This Belenky called 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.

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The reason for introducing this work here is that it provides us with a strong point of differentiation between the 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 a part of me that I didn’t know I had until recently – instinct, intuition, whatever. It helps me and protects me. It’s perceptive and astute. I just listen to the inside of me and I know what to do.7

In this stage of subjective knowledge things cease to be clearcut and personal freedom and personal opinions are asserted. Inez goes on to say:

> 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.7

I don’t want 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 et al.11 in their early work on ‘knowing the patient’, with its indepth 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 doesn’t listen to the mother’s report on her child’s condition and, particularly, on subtle changes in condition. This mother knows her 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.

As an aside, an interesting difference in the wording of subjective knowledge and Perry’s second level, called multiplicity, is the masculine assertion, ‘I have a right to my opinion’, contrasted with the less confrontational position, ‘It’s just my opinion’. The qualification ‘just’ characterises women’s description of their intuitions, as does the description of the ‘feeling’ component.

In moving to procedural knowledge there is a profound shift – a shift to appreciating the fallibility of gut feelings and of the importance of shared knowledge and understanding which 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 directly experience? This is the research and theory base of the procedural knowledge of Belenky et al.7 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 for practice and practitioners here is not necessarily the lack of research and theory but the issue of having practitioners incorporate the research findings into practice, particularly those identified as ‘should be abandoned’. Procedural knowledge gives the novice-to-competitive nurse a basis for determining: What can be wrong? What can go wrong? What can be done? This then allows the nurse to enter the clinical field with a framework of generalised knowledge from which to personalise and contextualise for a specific patient: What should be done for this person, 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 et al.\textsuperscript{11} 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: ‘indepth knowledge of the patient’s responses’ and ‘knowing the patient as a person’. Indepth 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.\textsuperscript{11}

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.\textsuperscript{11}

An extension of this work by Liaschenko and Fisher gave even greater clarity to this notion. They suggest there are three types of knowledge, which they call case, patient and person knowledge. Case knowledge is that generalised knowledge which we were just discussing. The two 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, the individual’s responses to therapeutics, how to get things done for the person within and between institutions, and a knowledge of other providers 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.

Stein-Parbury and Liaschenko\textsuperscript{12} took this concept further when exploring the collaborative work of nurses and doctors in the intensive care context. They used the classifications of case, patient and person knowledge to analyse situations in which 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, i.e. through having patient knowledge.

Liaschenko and Fisher elaborated the importance of social knowledge that links patient knowledge to person knowledge, and here they stressed the importance of understanding illness trajectories 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 of accounts of illness experience, through poetry and in movies. These 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 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. Here Ramsden’s\textsuperscript{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 holds much challenge.\textsuperscript{14,15} This challenge is posed to all nurses by the Council for Aboriginal and Torres Strait Islander Nurses. 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,\textsuperscript{16} although writing over two decades ago now, makes the point in a way I’ve not seen bettered when he states: ‘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'.

Knowing the patient at all three levels of case, patient and person allows the nurse
to accrue layer upon layer of clinical pictures and patient responses which, on reflec-
tion, enable the nurse to have a body of experience on which to draw ‘intuitively’
when faced with any of Dreyfus and Dreyfus’ aspects of intuition, i.e. pattern recog-
nition; similarity recognition; common-sense understanding; skilled know-how; sense
of salience; and deliberative rationality.

This is the experience described by Benner and Schon. 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 with a disturbing
of the taken-for-granted and expected happenings through reflection in action or
reflection on action. In Benner’s words, experience results when ‘preconceived
notions and expectations are challenged, refined, or disconfirmed in the actual situ-
aton’ 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 quantita-
tive 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.

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
the very thorough ‘knowing the person’.

McCormack and McCance have developed a theoretical framework for person-
centred nursing which is predicated on the work of Benner, Tanner et al., Liaschenko
and others and captures these organisational and staffing issues as well as those of
nursing skill acquisition. The framework has four central constructs:

1. prerequisites, which focus on what they call the ‘attributes’ of the nurse
2. the care environment, which focuses on the care context
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 which form McCormack and McCance’s prerequisites
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 which 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’. These ele-
ments 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 the provision of holistic care. With the above in place the outcomes should be manifest by 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 are 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 to the developing practitioner, most notably by Schon, but it has been elaborated on within nursing by many. Reflective practice is the subject of a chapter of its own (Ch 19) but is referred to briefly here as it is critical to practice skill acquisition and movement towards expert practice. Johns and Hardy provide an excellent example of the transformation of novice to expert learning from practice through reflection by using Belenky et al.’s ways of knowing, as described earlier. This will give you a clear exemplar of this movement in thinking. Rolfe is also helpful here as he provides a framework for different levels of sophistication of reflective thinking. These he calls descriptive, theory–knowledge building and action-oriented reflection. Descriptive reflection asks the question: what? What happened? What was my role? What was the response? Theory–knowledge building reflection asks the question: so what? What does this teach me? What was I thinking? What could or should I have done better? Action-oriented reflection asks the question: now what? What do I need to do to improve care?

There are many texts that will assist you in gaining reflective practice skills. Two of the most accessible ‘how to’ books are Bev Taylor’s Reflective Practice and Lioba Howatson-Jones’ Reflective Practice in Nursing, where the skill development options are extensively laid out. Both books assist you to write, draw, meditate, use a diary – to do whatever will help 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.

Deep engagement in clinical practice, deep connection with patients in their circumstances and deep reflection on the process are the essential ingredients of what Belenky et al. 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’. The real learning of artful practice is through the intelligent watching of the practice of ourselves and others and reflecting in and on that practice. This highest level of knowing, necessary for the development of expert practice, allows 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 gains 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. Bring them together 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’s 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
Sally is the senior nurse on the general medical surgical ward to which Jane has been allocated for her second new graduate rotation. After dinner one evening, Mr Falter in bed 1 appears unwell and is complaining of epigastric pain but says it’s just his heartburn playing up again. Jane reports this to Sally 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 Jane and Sally have time to debrief later that shift they discuss the differences in what they saw, what it may have signalled and what action they would have planned.

REFLECTIVE QUESTION
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. When you have finished your account, ask the experienced registered nurse to recount his or her recall of the event and what he or she saw as the most significant aspects. How did your account 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

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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 as the hospital food is flavourless.

Which pieces of the above information are case knowledge, patient knowledge and person knowledge?

REFLECTIVE QUESTION
Explore your clinical work on your next shift and note examples of ‘knowing the patient’ using Liaschenko and Fisher’s topology: case knowledge, patient knowledge and person knowledge.

In what way do they each provide different aspects of the information on which you base 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 really respond well to him and the feedback the nursing unit manager receives is always that he is such 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.

Assess Asham in terms of his attributes to engage in person-centred nursing. What other information would you want to know before completing this assessment?

REFLECTIVE QUESTION
In McCormack and McCance’s patient-centred nursing framework, give yourself a score out of five for the ‘prerequisites’ or ‘attributes’ of the nurse:
1. professional competence
2. interpersonal skills
3. commitment to the job
4. clarity of beliefs and values
5. self-knowledge.

Studying these results, what actions might you take to increase your score so that it is closer to 5 out of 5.

RECOMMENDED READING
TRANSITIONS IN NURSING


REFERENCES
2 BECOMING A COMPETENT, CONFIDENT, PROFESSIONAL REGISTERED NURSE