Learning During the First Three Years of Post Registration/Postgraduate Employment – The LiNEA Project

INTERIM REPORT FOR NURSING

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EXECUTIVE SUMMARY

Introduction

This report describes some of the data obtained from newly qualified nurses about their learning and development in their first posts. It covers the first two years of a four-year project and includes data from the nurses’ preceptors/mentors and managers. The main themes have been selected from these data in order to facilitate the next ‘action’ phase of the research. This forms part of a project that also involves engineers and accountants in their first posts and reports are also being produced for these groups. At this stage, we will discuss with our employer partners any changes they might wish to take forward on the basis of the data and how the research should monitor such changes.

The aims of the whole project are: to identify what is being learned in the workplace, how it is being learned, the factors affecting the level and direction of learning, as well as the use and extension of prior knowledge and generic skills brought into employment from higher education and other life experience.

The objectives of the project are to contribute to evidence-based practice in the management and support of newly qualified employees; to further knowledge of learning in practice in the workplace; and to develop understanding of the transition from higher education into employment.

Methods

Design

The research is in three parts:

1. Observation of newly qualified nurses at work in the wards and interviews with them, their managers and preceptors/mentors. There are four workplace visits over a three-year period. The same pattern of visits is undertaken in the engineering and accountancy sectors. During this period, the interim report of the fieldwork is produced for employers.

2. An action research project, to be implemented in the 3rd and 4th years of the study, in collaboration with employers, that builds on the findings of the fieldwork. This stage involves visiting a new sample of novices who are going through the changes resulting from the action research.

3. A study of the transition from higher education into employment, in relation to technical knowledge and generic skills.

Sample

Four NHS Trusts are involved in the Project, with a total of eight individual hospitals in London and the South East. The sites include small, district general and large inner city hospitals, serving different populations.

40 nurses were recruited for the initial interview and observation process. They
had trained in ten different locations, but the majority (n=32) had trained in teaching hospitals affiliated with universities. Only one trust was able to provide an accurate list of the location of newly qualified nurses, so novices were usually traced via ward managers and everyone identified was invited to take part. All those who agreed were recruited to the Project. Participants worked in fifteen specialist areas at the time of the first visit. They had been in post for between two and fourteen months, with the majority between five and seven months.

For each newly qualified nurse a manager and/or preceptor/mentor was sought for interview during the workplace visits. In total 28 managers and eight preceptors/mentors were interviewed.

**Observations and Interviews**

38 observation periods from one to six hours were carried out, two newly qualified nurses were not observed where circumstances were inappropriate.

Interviews lasted from 30 minutes to two hours. Questions about the nurses' experiences in their first post included the change of role from student to staff nurse, the support they received and felt that they needed when they started work, their working context and how they organised their work. Managers and preceptors/mentors were asked about their roles in relation to supporting newly qualified staff on the ward, their expectations of newly qualified staff at this stage of their career and how they assessed their progress.

**Findings**

**The transition from student to staff nurse** was typically seen by newly qualified nurses as being massive. At the start of their ward experience they recounted four main areas of concern: striving to achieve tasks, such as technical tasks like drug rounds; being accountable and responsible; ‘doing everything’; and getting to know new people and equipment.

1) To be actively engaging in a task was equated with successfully getting on with the job of being a nurse. They were concerned not to look inadequate and to make a good impression as competent nurses.

2) Novices felt responsible for the total care of the patient. In their relative inexperience, this was seen as a daunting task; especially as they believed that they must show that they could do everything well.

3) The increase in accountability and responsibility that came with the qualification was overriding since novices had not experienced them as students. They missed the safety net of having someone to ask without the burden of being ultimately responsible for the patients.

4) The new nurse wanted to get to know the ward, the members of the team and the routines, orient themselves within that setting and learn the language used there.

**Induction Processes and Support** varied enormously: at ward level, in staff development programme provision, allocation of supernumerary status, use of competency booklets,
allocation of preceptor/mentor and feedback on performance. How well the newly qualified nurses settled into their role was largely dependent on how supported they felt.

All 40 novices received some form of formal induction and they found this valuable. The induction usually consisted of formal lectures covering hospital policies and procedures, such as sickness and annual leave, plus mandatory training days to cover things like fire precautions, security and basic life support.

All trusts offered some form of staff development programme. However, only eleven novices were aware that such a programme existed. Study days were offered that allowed the novices to update their mandatory training skills and learn new ones, such as IV administration or venepuncture and cannulation. However, access to and attendance on, these study days were very much dependent on staffing levels and the busyness of the ward area.

Ward level orientation was provided for 21 of the 40 novices, but there was no consistency in its length and content. Those orientations seen as most helpful involved going to visit linked areas of the hospital to meet people whom the ward normally worked with. If the novices had worked on the wards previously as a student, then it was sometimes assumed that they had already met the staff in these linked areas and so visits were not repeated.

28 novices had supernumerary status when they first started on the ward and this ranged from one day to six weeks or longer. During this time, the novices usually worked alongside their preceptor/mentor or another member of staff, although some worked on their own from day one.

Ten novices were given a competency booklet to complete during their supernumerary time on the ward. However booklets were not always completed and competencies not always assessed, which could cause novices to doubt their abilities.

A preceptor/mentor was allocated to 35 novices. However, seven never actually worked with their mentor or had limited access to them in the clinical area, whereas others worked with their mentor consistently for their supernumerary period.

**Key elements of the Preceptor/Mentor role,** which enabled the novice to settle in more quickly at work and learn more, were that the mentor:

- **Spent time working with** the mentee in the clinical environment;
- **Showed an interest** in the mentee as a learner and in their development as a staff nurse;
- ** Trusted** the mentee to practice their skills and to ‘have a go’ in a safe environment;
- ** Actively questioned and challenged** the mentee in a non-threatening way, encouraging them to think about their practice; and
- ** Gave formal and informal feedback** on a regular basis, thus allowing the mentee to take stock of their progress.

A team approach to mentorship could be helpful, especially where there was high staff turnover.
Feedback on performance influenced how well supported novices felt. Again there was a lack of consistency. The nurses generally received informal feedback from their preceptors/mentors, seniors and colleagues, mainly by way of informal chats or passing comments.

Twelve novices had had formal appraisals with their ward managers/ward sisters and this involved discussing how they were settling in, their progress and setting objectives.

If managers/sisters showed little interest in the novices’ abilities and were unaware of their learning needs, then the novices felt lacking in direction. Lack of feedback also seemed to trigger feelings of self-doubt.

On occasion, ward staff inferred that novices were confident from their behaviour and thus erroneously assumed that feedback was not needed until a crisis showed otherwise. All the nurses needed some form of reassurance as to whether or not they were on the right track as this helped them to take stock of their progress. Constructive feedback helped them to reflect on their practice and to improve patient care. This has implications for sustaining their confidence and ultimately for retention.

Learning to Prioritise is a key aspect of nursing activity and managers agreed on its importance, yet it is a skill that few seemed to have on qualifying and is an important part of their further development. Going into nursing, novices expected to be caring for patients most of the time, whereas the reality was that there were a multitude of hidden tasks that they were expected to deal with, such as finding a patient’s drug chart, escorting patients to procedures and waiting for them, filling in forms, and waiting for doctors to call back after being bleeped. This may well be the reality that they have to get used to but, as new nurses with high expectations of themselves and insufficient comparative experiences to draw on, they were often overwhelmed and had less in reserve to cope with such circumstances, often ending up frustrated and blaming themselves for not doing their job properly. Being able to prioritise and accommodate changes in circumstances were an essential part of their learning. The main elements of prioritising were: knowing where to start, knowing what to look for; knowing what help is required or useful, and understanding how to proceed. Very few novices said that they were taught how to prioritise as students.

The novices who were past the initial stage of being overwhelmed by patient needs, learned how to prioritise their patient care from what they were told during handover at the start of their shifts, the ward routine, such as times of the drug round, and by watching other nurses on the ward. They needed to be able to recognise that something was wrong with a patient and give priority to passing that information on to a senior to deal with, rather than feeling that they should be dealing with the problem themselves. This was quite traumatic for some of the novices.

Prioritising abilities were difficult to learn in an environment of constant interruption from doctors, patients, and relatives, answering the telephone, dealing with queries, waiting for staff or equipment and changing the order of work to accommodate them.

Delegation had to be learned by novices who start by feeling that they should be ‘doing everything’ and completing all of the tasks that they see have to be done. They realised, after a couple of months that they needed to delegate to others, such as health care
assistants. This meant that they had to be able to distinguish between tasks that they could do and those that health care assistants could do.

**Learning skills** adopted by novices included asking questions, practising skills, using trial and error, demonstration, teaching others such as students, reflecting, and attending study days and courses.

**Asking questions**, seeking advice or checking with a more experienced member of staff was the most common way of finding out information, and it was often the quickest method. It relied on a ward culture in which it was 'safe' to do this.

**Practising skills** was said by some nurses to be the only way to learn, by doing it themselves, ‘having a go’ and picking things up as they went along.

**Trial and Error** was also mentioned, although this was not always the best method for learning and seemed to be in effect, learning in reverse after feedback from a mistake.

A demonstration of a procedure by a more experienced nurse, and then being supervised doing it themselves, was in a lot of cases a good learning experience for novices. This gave them the confidence to perform that skill alone.

**Teaching others** e.g. students was also something that helped the novices to learn.

**Reflecting** either individually or as a group was an important learning tool since this helped novices to look at their practice and see how they could improve things.

**Attending study days and courses** was also a good way of learning.

**Being challenged in the work** also determined how the novices learned, for example, having the opportunity to nurse patients with different conditions and dependencies. This could be done by rotations around different areas within the ward or going to different wards on a 6-month basis. The novices needed to be supported in order to do this.

**Being actively encouraged to question practice** enabled the novices to develop their confidence and use their own clinical judgement in situations.

Those novices who had been both challenged and supported seemed to be getting up to speed more quickly than those who were not challenged or supported.

**Doubting their abilities and a crisis of confidence** occurred in a significant proportion of novices at between four to six months into their first post. Some also said that at around this time, they came to a point where they found themselves still having difficulties prioritising and delegating, and began to doubt their ability to cope, and questioned whether they should be in nursing. This important stage needs to be recognised and help given.

At this point the whole question of feedback and acknowledgement of their efforts became absolutely key. Support from preceptors/mentors, managers and colleagues to confirm that their work was along the right lines and that they were doing a good job, gave them the confidence to continue in their efforts to learn the skills of prioritisation and delegation. Facilitators of this process included clinical supervision in company with peers, since they took comfort from knowing that other novices were going through the same thing.

Although this crisis of confidence can be experienced very negatively, it is a sign that newly qualified nurses are recognising a need to reassess how they are coping and that they need to delegate more effectively. Such crises are often the precursor to change and
can be a positive stage if handled well. It seemed that this was an opportunity for the novices to reframe, to take a good look at their job and reassess their position. Those who were supported were able to move on, to make progress and develop, whereas the learning of those who were not supported was delayed and 3 novices left their posts and sought employment elsewhere.

**Action Points**

**At trust policy level, senior managers need to:**
1. Be aware of the location of newly qualified nurses so support can be targeted and progress monitored.
2. Provide programmes of induction to the trust, which are evaluated by novices to ensure that they are covering what they need.
3. Ensure that novices are made aware of all staff development programmes offered; ensure that novices can attend the programme; and monitor that novices have attended and that it has met their needs.
4. At policy level novices should be supernumerary during their period of induction. But after this, supernumerary status by itself is not necessarily helpful unless structured and well supported.
5. A competency booklet can be helpful to learning provided that the competencies are followed up with constructive feedback.

**At ward level, nurse managers, preceptors/mentors and the nursing team in general should:**
1. Be aware of the concerns that newly qualified nurses have when they start work.
2. Be explicit about what they expect of newly qualified staff.
3. Incorporate visits to linked departments and personnel within the trust during the orientation period.
4. Provide a preceptor/mentor, who can be a positive support, which reduces the time taken to learn. Positive conditions for this are spending time working with the mentee, showing an interest in them and their development, trusting them to practice skills safely, questioning them constructively and giving feedback. If no one person can provide this, team mentoring has advantages.
5. Give regular, meaningful feedback to newly qualified nurses, regardless of their performance. This has implications for sustaining their confidence and ultimately for staff retention.
6. Give guidance to newly qualified nurses regarding prioritising their patient care e.g. after handover.
7. Encourage novices to ask for help within a supportive team.
8. Be aware that novices need help with delegating and be willing to talk about and share their knowledge.
9. Demonstrate procedures to newly qualified nurses to enable them to learn more quickly.
10. Ensure that novices are challenged, both by constructive questioning of their practice and also by exposing them to different aspects of patient care, which may involve rotation to different ward areas.
11. Novices’ crisis of confidence between four and six months needs to be recognised and help given, in for example prioritising and delegation, if those are at the root of the difficulty.
INTRODUCTION

The Purpose of this Report
The material in this report is based on a considerable amount of data gained from newly qualified staff (from nursing, engineering and accountancy) over a period of two years. The main themes have been selected from these data in order to facilitate the next ‘action’ phase of the research. At this stage we will discuss with our employer partners any changes they might wish to take forward on the basis of the data and how the research should monitor such changes. This report focuses on the nursing sector.

The Project comprises:
- Following 30 newly qualified nurses (40 recruited to allow for attrition), 30 trainee accountants and 30 trainee engineers through their first three years of employment.
- Four workplace visits to the novices over a three-year period to observe and interview them and talk to preceptors/mentors and managers.
- An action research project to be implemented in the fourth year of the study, building on the findings of the fieldwork. This stage will involve visiting a new sample of novices who are going through the changes as a result of the action research.
- A study of the transition from higher education into employment, in relation to technical knowledge and generic skills.

The Project’s Aims:
Are to identify what is being learned in the workplace, how it is being learned, the factors affecting the level and direction of learning, as well as the use and extension of prior knowledge and generic skills brought into employment from higher education and other life experience.

Outcomes of the Project will contribute to
- Evidence-based practice in the management and support of newly qualified employees;
- Theories of informal learning in ‘apprenticeship’ and other workplace contexts;
- Understanding of the transition from higher education into employment.

The Three Professions
Have been chosen because they play key roles in the UK economy and public services and they use contrasting approaches to professional formation. Trainee accountants and engineers are formally contracted trainees and as such, have systems of organised training support. Newly qualified nurses start full-time work with greater practical experience than accountants or engineers. However, their still substantial learning needs may be neglected. The UKCC (1999) proposed a properly supported period of induction and preceptorship when nurses begin their employment. This project will contribute evidence for decision-making about the induction’s content and emphasis, and data about longer term learning needs.

Theory and Methodology
Eraut et al’s (1998) study of mid-career professionals provides a conceptual and methodological platform for this research (See Appendix I). The project’s methodology
addresses the problems of accessing information on what people need to know at work. Chief among these problems are:

- Only knowledge acquired in formal educational settings is easily brought to mind, articulated and discussed;
- Tacit, personal knowledge and the skills essential for work performance tend to be taken for granted and omitted from accounts;
- Often the most important workplace tasks and problems require an integrated use of several different kinds of knowledge, and the integration of those components is itself a tacit process.

These constraints affect people's awareness of learning and their ability to recognise and articulate their personal knowledge and understanding which enables them to think and perform at work. Therefore the more researchers are able to ground conversations with informants in the actuality of daily working life (tasks, relationships, situational understandings, implicit theories etc), the greater the chance of eliciting information about the full range of what is being learned, how it is learnt, and the factors which affect learning, especially the informal learning of key skills such as team working (Miller et al. 1999).

METHODS

The data described here are derived from interviews with newly qualified nurses, their managers and/or their mentors/preceptors and observations of nurses at work in the wards.

Recruitment of the Sample
First MREC approval was obtained, which took several months, then the study sites for the main Project were chosen to reflect a wide range of workplaces and to include small, district general to large inner city hospitals, serving different populations. Four NHS Trusts are involved in the Project, with a total of eight individual hospitals in London and the South East. Participant nurses had trained in ten different locations but the majority (n=32) had trained in teaching hospitals affiliated with universities. Access to the study sites was negotiated with the trusts’ Directors of Nursing Services, who were all keen and interested to take part. Only one trust was able to provide an accurate list of the location of newly qualified nurses, so novices were usually traced through contacting ward managers and inviting everyone who was identified to take part. All those who agreed were recruited to the Project. Managers and preceptors/mentors associated with the nurse sample were recruited on the same principle.

Sample of Nurses
Our initial aim was to recruit 30 newly qualified nurses to the Project. However, owing to the longitudinal nature of the Project, we anticipated that staff would leave and move on within the four years. Therefore we over-recruited and visited a total of 40 participants for the initial interview and observation process.

Sample Characteristics
Participants worked in a variety of hospitals and in fifteen specialist areas at the time of the first visit: acute admissions (2), cardiac (5), digestive diseases (2), endoscopy (1), general
medical (8), general surgery (4), haematology & oncology (5), neurosurgery & neuro-medicine (3), orthopaedic (3), paediatric (2), recovery (1), renal (2) and urology (2).

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<td>Previously a student on 1st ward</td>
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**Table 1: Sample characteristics**

Four of the participants had nursing degrees, 36 had nursing diplomas and four had studied for GNVQs prior to their nurse training. Length of time in post at the first visit, age, sex and previous experience are given in Table 1.

**Sample of Managers and Preceptors/Mentors**

For each newly qualified nurse a manager and/or preceptor/mentor were sought for interview during the workplace visits. In total 28 managers and eight preceptors/mentors were interviewed.

**Observations**

Normally interviews with newly qualified nurses took place during the shift when they were observed (two exceptions with interviews the next day). Thirty-eight observation periods were carried out; two newly qualified nurses were not observed where circumstances were inappropriate. The observation period ranged from one to six hours depending on how comfortable the participants felt with the process. During this observation period the researcher shadowed the newly qualified nurse and took detailed notes. Interviews lasted from thirty minutes to two hours depending on time available and the busyness of the ward area.

**Interview Questions**

Newly qualified nurses were asked questions relating to their experiences in their first job. These included the change of role from student to staff nurse, the support they received and felt that they needed when they started work, their working context and how they organised their own work. Managers and preceptors/mentors were asked about their roles in relation to supporting newly qualified staff on the ward, their expectations of newly qualified staff at this stage of their career and how they assessed their progress.
FINDINGS

Transition from Student to Staff Nurse

For the majority of newly qualified nurses, the transition from student to staff nurse was ‘massive’. It seems formally that the transition happens overnight, with all the accountability and responsibility of being qualified thrust upon the novice staff nurse. But the personal transition takes longer; as N1 said:

“…Well, it doesn’t just change overnight, does it? You’ve got 3 years of being a student and it’s drummed into you that you are a student and to forget that overnight, and I know that I’ve learned a lot over the last 3 years, but it’s going on to the wards and you think ‘Oh my God, I don’t know anything’ and it’s like ‘aahhhh scary’…” (N1, 9m)

“…I just wasn’t prepared to do it, I didn’t feel qualified to do it even though I was qualified on a bit of paper I didn’t feel qualified at all…” (N35, 2m)

The feeling of ‘being out there on your own’ (N5) resulted in a number of worries and concerns that were raised in the interviews at the start of their ward experience. As time went on there was a settling in process and newly qualified nurses discussed the nature and levels of support that they needed and experienced.

Concerns

There were four main areas of concern to the novices: striving to achieve tasks, such as technical tasks like drug rounds; being accountable and responsible; ‘doing everything’; and getting to know new people and equipment.

Striving to achieve the tasks

Newly qualified nurses’ chief concerns were to settle in to the ‘new’ ward environment and to understand and carry out practical tasks successfully. The emphasis was on ‘doing’ for the patient, which superseded ‘being’ with the patient. The novices may be aware of their over-focus on a task but were unable to do anything about it at this stage as this quote illustrates:

“I think I’ve got better as I’ve been here longer but I know sometimes I’ll be doing things and like it could be a tracheostomy and you can be forgetting to talk to the person as well because you’re so concentrating on it, so you forget, you’re just dealing with that side…” (N3, 8m)

To be seen to be active and useful was what they expected of themselves and what they thought others would expect of them too. To be actively engaging in a task was equated with successfully getting on with the job of being a nurse. They were concerned not to look inadequate and to make a good impression as competent nurses, as one novice said:

Action Point:
Senior Managers need to be aware of the location of newly qualified nurses so that support can be targeted and progress monitored.

1 N1 indicates a newly qualified nurse with the number allocated being a research identification code. 9m indicates that the nurse had been working for 9 months when the first interview was undertaken. This numbering convention will be used throughout the report.
“I don’t think, no-one ever just sits down and says ‘By the way, you can ask for help’ well I suppose they do, they always do say ‘You can ask for help at any time’ we don’t, we see it as help as if you’re not coping, nobody wants to come across as though ‘Oh I’m not coping’ so we kind of take too much on, trying to work so hard, we run around so hard trying to complete all the tasks that are required for that whole day so it doesn’t reflect badly upon yourself, I think that’s the association, you feel it reflects upon me, my ability, ‘If I’m not coping and I’m having to ask for help, the other newly qualified aren’t, I’m the one who’s not very good’ there is a bit of competition (I: Is there) yeah I would say yeah because no-one wants to be like ‘Oh I’m really crap, you’re really good, I wish I could be like you’...” (N14, 10m)

The tasks that caused the most concern were technical tasks and doing drug rounds:

**Technical tasks**
Technical tasks such as putting in naso-gastric (NG) tubes and urinary catheters were anxiety provoking especially if the novice had only done it once or not at all in the past, as various novices commented:

“...Clinical skills basically...because I don’t think people did get enough clinical skills I mean for example myself, I’d put one urinary catheter in, I did one naso-gastric tube...and a few weeks ago I was expected to...put a naso-gastric tube down and y’know I’d only done one and I think things like that are important really, you need to know how to do these things, because especially...today as there is such a shortage, you haven’t always got people around that can talk you through all these things...” (N2, 9m)

“...Well definitely clinical skills I mean there is so much that I never saw in my training I mean because this idea of having home-bases for a year, one of my home-bases was an elderly care ward...they never did IM injections or a pump was a totally alien thing to them, we didn’t have anything like that so I wasted a whole year...” (N24, 5m)

Another novice illustrated the fact that, as a qualified nurse, she has certain expectations of what she should be able to do:

“ Well the expectations, peoples’ expectations of what a newly qualified nurse would be able to do because there were a lot of things that I felt I didn’t know like for example today was my first experience of catheterising someone and I don’t want people to think ‘Oh she’s a nurse, why can’t she do this?’...” (N38, 3m)

**Doing drug rounds**
Carrying out drug rounds, with the potential for harming patients and making mistakes, was clearly a concern for many:

“...I had to look at everything in the BNF, and I still do, it takes me forever and that’s why I’m way behind on the drug rounds, not that that’s a big thing but I constantly have to check up drugs, I’m not confident in my knowledge of them all so I just check with the pharmacist and the BNF but it just takes longer...” (N31, 6m)

“I was scared of doing some major error and really that no-one is watching what you’re doing scares you at first because you’re used to someone always checking what you’re doing and all of a sudden people are letting you just get on with it (laughter) so that was a bit scary at first but I think you just learn to be a bit more cautious than you ever were when you were a student so...” (N40, 5m)
“I was worried about doing drugs and doing IVs...I think it’s just the responsibility, knowing that if you do the wrong thing, you can do someone some serious damage...” (N46, 6m)

**Accountability and responsibility**

The increase in accountability and responsibility that came with the qualification were over-riding since novices had not experienced them as students. They missed the safety net of having someone to ask, without the burden of being ultimately responsible for the patients:

“...I think it was the added pressure of...being qualified and suddenly thinking ‘Oh my God I’m accountable for what I’m doing now’ and...I can’t just go up to a staff nurse and go ‘Oh I’m not quite sure if I’ve done the right thing here’ because as a student they’re always there to...pick up the pieces I suppose and I didn’t feel they were...anymore...” (N16, 6m)

“...it’s very, very different being a student to being a staff nurse, very different and it’s almost like some sort of shock to a certain extent when you’re a student you’re protected, they give you a couple of patients and they let you go early and if you don’t want to do things ‘Oh don’t worry about that I’ll do it’ and as a nurse, you’re flung in the deep end and you have to do it because there’s only you...” (N29, 6m)

“...the last eighteen months when I was rostered, that’s when I learnt the most but it just doesn’t prepare you for being a staff nurse because it is totally different, I can’t explain why but it is and you just feel that responsibility like in that first couple of weeks when you’re accountable for everything, you don’t even want to do a blood pressure because you’re scared...” (N47, 7m)

**Doing everything**

Novices did not know what their managers expected of them when they started work. They assumed in their relative inexperience that they should be doing everything. This was seen as a daunting task, especially as they believed that they must show that they could do everything well:

“When I first started I thought I had a lot to do and cope with on my own...I was allocated my 8 patients and I felt it was my responsibility to ensure that all those patients, I did all the work, I did all the observations, that if any of them had chest pain it was my responsibility to be there, to be taking control of that, doing all their ECGs, doing everything...” (N14, 10m)

“...at first it was quite difficult because you felt like you had to do everything, that was quite a big change...” (N26, 5m)

Responding to everything was also extended to the other activities in the ward as well:

'...when I first started I’d answer the telephone as it rang every time when I passed, if somebody else's buzzer went in another bay, I mean I’m not saying that I wouldn't do it now if it was necessary but I would be trying to do absolutely everything and it took me 3 or 4 months to realise that I couldn't do that...' (N3, 8m)

**Getting to know people & equipment**

Settling into the ward could pose anxieties about getting to know new people and where things were kept. In this context of anxiety and needing to focus on practising well, one of the first things the new nurse wanted to do was to get to know the ward and orient themselves within it; to learn the language used on that particular ward and how things were done there e.g. the ward routine and ward rounds. They also needed to get to know “who was who” in the nursing team and other members of the multi-disciplinary team.
Getting to know the doctors caused anxiety for a few nurses. This seemed to be related to the newly qualified nurses’ perceived lack of knowledge and credibility on the ward:

“...I found them [the doctors] really intimidating when I first started, it was horrible, sort of towards the end of my training and I was just beginning to speak to doctors and feeling confident and then when I came here and I had to do it there was no ‘Oh ask another nurse to do it’, I had to do it because I was the nurse so...and I don’t like talking on the phone as it is and to phone up another doctor it’s just, I don’t like doing it...” (N42, 5m)

Since the majority of new nurses had worked on the ward as students before qualifying, they were somewhat familiar with the ward area and routine and this eased their transition, as N19 stated:

“...I knew it was a nice ward, I wanted familiarity, I wanted to be able to come here and I knew everyone, and I knew the system or the way the ward worked...” (N19, 4m)

For those who had not worked on the ward before, understanding “just the way they do things” (N3) was more of an issue, and so more difficult to get to grips with, as one nurse said:

“It was a bit daunting because I didn’t know anything, I didn’t know the ward layout or anything...” (N47, 7m)

Knowing the location of equipment, forms and telephone numbers was mentioned. It seemed that the simplest things were often the most problematic, as N3 illustrated:

“...the most frustrating things are looking for where things are...and where bits of paper are kept...” (N3, 8m)

**Action Points:**

1. Ward managers should be aware of the concerns that newly qualified nurses have when they start work.
2. Ward managers should be explicit about what they expect of newly qualified staff.

**Induction Processes and Support**

This section covers induction to the trust, ward level orientation, supernumerary status and allocation of a preceptor/mentor, staff development programme, competencies and receiving feedback.

Induction processes and support varied enormously: at ward level, in staff development programme provision, allocation of supernumerary status, use of competency booklets, allocation of preceptor/mentor and feedback on performance. How well the newly qualified nurses settled into their role was largely dependent on how supported they felt. The kind and amount of support given to the nurses varied according to where they worked and the attitude of their ward manager/ward sister.

**Induction to the Trust**

All forty novices received some form of formal induction to the hospital in which they were working. The induction usually consisted of formal lectures covering hospital
policies and procedures such as sickness and annual leave, plus mandatory training days including fire, security and basic life support:

“I think I had about two weeks, you have a hospital induction which gets you all the paperwork signed, gives you all the basic training like fire training and things like that and then I had a week of oncology induction which was welcoming me to the ward, meeting all the different members of the multi-disciplinary team, sort of getting to know my bearings...” (N34, 9m)

“The week’s induction that we did was based in a classroom where you did your basic life support, your manual handling, your Glucometer training, your induction to the Trust, going through all different policies, saying what the Trust does for us, all that sort of thing...” (N46, 6m)

**Action Point:**
Programmes of induction to the trust are valued by novices and should be evaluated by them to ensure that they are covering what they need.

**Staff development programme**
All trusts offered some form of staff development programme. However, only eleven newly qualified nurses were aware that such a programme existed. Of these, two were on a rotational programme, which consisted of moving them to different wards every six months. Both programmes consisted of a series of study days that allowed the novices to update their mandatory training skills and learn new ones, such as IV administration or venepuncture and cannulation. However access to and attendance on these study days were very much dependent on staffing levels and the busyness of the ward area. A couple of novices also commented on the fact that they were not enrolled on such programmes despite them being available. They found this unfair, especially when peers with whom they had trained were enrolled and attending such days, as one novice commented:

“...I still haven’t done the D grade development which I think might be my fault but I’m not sure...I don’t know whether I’m beyond it now, whether I’ve been here too long to do that or not...I don’t know whether I was supposed to put myself on the study days or they were, I mean when I first started I said ‘Can I go on them?’ and Sister said that they were too short staffed and I couldn’t and then as staffing got up I just, I guess I forgot...but people that I trained with...keep going ‘You’re not on the development days’ and they all are but I mean when I talk to them, it’s their ward managers or facilitators that have put them on them, I don’t know whether I’m not being very proactive or they’re not, either way I think it’s a bit gone now...” (N16, 6m)

**Action Points:**
1. Managers should ensure that novices are made aware of any staff development programme offered.
2. Managers should ensure that novices are able to attend such a programme and monitor their attendance.
3. Novices should evaluate such a programme to ensure it has met their needs.
Ward level orientation

Of the forty novices, twenty-one had an orientation to the ward area in which they were working, but there was no consistency in length and content. Those orientations which were seen as most helpful involved going to visit linked areas of the hospital to meet people whom the ward normally worked with, such as the dietician, stoma nurse, outpatients and theatres. If the novices had worked on the wards previously as a student then it was sometimes assumed that they had already met the staff in these linked areas and so visits were not repeated when qualified. These visits were seen as valuable in order for the novices to get to know the people they would be working with on a regular basis.

“I’ve had 2 weeks induction where I wasn’t even working with the nursing team, I had a day in endoscopy...I spent a morning with the physiotherapist, a morning with the dietician, the stoma nurse, I did a day in theatres, a day in ITU, a day in recovery and then I did 2 morning shifts with my mentor...and it’s been good because it’s given me, like things that my patients can go through especially ITU because I think they get a lot of our patients up there” (N1, 9m)

**Action Point:**

Orientation to the ward should incorporate visits to linked departments and personnel within the trust.

Supernumerary status

Twenty-eight novices said that they were supernumerary when they first started on the ward but this ranged from one day to six weeks. Sometimes it was longer whilst novices waited for their registration documents to arrive. During their supernumerary time the novices usually worked alongside their preceptor/mentor or another member of staff, although some worked on their own from day one:

“I think I was meant to be supernumerary for the first 2 weeks...I don’t remember it happening …” (N32, 6m)

Competencies

Ten novices were given a competency booklet to complete during their supernumerary time on the ward. Such competencies related specifically to the area in which they were working and covered aspects such as taking a blood pressure or taking a patient back from theatre. Completing such competencies seemed to give the novices something to work towards and clarified expectations of them at this stage. However booklets were not always completed, and competencies not always assessed, which caused problems in terms of the novices doubting their abilities, something that N9 and N22 experienced:

“...when I first started, the clinical practice facilitator...was the person that was actually meant to go through the preceptorship booklet and every time we met she would say to me "We must go through the book, I must sign stuff off in your book." and never did...and so I did feel very unsupported when I first got here…” (N9, 7m)

“I’d not been formally assessed which is the biggest stumbling block that should be done at six weeks and we’re now coming up to six months and I haven’t been assessed yet…” (N22, 4m)

**Action Points:**

1. Novices should be supernumerary during their orientation period but after
this, supernumerary status by itself is not necessarily helpful unless well supported.

2. A competency booklet can be helpful to learning provided that it is followed up with constructive feedback.

Preceptor/Mentor

35 newly qualified nurses had preceptors/mentors allocated when they started work. However, they experienced a range of interaction. Seven never actually worked with their mentor or indeed had limited access to them in the clinical area (n=9), whereas others worked with their mentor consistently for their supernumerary period. The newly qualified nurses described the effects of having, or not having a preceptor/mentor relationship, which influenced how supported they felt, how they managed their transition from student to staff nurse and indeed what and how they were learning. Nineteen novices felt that their preceptor/mentor had fulfilled their needs, as N42 illustrated:

“I was given a mentor straight away and she was excellent, she showed me around, she would help me with my patients and everyone has just been really helpful, if you don’t know anything they’ll help you, if you’re feeling that you’re not doing something right, they’ll help you, they’re just really good here…” (N42, 5m)

If this was not the case then some often received the support they required from the rest of the nursing team.

Personalities played an important role in determining the success of the relationship, so if the mentor and mentee got on with each other then the novice settled in well and felt they were learning. This is illustrated by N3 whose mentor trusted her abilities and encouraged her to learn by having a go:

“…at the beginning when I was supernumerary…she made me feel confident because I felt that she trusted what I was doing…she would ask me to go and do things and then…trust me to do it therefore that made me feel more confident…” (N3, 8m)

Mentors who actively questioned and challenged the novices in a non-threatening way were also seen as positive since they encouraged them to think about their practice. This in turn helped their learning:

“…the way that teaching’s done on this ward is very much a two way discussion for instance asking questions ’What do you know about this and how does this work’, rather than verbally talking y’know this, this, this and this, it is very much getting you to think about what things are and obviously answering questions and things like that…” (N36, 3m)

If the mentor and mentee did not get on, then their working relationship was often strained and the novice took longer to settle in. N24 only had the opportunity to work with her mentor six months after starting because the ward was always too busy and short-staffed. However this supernumerary day did not turn out to be what she had expected because she felt ‘policing’ by her mentor:

“I thought…they were going to help me organise things more but they didn’t really stay with me they went off so they were in charge as well…she just kept coming up to me a couple of times
During the morning and saying “Have you done this, this and that” and I said ‘Yes’ and that was it really...” (N24, 5m)

Whether the mentor and mentee shared similar expectations about the relationship was also important. N29 had differences of opinion with her mentor regarding what her role, as mentor, should be and as a result never worked with them again:

“...I said to her in the first week...‘How does this work?’ ‘Do...we set up meetings...’ and...I always remember her reply she said ‘Oh...I’m not actually here to teach you, I’m here in case you get a problem...it’s not like when you were a student...I’m not actually here to teach you things...’ so I never asked after that...I don’t know what she thinks the role of the mentor is.” (N29, 6m)

Where a mentorship relationship was lacking, novices often looked to other members of the nursing team to provide them with the support they needed. Such informal support was conditioned by the ethos of the team, so if they felt able to ask basic questions in a low risk environment, for example:

“It would have been nice but, even though I didn’t have a preceptor, I’ve always felt that no matter what, even the most stupid question I can quite happily go and ask one of the other nurses here and they always...sometimes they’re busy and it might take a bit of time before they can come and help you out, but sooner or later they’ll always come and get you sorted...” (N28, 6m)

**Key Elements of the Preceptor/Mentor:**

It seems that there are certain elements that defined a positive mentor-mentee relationship and thus enabled the novice to settle in more quickly at work and learn more:

- **Time Together:** The amount of time the mentee spends working with their mentor in the clinical environment;
- **Interest:** The mentor shows an interest in the mentee as a learner and in their development as a staff nurse;
- **Trust:** The mentor allows the novice to practice their skills and to ‘have a go’ in a safe environment;
- **Questioning:** The mentor actively questions the mentee, encouraging them to think about their practice; and
- **Feedback:** The mentor gives formal and informal feedback on a regular basis, thus allowing the novice to take stock of their progress.

If one or more of these elements was present in the mentor-mentee relationship then the novice seemed to settle in well and learn from their mentor. If none or few of these elements were present then the novice felt that they ‘worked things out for themselves’ (N7) and in turn felt that it had taken them longer to learn things:

“I think it’s probably taken me longer [to learn things] but then there is still...the chance there that I can ask any of the nurses that have been here long enough to be able to answer my questions...” (N9, 7m)

“...I’ve probably had to find things out for myself a little bit more or I’ve probably had to ask things more than like be explained them...” (N21, 8m)

**Team mentorship**

In one ward area, team mentorship had been recently adopted because the poor staffing levels meant that there were not enough senior staff to mentor all of the new staff and
students. In another ward, within an inner city hospital with a high staff turnover, one novice had three mentors. This team approach seemed to share the burden, as this quote shows:

“...we’ve had a massive, massive change over of staff which started off as one or two people leaving and now a big wave has happened...so we’ve almost had a complete change over, right from the F grades right the way down to the D grades...so yeah the support is still there but it’s difficult when you haven’t got the same, you haven’t built up the same relationship with the people that were supportive before...I know there is always support from my manager that’s never changed...because we all support each other especially when there’s new people or new say for instance E grades and they’re asking us who are the D grades what is happening so...I mean yes there’s definitely support...” (N36, 3m)

The novice felt well supported. However there is always the danger that in a team approach, responsibility for the novice can fall between different members of the team.

**Action Points:**

1. The preceptor/mentor is a positive support, which can reduce the time taken to learn. Positive conditions for this are spending time working with the mentee, showing an interest in them and their development, trusting them to practice skills safely, questioning them constructively and giving feedback.

2. If no one person can provide this, team mentoring has advantages.

**Feedback**

Feedback on performance was also a factor that influenced how well supported the novices felt. Again there was a lack of consistency and the nurses generally received informal feedback from their preceptors/mentors, seniors and colleagues, mainly by way of informal chats or passing comments at the end of the day, as N5 and N1 illustrated:

“...I get feedback from the ‘E’ grades and...the coordinators...sometimes after a shift they’ll make a comment and say ‘You’ve done very well’ or ‘Thanks for your help’...” (N1, 9m)

“...about twice formally sat down...we do talk about things but they’re just general conversations over coffee...sometimes I’ve actually asked ‘Did that go okay and did I do that right?’...most of it’s just been sitting down and people have said ‘Oh how do you think you’ve been getting on?’...” (N5, 10m)

Some of the novices (n=12) had had formal appraisals with their ward managers/ward sisters and this involved discussing how they were settling in, their progress and setting objectives. If the ward manager/ward sister was aware of the novice’s capabilities and was encouraging, then the novice felt challenged. One manager ensured that their new staff were nursing a variety of patients with different dependencies so as to maximise their learning. This manager kept a close eye on her staff and monitored their progress, allocating more responsibility as the nurse developed, as she said in one appraisal:

“...I’ll be pushing you to learn more things, to do more things, to start thinking about management, to start thinking about maybe pushing up to your ‘E’ grade in a year’s, maybe a year and a half time, so she’s like ‘Don’t get too comfortable, I’ll keep you on your toes’...” (N1, 9m)
If managers/sisters showed little interest in the novices’ abilities and were unaware of their learning needs, then the novices felt lacking in direction. Lack of feedback also seemed to trigger feelings of self-doubt:

“...I’ve asked people like just occasionally said “Am I doing alright” because I am a person that I think I do need feedback because sometimes I think I’m 7 months into my ward, into my trained career and everything and I think “Am I at the stage I should be”...” (N21, 7m)

One novice seemed to have a good support network, a preceptor/mentor, an education package, competencies to complete and a good team; however he had not received any feedback on his performance and so did not feel supported at all:

“...I feel the department have let me down...because they haven’t really been supporting me, I didn’t feel that they’d been supporting me but they felt...that they didn’t have to because they felt I was too confident, well not too confident, they felt I was exuding so much confidence that I was...coping well when in reality I wasn’t...” (N22, 4m)

The fact that this novice felt unsupported was a complete surprise to the unit staff, because they had misinterpreted his confidence and thus did not feel that he needed feedback. The fact that nobody had said anything meant that N22 felt undermined and lost his confidence. Ironically they he received plenty of feedback after the event:

“...funnily enough everybody came running up to me telling me how wonderful I was after I’d burst into tears and ran out the department...and I did comment to a few and said ‘Well thanks very much but I’d like to have heard that about 2 weeks ago....’” (N22, 4m)

This case illustrates an important point regarding feedback, namely that it needs to be given whether the nurse is performing well or not. All of the nurses needed some form of reassurance as to whether or not they were ‘on the right track’ (N1) as this helped them to take stock of their progress.

The nature of the feedback and how it was given was also of importance. Constructive feedback was seen as important in helping the nurses to reflect on their practice and improve patient care, as N27 said:

“...I do find myself getting feedback from people...both kind of positive...'I thought you handled that situation really well’ and...I’ve also had some negative feedback from one of the senior nurses...for something that I did wrong...it wasn’t a criticism it was like ‘Next time you could probably do it better if you did it this way’...and so I found that really useful and I didn’t feel I was getting a telling off...” (N27, 5m)

Learning can therefore be seen to depend largely on the support that newly qualified nurses receive from their manager, preceptor/mentor, seniors and colleagues. Without such support, novices lack direction and are unsure of their capability, which affects their confidence and influences whether they stay in their present post. So far three of the sample have moved elsewhere specifically because of lack of support. Their feelings were not evidenced in the observations of their work, which was well carried out.

**Action Point:**
Regular, meaningful feedback needs to be given to newly qualified nurses,
regardless of their performance. This has implications for retaining their confidence and ultimately for staying in their post.

<table>
<thead>
<tr>
<th>Support Process</th>
<th>Number of Participants</th>
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<tbody>
<tr>
<td>Induction to the Trust</td>
<td>40</td>
</tr>
<tr>
<td>Ward level orientation</td>
<td>21</td>
</tr>
<tr>
<td>*Staff development programme/rotation available in trust</td>
<td>11</td>
</tr>
<tr>
<td>Attendance at staff development programme</td>
<td>5</td>
</tr>
<tr>
<td>Given period of supernumerary status</td>
<td>28</td>
</tr>
<tr>
<td>Given set of competencies to achieve</td>
<td>10</td>
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<tr>
<td>Assessed at set of competencies</td>
<td>6</td>
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<tr>
<td>Allocated a preceptor/mentor on starting work</td>
<td>35</td>
</tr>
<tr>
<td>Preceptor/mentor fulfilled novices’ support needs</td>
<td>19</td>
</tr>
<tr>
<td>Limited access to preceptor/mentor at work</td>
<td>9</td>
</tr>
<tr>
<td>Never worked with preceptor/mentor on clinical shifts</td>
<td>7</td>
</tr>
<tr>
<td>Formal appraisal from ward manager/ward sister</td>
<td>12</td>
</tr>
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</table>

Table 2: Overview of Support Processes Provided

* Some form of staff development programme was offered in all trusts, but only 11 novices identified that such a programme existed.

What is being Learned?

The Novices’ Working Context

The pattern of the novice’s day was largely determined by the organisation of the ward and the work that needed to be done. Such organisation was affected by: the speciality of the ward, the personalities of the staff who worked there, the ward manager/ward sister, trust policies, trust management, the dependency of patients on the ward, patient turnover, the staffing levels, skill mix and the layout of the ward. In order to understand just what it is like to be a newly qualified nurse working on the wards, it is important to have an appreciation of their working day. To this end, a number of observational vignettes have been included in this report that illustrate what is involved in being a newly qualified nurse and the context in which they find themselves working.

Shift times and structure heavily influenced the novices’ work. There were certain duties that the novices performed at certain times e.g. drug rounds were usually done at 0600/0800 hrs, 1200/1400 hrs, 1800/2000hrs and 2200 hrs. Attending to patient hygiene needs and mobilisation dominated nursing work on morning shifts. Such work was interspersed with doctors’ ward rounds, physio ward rounds, and liaising with other professionals such as the pharmacist and working with student nurses. The speciality of the ward also determined the priorities for nursing work. On a surgical ward, getting patients ready for and escorting them to theatre and procedures dominated. Work on afternoon shifts was dominated by picking up from where the morning shift left off, finishing anything that the early staff started. This could be completing paperwork, making referrals to social services, doing patient discharges and talking to relatives, the drug round, physio rounds, doctors rounds etc.
The busyness of the work, the overlap of different activities and the consequent variety of demands made on novices’ time meant that learning to prioritise and delegate work, as well as to enhance their skills were key issues for novices, which will be illustrated in the following vignettes.

**Observational Vignette 1: N26 (5m) does the drug round**

This vignette raises the following points about doing drug rounds:

1) The novice is anxious to get it right and not make potentially fatal mistakes.
2) There are a number of other needs expressed by the patient, who takes the opportunity when having the nurse nearby.
3) There are frequent external interruptions from other staff and relatives (which involved locking the drug trolley each time).
4) As students, novices are advised to concentrate on doing the drug round and avoid interruptions. However, this vignette shows how difficult this is in the work context.

**Getting a bedpan**

Field Note: 1210pm: N26 goes to get the drug trolley. The pharmacist is in the treatment room and they say ‘Hello’. There are some drug charts on the trolley. N26 looks through them to see which ones are his patients. He explains to me that the nurses administer drugs to their own patients. N26 takes the trolley into bay six and starts at patient one. ‘How are you feeling, do you have any pain?’ The patient would like some paracetamol. N26 says he’ll break the tablets in half for her. ‘They’re easier to swallow that way’. N26 finds the paracetamol pack in the trolley, takes out two tablets, breaks them in half and puts them in a medicine pot. N26 signs the drug chart and takes the pot to the patient. The patient says they need to spend a penny. ‘Okay if you hold on a sec’. N26 locks up the trolley and goes to get a bedpan for the patient.

**Doctors’ Visit**

1215pm: Three doctors and an accompanying nurse come into bay six and stop at patient one. N26 comes back with the bedpan and one of the doctors asks N26 about the patient’s mobility and social situation. N26 gives the doctor a brief overview of the patient’s condition. He then pulls the curtains round and asks the HCA to help him get the patient on the bedpan. They roll the patient on her side and pop the pan under. N26 gives the patient the buzzer ‘Call us when you’re ready’. He asks the HCA to stay in the bay until the patient is done. N26 washes his hands and moves the drug trolley on to the next patient.

**Gets new name band**

N26 asks the patient how his pain is. The patient says it’s not bad. N26 says ‘Hmm but you just know it’s there…well I’ve got some paracetamol for you’. He takes the tablets to the patient in a pot. ‘Can I look at your name band?’ The writing is all blurred so N26 can’t read it. ‘I’ll pop a new one on…are you allergic to anything?’ The patient asks N26 about what happens when he needs to go out to the toilet. ‘That’s okay if you need to go someone will help to wheel you out’. N26 locks the trolley and goes to get a name band. He comes back and writes the patient’s name, hospital number, consultant and ward on the band before putting it on the patient’s wrist. He gives the tablets to the patient and signs the drug chart. ‘Have you got enough water, I’ll get you some more’. He pours a glass for him. One of the doctors on the ward round goes in behind the curtains to see patient one. He takes a blood sample whilst she is on the bedpan.

**Patient off bedpan**

N26 moves on to patient three and looks through his drug chart. The doctor finishes and comes out but leaves the curtains open. N26 notices and goes to close the curtains. He asks the patient if she has finished. ‘Yes’. He locks the drug trolley, puts on a pair of
gloves and goes in to help get the patient off the bedpan with the HCA. Another HCA comes into the bay and offers to help so that N26 can carry on with drugs. ‘Well great if you don’t mind, thanks’.

Gets a glass of water for a patient

N26 goes back to patient three, opens the drug trolley and looks through the patient’s drug chart. He gets a tablet pot, looks for a tablet in the trolley, dispenses it in the pot, dates the chart and signs it. N26 asks to see patient three’s name band, ‘Are you allergic to anything?’ N26 explains to the patient what tablet he is giving him. The patient is hard of hearing and N26 repeats it three times before he understands. ‘Have you got your hearing aid in?’ ‘No’ N26 gets a glass of water for the patient and stays with him whilst he takes his tablet.

Patient and relative enquiry

N26 then moves on to the next patient. He repeats the same actions, drug chart open on trolley, looks through to see what’s due, searches for the tablets in the trolley, dispenses them in a pot and signs the drug chart. He looks at his watch it’s 12 o’clock. He asks the patient whether she has pain. The patient had paracetamol earlier. ‘Is it sufficient for you?’ ‘Yes’ He explains that she has Tramadol scripted if she needs more. ‘Okay let me know if you want it’. They talk about how bruised the patient is from a bone marrow aspirate. N26 checks the patient’s name band. The patient’s relative asks N26 about the patient’s condition. The patient asks about her discharge date. N26 explains that it depends on her rehabilitation. He reassures her and says that he’ll check to see if anything’s been planned.

Relative enquiry

1235pm: N26 takes the trolley into the next bay and stops at patient two. The patient’s relative asks N26 about the patient’s urine because it looks dark. ‘Yes it does look dark’. N26 explains that she may have a urine infection that would make her urine cloudy. He checks that her IV drip is running. It doesn’t seem to be dripping even when N26 adjusts the roller clamp.

Request to Sister

N26 asks the Sister who is in the bay about the patient. He explains that she has cloudy urine and her drip isn’t running. He asks the Sister if she could flush the venflon. She says that she’ll check the patient’s blood sugar. ‘We may need to put up a different IV if it’s low’. N26 explains to the patient that they need to check her blood sugar and so the Sister needs to prick her finger. The Sister prepares the equipment. In the meantime N26 carries on with the drugs. He asks the patient if she has any pain. ‘No’ Let me know if you have any pain won’t you’. 1245pm: N26 finishes the drug round.

Observational Vignette 2: N1 (9m)‘liases’ with other health care professionals

This vignette raises the following points:

1) It can be difficult for the novice to become part of the multi-disciplinary team, as shown here, as the nurse was not included in the patient consultation, although she was working in an open bay. Nor was she involved in discussion of the outcome and indeed had to ask the patient. The expectation was that she would read the drug chart and follow instructions accordingly.

2) The opportunity to set up a communication channel has been lost whereas it could be very important in reporting back any future concerns about the patient, particularly for a novice nurse trying to learn about teamwork.
Field Note: 0940am: A team of five doctors come in to see patient three, accompanied by the nurse in charge. They head straight for the patient and pull the curtains round. I can hear N1 talking to herself about whether she should go in with them. She makes to go in but then stops, deciding that there are too many people behind the curtains and not enough room for her. She says to me that she can hear what’s going on from outside the curtains anyway.

She leaves the bay and comes back with clean sheets and starts to make patient two’s bed. This patient is still in x-ray. She clears the bed space of equipment – there’s a drip stand and an old CVP line that has been taken out – which she disposes of. She gets the linen skip, takes off the sheets, puts them in the skip and washes her hands. The doctors pull the curtains back and leave patient three. N1 goes over to see the patient and looks at her drug chart. The doctors have prescribed a laxative called picolax. N1 asks her if she wants it now. She replies that she ‘Might as well’.

N1 goes to get a spoon from the kitchen and opens the patient’s drug locker behind her bed. She asks the patient what the doctors have said. The patient says they want her to have the picolax. N1 looks at the drug chart again. She asks her to sip a bit of water, the patient asks how much and N1 says just a bit. N1 adds the picolax to a cup of water and stirs. N1 – ‘You don’t have to gulp it all down at once...you’ve taken it before...?’. The patient says ‘Yes’. N1 signs the chart.

N1 asks the patient how much she’s had to drink this morning so that she can write it on her fluid chart. She says a cup of tea. N1 asks ‘Was that a full jug this morning?’ ‘Yes’. The patient says to N1 ‘I don’t always understand Mr H...’ and asks N1 about her operation. N1 explains what will happen to her - that the stoma nurse will come and see her to mark the place on her abdomen and to explain all about the stoma procedure. N1 also says she will see the dietician, Macmillan nurse, social worker, discharge coordinator and the pain team at some point today.

Observational Vignette 3: N16 (6m) Chases equipment

This vignette raises the following points:

1) Novices need to acquire the knowledge about whom to ask or whom to ring in order to meet patients’ needs quickly.

2) Chasing equipment adds to novices’ frustrations in that it takes them away from their patients.

Field Note: 1515pm: N16 rings a ward to ask if they’ve got a Bradford sling for patient sixteen, who has their arm in plaster. She waits for an answer but she doesn’t get one. She puts the phone down and walks up to the clinical room to see if there’s a sling in there. She comes back to the desk and says to the Sister and nurse there ‘I need a Bradford Sling’. She rings another ward, explains who she is, what ward she’s from and what she’s looking for, but they don’t have one. She tries another ward. She chats with the ward clerk whilst she waits for the ward to answer. The ward answers and N16 repeats what she said to the previous ward. She also explains what a Bradford sling is. ‘It’s made of foam and is usually green…it’s used to elevate a patient’s arm’ She lifts her arm as she says this. No joy. She asks the nurse at the desk where else she can ring. The nurse isn’t sure.

N16 sees the nurse in charge in the bay opposite. She goes into the bay and asks him what he’s doing. He seems to have a problem with getting a cot side off a bed. N16 offers to help him. During this she asks him whom she can ring for a sling. He suggests the fracture clinic. N16 says she hasn’t tried them. She finishes helping, goes to the desk and rings the clinic. She explains the
situation again ‘I’ve tried all the wards, you’re my last resort’ But they don’t have one ‘It’s alright don’t worry about it, I’ll make one...no but I’m sure someone does, I’ll improvise’. N16 ends the call. She asks the Sister who is just about to go home if she knows how to make a sling using a sheet or a pillowcase. ‘Do you need a whole sheet?’ ‘Yes’. N16 gets a sheet from the linen cupboard. The Sister asks ‘Have you tried B ward?’ ‘No I tried X’. N16 rings B ward and they have one. Yes! We go up in the lift to collect it from the ward. There’s a porter waiting for the lift and he has a moan that it’s always breaking down. We take the stairs back to the ward.

N16 goes up to the desk ‘I’ve got one’. The nurse in charge says ‘I’m trying to get you an IVAC pump, I’ve bleeped the bed manager if they ring back we want an IVAC’...The bed manager rings back. N16 answers and says ‘We really, really need an IVAC’. The bed manager says there is one free on G ward. N16 thanks her. She rings the porter’s lodge ‘Hello porters could you collect an IVAC pump from G ward to come to B ward please...thank you’.

**Observational Vignette 4: N20 (4m) Escorts a Patient to a Procedure**

This vignette raises the following points:

1) Novices have to reprioritise their own workload to suit another’s agenda
2) Dealing with external interruptions from relatives and staff that direct the novice’s attention away from their present work
3) Novices worry about getting everything done before the end of the shift
4) Novices may be left with equipment that they are not trained or feel competent to handle

Field Note: 1130am: N20 has to escort a patient from the bay next-door down to x-ray because there’s no other nurse who can go with him. The porters arrive with a trolley for him. N20 goes to fetch the patient’s notes and she is stopped by a relative of patient three who asks her how he is doing. He wants to know how his operation went. N20 stops and gives the relative information about the patient and his condition. She says he was in pain but that he’s up and about now. This delays the escort for about five minutes. The porters wait for N20.

We leave for the CT scan and arrive at 11:50am. The porters leave us in the CT reception area. They connect the oxygen tubing to a cylinder. A receptionist takes the patient’s notes and N20 tells her who the patient is and which ward he’s from. N20 asks the patient how he is doing. We wait. N20 tells me she is thinking about all the things she has to do when she gets back to the ward. She asked the coordinator to start her 12 o’clock drugs before we left, so she’ll finish them off when we get back. She has to admit the new patient – who needs a line change and dialysing later today. She also has to discharge a patient, so she needs to check his TTOs, give him his TED stockings and explain his drug treatment regime to him, which is written on a white card.

1200pm: We wait some more. N20 tries to find out how long they’ll be but there are no staff about, they’re all busy in the x-ray room. We hear rumours that they’ve had an emergency, but no one confirms this. N20 says we may be here for some time.

1230pm: We’re still waiting for the CT scan. N20 rings the ward to tell them what’s happening. She comes back and the patient’s IV pump is alarming. She has a look at it and presses the ‘alarm off’ button; she straightens the giving set line that has become tangled. She says to me that she’s not pump-trained so if there is a problem with the pump, she’ll have to get a trained nurse from the ward to come and sort it out. The battery on the pump
is low and it starts alarming again. We move the patient on the trolley nearer to the wall where there is a socket, N20 plugs the pump in and it stops alarming.

1320pm: We’re still in CT. N20 tries to find a phone to call the ward again but they’re all busy. She asks a doctor in his office whether she can use his because he isn’t using it, but he categorically says ‘No’. She goes back to the receptionist’s area and waits until one becomes free.

1340pm: A nurse from the late shift on the ward comes to relieve N20. N20 hands over what she knows about the patient, which she admits isn’t much, and leaves to go back to the ward. N20 is relieved to get away.

The Effects of the Working Context
From these vignettes it is possible to see the effects of the environment on the working lives of newly qualified nurses. Going into nursing, novices expect to be caring for patients most of the time, whereas the reality is that there are a multitude of hidden tasks that they are expected to deal with; such as finding a patient’s drug chart, escorting patients to procedures and waiting for them, filling in forms and waiting for doctors to call back after being bleeped. These scenarios may well be the reality that they have to get used to but, as new nurses with high expectations of themselves and insufficient comparative experiences to draw on, they are often overwhelmed and have less in reserve to rise above such circumstances. They often end up frustrated and blame themselves for not doing their job properly.

Prioritising
Prioritising is a key aspect of nursing activity and managers agree on its importance, yet it’s a skill that few seem to have on qualifying. As one manager said:

“...I would expect them to be able to organise themselves and prioritise themselves and have reasonable time management skills of which I think those are the major things, the 3 major things that actually stop them from enjoying their work...”
(N1’s & N4’s MA)

The main elements of prioritising seem to be: knowing where to start, knowing what to look for and what help is required or useful in how to proceed.

1) Knowing where to start
As students, novices provided care for patients under the direct supervision of a qualified staff nurse. However, as qualified staff nurses themselves now, they provide the care and are thus expected to make autonomous decisions for their group of patients. It seems, from talking to novices, that this is quite an obstacle to overcome and often the psychological shift from student to qualified nurse and all that it entails hampers their ability to do this. Knowing where to start is a problem because they feel so overwhelmed by their patients’ needs. As one manager said:

“...I mean the worst of all is if you see a very junior staff nurse come on the ward with eyes like a frightened rabbit and looking round and it’s like…”You’ve got 1 to 5 okay” “Okay so throw all the numbers up in the air and whichever one comes down okay I’ll look after that patient now” ...if you see that, that’s not the kind of thing…you want, you want them to have some kind of way of planning their care and they’re only as good as you teach them...”(N23’s MA)
One novice identified with this as she explained how she used to go round her patients in turn when she first started work:

“...I think originally say you’re given 6 patients, you tend to go round them in order of how they are first of all...” (N5, 10m)

Very few novices said that they were taught how to prioritise as students. One newly qualified nurse said that a mentor on a ward as a student had taught her how to think about prioritising her different patients’ needs and she’d found this very helpful. She was given different case examples and her mentor critiqued her analysis:

“It is covered in the course and also you do learn it whilst you’re a student on the wards when you start to be given patients to care for, your preceptor/mentor whatever you want to call them, often goes through and says ‘Look you’ve got X, so-and-so and so-and-so, where are you going to start, what are you going to do first, where’s your priorities, what would be the most important to you?’ and you might say ‘Da-da-da-da’ and they’ll say ‘Well actually this might happen, that might happen, maybe you should start here or start there’ and it’s just trying to think about things as a whole isn’t it and you have to start somewhere so where’s the best point to start, I don’t get it right all the time”. (N1, 9m)

However even for this novice dealing with changing circumstances was still a major obstacle, especially when the change happened fast and was beyond her control:

“...things can change very quickly...if you’ve got a post-op patient that is scoring quite high on the MEWS [early warning scoring system] or is a bit unstable and you might have somebody else...who might be confused or the doctors have been round and they’ve changed something and...you’re trying to do a lot of things at once...and you’re trying to get the sick patient reviewed and you’re trying to do this and you’re trying to take phone calls and you’re trying to talk to patients’ relatives....sometimes you just feel like ‘Oohh...stop... ’...” (N1, 9m)

Situations such as this overwhelmed the novices because they had very rarely encountered so many conflicting priorities before. This led to them feeling that they did not have control of the situation; and this could only be achieved by gaining more experience of similar situations. Gaining such experience was a gradual process for which learning support was particularly helpful. The novices also felt that they would improve their ability to recognise and respond to situations with time and experience and that reflection would enable them to do this:

“...if you’ve been in the situation before, you can remember what’s happened last time...and what you could change and perhaps do it differently then when you have that situation again...” (N4, 9m)

2) Knowing what to look for

At this very early stage of their career, novices needed to be able to recognise that something was wrong with a patient and give priority to passing that information on to a senior to deal with, rather than feeling that they should be dealing with the problem themselves. This was also quite traumatic for some of the novices and caused anxiety, as N4 related:

“...it’s very easy to panic when something doesn’t go quite right...I tend to panic a bit especially if something goes wrong in a situation I’ve not experienced before...it’s very stressful to know that something is wrong but not know what to do about it...I was looking after a lady whose urine output
dropped quite substantially...I was panicking but it was something that needed observing and not something I could do anything about immediately...it’s about knowing what needs immediate medical attention and what needs to be observed...” (N4, 9m)

The novices who were past the initial stage of being overwhelmed by patient needs, learned how to prioritise their patient care from what they were told during handover at the start of their shifts:

“...you do get used to once you’re in hand-over, picking out those that will need medication or those that have been particularly poorly or those that are going to theatre and obviously the theatre starts early so they’re bit of a priority but you do pick it up...” (N5, 10m)

They deduced from the information given, the patients they would be looking after and what their needs were for the day. From this information, they could usually tell what they needed to do first in their shift. The novices also annotated their patient handover sheet, or wrote their own lists of things to do for their group of patients, which helped them to remember what they needed to achieve during their shift:

“...after the morning handover I always just take 2 minutes, sit down and write myself out a little separate list of all the medical jobs that I need to do for them, then all the social things, or referrals that I’ve got to write, all the things that I’ve got to ask the doctor when they come round...I do it every day without fail because I can’t function otherwise....” (N27, 5m)

Novices’ priorities for the shift were heavily influenced by the ward routine, for example, they knew that they had to do the drug round at certain times of the day; so other activities were arranged around these times. If the novices had the same patients as the day before, then they found it easier to plan their time since they had an idea of what to expect in terms of patient need, as N1 said "you know sort of what's going on with them”. This was harder to do if they had been off work for a few days and so did not know their patients, as N12 said:

“...it’s always a good advantage if you know the patient or if you’ve looked after them the day before so at least you’ve got something to compare it to. I remember looking after one gentlemen who was deteriorating and I’d only met him that morning, until I asked another nurse and she said ‘Well no he wasn’t like yesterday, he wasn’t that sleepy’ so then you take action from that as well...you get to know them and you pick up on their personalities and their conditions especially; so you would notice any changes rather than just coming on shift and meeting someone for the first time...” (N12, 9m)

Novices said observing more experienced nurses on the ward also helped them in knowing what to look for.

“...I suppose you see everyone else and they seem so organised and they seem to have it down to an art and you think ‘Oh well maybe if I did that’...I think it was more from looking at other people and thinking ‘Oh well yeah, that’s a good idea to get all of that out of the way first’...”(N5, 10m)

From the observations it was clear that prioritising abilities were learned in an environment of constant interruption from doctors, patients, relatives, answering the telephone, dealing with queries, waiting for staff or equipment and changing the order of work to accommodate them:
“...sometimes I just get caught out I think (laughter), I’ll have thought in my own head ‘I want to do this first then that, then that’ but you always get distracted in between while you’re doing something else, before you move on to the next. I suppose it’s things like you can’t help really but I do try and prioritise because most of our patients go to theatre and at times they’re collected really early in the morning so and you have like a post op patient from the previous night or something and I’ll probably just run over and check if the obs are fine and get the next patient ready for theatre and then get back to them, like running around (laughter), I just try and observe how other people and I think people just do it differently, so I just stick to the way I do it really…” (N43, 7m)

The humour with which this novice described the interruptions indicated that she was much more relaxed at this stage about prioritising. Indeed, those novices who had developed their skill in knowing what they should be looking for, did feel more relaxed and confident in prioritising their time and patient care, as N1 and N5 indicated:

"...you get a feel for it..." (N1, 9m)

“...generally it just comes naturally now...” (N5, 10m)

3) Knowing what help is needed to prioritise successfully: the art of delegation

The initial stance that novices take is that they should be doing everything and completing all of the tasks that they see to be done. They realise, after a couple of months, that in order to meet their expectations of getting everything done that they will need to delegate to others, such as health care assistants. This means that they have to be able to distinguish between tasks that they can do and those that health care assistants can do. They also have to be confident in that, if they ask someone else to do a task for them, then that person will respond positively and not challenge them. They are keen not to look lazy or bossy and show that that they can pull their weight. It takes the novices a while to size up other people on the ward, to know who is approachable and who will help them out in different situations.

At first, novices are not confident to ask others. This may be for a variety of reasons; they may not know everyone in the team or they may be worried about the reaction they will receive from others if they ask for help, which influences whether or not they ask that person again. Some do not feel knowledgeable enough to ask others; because they may have to justify why they need another person to do this task and some may just be too shy to ask. N14 illustrated how she felt at first delegating to others:

“...because you don’t have the knowledge, the confidence, the experience, you just think ‘If I ask anyone to do anything and they question me’, not even in a nasty way but in a genuinely nice way, ‘So do you want me to do it this way or that way’ and you go ‘I don’t know’ and you’d feel completely incompetent so you just think ‘I’m just going to shut up and say nothing’ if you can’t back up what you’re asking you just kind of don’t ask...” (N14, 10m)

However in working on the ward she soon started to realise that she needed to delegate in order to get her work done, and that asking for help did not reflect badly on her:

“...you learn over a 6 month period teamwork, how important it is and it is not a reflection upon you, if someone else is free use them, I should be able to say ‘My patient in bed 6 has got chest pain, can you do a set of observations and an ECG and I’ll be there in 2 minutes or 5 minutes’ or ‘I can’t make it there because I’m with a patient who’s unwell with a vaso-vagal’, another person with chest pain and I’ll say ‘Show it to another nurse or go and find a doctor’ and I’ll expect that
person to be able to cope with that because it happens to me and I don’t feel ‘Oh they’re not coping, I’m having to do their work load’ at all so we all just have to get on and help each other…” (N14, 10m)

N14 thought that experience and watching other, more experienced staff nurses on the ward helped her to work this out. Once she had realised this she felt much happier about her workload:

“I don’t think there was one thing in particular, something just kind of clicked about how a ward worked even just watching other nurses who I thought ‘God they’re really good, they’ve got so much knowledge base’ so you watch them and you see that they do delegate and you just think ‘Aah that’s they way to do it’ yeah and that also kind of made sense to me and I was so exhausted, I was having to delegate and I found that delegating actually worked very well, I was coping much better with my work load, I was happier, I wasn’t as exhausted by the end of the day, the patients were happier, I was getting a chance to sit down more often…” (N14, 10m)

Novices, who had learned where to start, knew what to look for and knew what help they needed to proceed with prioritising were better able to weigh up the different needs of their patients. They also understood that delegation was an essential part of this process.

Prioritising is a difficult skill to learn. For example, one manager said that more experienced D grades whom she had employed from different wards and hospitals, still had not learned how to prioritise. She found it much more difficult to help people to relearn that skill at this later stage of their development.

### Action Points

1. Newly qualified nurses need guidance from seniors with prioritising their patient care e.g. after handover
2. Novices should be encouraged to ask for help within a supportive team.
3. Seniors should be encouraged that novices need help with delegating and be willing to talk about and share their knowledge.

### How are newly qualified nurses learning?

The novices seemed to adopt a variety of learning skills including asking questions, practising or having a go, trial and error, demonstration, teaching others such as students, reflecting, attending study days and courses, reading books or manuals, being challenged by the work, and being encouraged to question practice. Which method they used depended on what it was they were learning.

**Asking questions**, seeking advice or checking with a more experienced member of staff was the most common way of finding out information, and it was often the quickest method:

“…asking lots of questions…if in doubt ask…that’s what I tend to do…” (N4, 9m)

Asking other members of the multi-disciplinary team was also helpful, as N27 found:
"...I said to one of our doctors 'Can you go through these bugs with me'...it was on the computer and she was like 'Yeah no problem' and went through it, so it means more to me now when I look at it on the screen or on a bit of paper..." (N27, 5m)

**Practising skills** was said by some nurses to be the only way to learn, by doing it themselves, ‘having a go’ and picking things up as they went along. As one novice said:

"...I think the best way to learn it is to practice it, it's like a lot of things with nursing I think the only way you get a feel for things is by actually doing it with the proper support..." (N1, 9m)

**Trial and error** was also mentioned although this was not always the best method for learning, as N29 illustrated:

"...a lot of it is being blind...and plunging in...I've found on this ward actually that when I make a mistake then they tell me what I should have learnt...it seems to be that when you do something wrong, when you make a mistake then...you learn what you're supposed to learn instead of learning first..." (N29, 6m)

N24 inevitably practised by trial and error, as the following quote illustrates:

"...people haven’t got the time to teach you and you’re always constantly being thrown in the deep end, I think if you’re thrown in the deep end to a certain extent is a good idea but there’s only a certain amount you can take...I feel yes there’s some things I do feel I have progressed with but then, on the other hand, a lot of this has knocked my confidence...I started off quite confident and I’ve gone backwards because I don’t feel as confident now as when I first started and I think it is because I just constantly don’t feel I can ask for help...and I think it gets worse as the time goes on, because in that first month or so everybody expects you to ask for help, but after a couple of months things still occur that you don’t know or haven’t done before...but by then everybody thinks ‘Oh gosh she’s been here long enough now...” (N24, 5m)

A more experienced nurse demonstrating a procedure, before being supervised doing it themselves was, in a lot of cases a good learning experience for novices. This gave them the confidence to perform that skill alone. This is illustrated in the following observational vignette of N44 being shown how to suction a patient with a tracheostomy.

**Observational Vignette 5: N44 (5m) is shown how to suction a patient with a tracheostomy by a senior**

This vignette raises the following points:

1) The novice and more experienced nurse have a discussion about the procedure prior to performing it, during which the more experienced nurse is open to a query from the newly qualified nurse.
2) That the type of involvement of the novice is negotiated with her neither being thrown in at the deep end nor told that she must observe only.
3) The experienced nurse is able to verbalise things that the novice should be anticipating in performing this procedure.

Field Note: 1420pm: Sam asks N44 when she wants her to show her how to use the suction. N44 says ‘I’m ready when you are’. They wash their hands and put aprons and gloves on outside the patient’s door. N44 says ‘I’ve seen it once’ Sam explains what to do before they go into the room. ‘So each time you put one down you need to change it’. N44 says ‘When I did it with another nurse on nights, before she put the suction down, she sucked up some water to lubricate the tube first
because the mucus can be quite thick, is that good practice?’ Sam says ‘Well you can do it but I’ve not seen it before’ N44 says ‘So you don’t need to use any water…you just do it?’ Sam says she’s heard of people putting a small amount of saline down the tube, ‘I don’t know if that’s good practice’ ‘you put the oxygen up prior to suctioning, I understand the rational for that’ Sam says ‘So if I do it now, do you want to do it and I watch or shall I do it?’ N44 says ‘What do you think?’ and then decides ‘I’ll watch you do it first.’ They go into the room. Sam asks the patient ‘How’s your mouth today?’ ‘Sore’. Sam says it’s a good idea to have a new catheter attached to the suction in case you need one quickly. ‘Make sure you have plenty of spare catheters…it’s a good idea to have some water handy too’ N44 pours water into a beaker until it’s half full and stands and watches as Sam suctions.

When asked about this episode at interview, N44 said that because she had the chance to observe her senior suctioning the patient, she now feels more confident to do it herself:

“Yeah just watched people do it to begin with and then I got people to watch me doing it and now obviously I feel absolutely fine with doing it and the suctioning the other day now I’ve had a go at that a few times I’m feeling a bit more okay, I don’t need to get someone to watch me to do it now…” (N44, 5m)

A more detailed step-by-step demonstration is given in Observational Vignette (6) in Appendix II. This illustrates an experienced nurse showing N19 how to set up a diamorphine pump for a patient.

**Teaching others** e.g. students, was also something that helped the novices to learn, as N2 said:

“…if you’re teaching you’re learning as well sometimes aren’t you…and if I didn’t know something I’d say ‘Well let’s go look it up then and we’ll find out’ so…in a way you can learn by doing that..” (N2, 9m)

**Reflecting**, either individually or as a group, was an important learning tool for the novices, since this helped them to look at their practice objectively and see how they could improve things, as N22 said:

“…we’ve had a learning set that…has been really helpful where we’ve gone through problems and different people have brought different aspects to it which has been invaluable…” (N22, 4m)

**Attending study days and courses** was also a good way of learning, as this vignette shows, which raises the following point:

1. This novice was applying the systematic way of interpreting ECGs that she had learned on an ECG course to her everyday practice.

**Observational Vignette 7: N46 checks a patient’s ECG following his angiogram**

Field Note 1210pm: N46 writes the patient’s name on the ECG and writes ‘post procedure, date, and what procedure the patient has had done’ She checks the ECG. She compares it to his ECG taken before the angiogram. She says she looks for ST changes, T wave inversion because if they’re different then this implies that ‘there’s ischaemic changes’ and she’ll need to inform someone. She looks at the rate, rhythm, QRS size which she says is an indication of ventricular function - if the QRS is broad, narrow, whether there’s ST elevation or depression or inversion and p waves. She says these were things she was taught on an ECG course.
Reading manuals or books on clinical procedures was also valuable. This can be illustrated in another Observational Vignette (8) in Appendix III. It shows how N38 used the Marsden Book of Clinical Procedures to read up on how to catheterise a patient before she had to perform this skill. It also illustrates the help that N38 received from two more experienced nurses in catheterising this patient for the first time.

Being challenged by the work also determined how the novices learned. For example, N1 was rotated around the different areas within the ward so she was given the opportunity to nurse patients with different conditions and dependencies and also given the support she needed to do this. However N24 worked in the same bay on the ward, nursing the same types of patient all the time. She was not given the opportunity to nurse more acute patients because of poor staffing levels on the ward and lack of support. This was a double-edged sword since she felt ‘stuck’ but also ‘safe’ in her bay, as she explained:

“...the trouble is I spend so long in those bays that I’ve got a bit of confidence just being there because I’m orientated to it now and then if somebody comes in and says ‘Oh go somewhere totally different’ and it throws me...” (N24, 5m)

Another nurse said that she was having similar problems because there was not the support available to enable her to look after sicker patients:

“...I took the job here because I do want to learn and I’d like to be good at what I do and I’d love the opportunity to work in Bay 1... we have a lot of patients with epidurals that come from ITU but you really can’t do that on your own, you really need to work with somebody so I would have loved to have done that with another staff member but that’s not really realistic so I’m thinking of other things basically, moving on again for some different experience...” (N31, 6m)

Those novices who had been challenged and supported seemed to be getting up to speed more quickly than those who were not challenged or supported.

Being encouraged to question practice enabled the novices to develop their confidence and use their own clinical judgement in situations, as illustrated in the following observational vignette and interview with N36. This vignette shows that:
1) The novice notes as anomalous an unusually high blood pressure.
2) She follows this up by asking a senior nurse and takes the initiative to inform the doctors.
3) She is able to describe her thought processes.

Observational Vignette 9: N36 questions her patient’s treatment

Field Note: 1155am: N36 takes patient 9’s BP, ‘I’m just taking your BP’ She records the result on her obs chart. She checks her pulse manually and records the result. The patient asks how it is. ’78...we need to have a look at your blood pressure tablet...your BP is still quite high...it’s been high since you’ve been in...can you remember what tablet you’re on...nifedipine...I’ll get the doctors to have a look’ She gets the patient’s drug chart and has a look, ‘It’s amlodipine, a new one...but it’s not doing brilliantly...I’ll chat to the doctors...they know it’s a new one...you’ve been taken off the monitor, because the last time I was here you were on one’ ‘Yes’

N36 sits at the desk and looks through the patient’s obs chart. Her BP is 166/78. N36 explains that the patient is waiting for valve surgery and that she has normal coronaries. I ask ‘What are you thinking?’ She says ‘Her BP is high and she’s only on one BP
tablet…amlodipine 5mg and atenolol…I’ll check if the doctors know…they usually wack up the ACE inhibitors…a BP that high is not usual here’. She checks in the patient’s notes but there’s nothing to say that the doctors are concerned. She talks to the senior nurse in the unit and shows her the obs chart. ‘It’s just patient nine, her BP has been high since she’s been here…they must know, they see the chart everyday…she’s only on 5mg of amlodipine and atenolol’. The senior nurse asks ‘Is there anything written in the notes’? ‘No’ ‘Well they probably do know but if you want to bring it up again then that’s fine’. N36 checks the notes again.’ No nothing…I’ll tell them later, they’ll be up again this afternoon, that’ll save bleeping them…”

When I asked N36 about this incident at interview, she explained what she was thinking about in more detail:

“…she’s [the patient] only on one anti-hypertensive and that’s quite rare for the ward, normally they’re on at least ACE inhibitors as well and different types of ones so yeah I’m going to speak to the doctors about that and see but I mean maybe it’s inappropriate for her, maybe she’s had y’know previous things or maybe she’s got renal failure that I don’t know about or something I don’t know, they’ve probably picked it up but that’s kind of an instinct thing now whereas maybe before I wouldn’t have been thinking about that…I think it’s something that I’ve just learned and that’s even been pretty recently over the last, I don’t know maybe month or so, just kind of looking at peoples’ drugs and realising why they’re on them and questioning with the doctors whether they still need to be on them or whether the doses need to be upped or downed or things like that, yeah and that is something that obviously I’ve observed in other nurses but also kind of the basics are starting to really click now and I’m just thinking ‘Okay well why does this person need to be on this drug’ for instance…yeah I think just practice and obviously questioning, questioning the doctors and being told the rationale as well and I think that rationale is beginning to stick now for why certain patients are on y’know certain drugs and what the correct doses should be…” (N36, 3m)

**Action Points:**

1. A good explanation of a procedure can give a newly qualified nurse confidence to then perform it themselves.
2. Novices benefit by being challenged both by constructive questioning of their practice and also by exposing them to different aspects of patient care.

**Doubting abilities: a crisis of confidence**

Twenty of the novices said that at around four to six months, they came to a point where they found themselves still having difficulties prioritising and delegating and found it hard to cope. They began to have serious doubts as to their abilities as nurses – and started to ask themselves ‘Should I be in nursing, am I doing okay, have I made the right choice?’, as N1 said:

“…I think six months was when…I went through that stage of ‘Oh my God what have I done, why am I here, what am I doing, do I really want to do nursing’…kind of that critical bit but after that I settled into things and everything clicked into place…from around then really…” (N1, 9m)

At this point the whole question of feedback and acknowledgement of their efforts became absolutely key. Support from preceptors/mentors, managers and colleagues to confirm that
their work was along the right lines and that they were doing a good job, gave them the confidence to continue in their efforts to learn the skills of prioritisation and delegation. Facilitators to this process included clinical supervision in company with peers, since they took comfort from knowing that other novices were going through the same thing, as N1 and N34 said:

“...other nursing staff that started around the same time as I did...had gone through it or were going through it as well and just talking about it; and it’s quite strange because my friend started about four months after I did and it was like the six month period and exactly the same thing happened to her and yeah it’s quite strange it seems to be that six month period where you just have a bit of a crisis and get over it and then everything’s okay...” (N1, 9m)

“...when I talk to my friends everyone’s found it a struggle, everyone’s had days when realistically “Oh I can’t go back to work” or “I want to quit” but most of my friends have gone over that six months period and we’re sort of “Yeah it’s not so bad, we’ve survived”...” (N34, 9m)

Receiving meaningful feedback and having a preceptor/mentor or colleague who was interested in their development was also crucial, whilst getting to trust and be trusted by others gave them the confidence to delegate, as did seeing more senior staff delegate. Although this crisis of confidence can be experienced as very negative, it is a sign that the newly qualified nurse is recognising a need to reassess how they are coping and that they need to delegate more effectively. Such crises are often the precursor to change and can be a positive stage if handled well. It seemed that this was an opportunity for the novices to reframe, to take a good look at their job and reassess their position. Those who were supported were able to move on, to make progress and develop, whereas those who were not supported left their posts and sought employment elsewhere.

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<td>Novices’ crisis of confidence at between 4 and 6 months needs to be recognised and help given, in for example prioritising and delegation, if those are at the root of the difficulty.</td>
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CONCLUSIONS

One of the most telling lessons of this research is that even when newly qualified nurses appear confident and are working competently, they still need to have a discussion of their own views of their progress. It was found that nurses who were contemplating leaving, in some cases, doubted their capabilities or had other problems associated with their management on the ward, which if acknowledged, might be able to be rectified. There is a strong argument for implementing a standardised form of support for all novices regardless of workplace and evaluating its appropriateness.

The action points from the evidence are brought together below.

**Action Points**

**At Trust Policy Level, senior managers should:**
1) Be aware of the location of newly qualified nurses so support can be targeted and progress monitored.
2) Provide programmes of induction to the trust, which are evaluated by novices to ensure that they are covering what they need.

3) Ensure that novices are made aware of all staff development programmes offered, ensure that novices can attend the programme and monitor that novices have attended and that it has met their needs.

4) At policy level novices should be supernumerary during their period of induction but after this, supernumerary status by itself is not necessarily helpful unless structured and well supported.

5) A competency booklet can be helpful to learning provided that the competencies are followed up with constructive feedback.

At Ward Level, nurse managers, preceptors/mentors and the nursing team in general should:

1) Be aware of the concerns that newly qualified nurses have when they start work.
2) Be explicit about what they expect of newly qualified staff.
3) Incorporate visits to linked departments and personnel within the trust during the orientation period.
4) Provide a preceptor/mentor as who can be a positive support, which reduces the time taken to learn. Positive conditions for this are spending time working with the mentee, showing an interest in them and their development, trusting them to practice skills safely, questioning them constructively and giving feedback. If no one person can provide this, team mentoring has advantages.
5) Give regular, meaningful feedback to newly qualified nurses, regardless of their performance. This has implications for retaining their confidence and ultimately for staff retention.
6) Give guidance to newly qualified nurses regarding prioritising their patient care e.g. after handover
7) Encourage novices to ask for help within a supportive team.
8) Be aware that novices need help with delegating and be willing to talk about and share their knowledge.
9) Demonstrate procedures to newly qualified nurses to enable them to learn more quickly.
10) Ensure that novices are challenged both by constructive questioning of their practice and also by exposing them to different aspects of patient care, which may involve rotation to different ward areas.
11) Novices’ crisis of confidence between 4 and 6 months needs to be recognised and help given, in for example prioritising and delegation, if those are at the root of the difficulty.
References


Appendix I

The Common Framework for Analysis

Four structuring dimensions were used as a common framework to analyse the three different learning contexts of nursing, engineering and accountancy. These were:

1.) The nature, range and structure of work activities
2.) The distribution of work activities between people and over time and space
3.) The structures and patterns of social relations in the workplace
4.) The outcomes of work and learning, their evaluation and the attribution of credit/praise or blame.

Key variables affecting the extent to which the activity structure required, facilitated or inhibited learning in the workplace included:

- the extent to which activities involved transactions with co-workers, clients/customers, suppliers or other outside people
- the range and variety of activities making up a person’s job, both during a specified period and over time
- the extent to which activities allowed flexible decisions to be made at the discretion of individual workers or their immediate managers, rather than being totally programmed
- the scope and demand for inventiveness, problem-solving or creativity from individuals or teams
- the extent to which the activity structure encouraged or provided time for meta-level activities such as planning, reviewing, strategic thinking, or quality improvement
- the degree to which the activity structure made it difficult for individuals and/or groups to perform at the level of their competence
- the nature of formal and informal communications within the workplace and across its boundaries
- the congruity between the activity structure, short-term organisational goals and strategic priorities.

We also found that, in spite of the affordances offered by modern communications technology to transcend some of the constraints of time and space, most social relationships and informal exchanges depended on people being together in the same place at the same time. Working relationships and the exchange of information significantly depended on mutual trust and regard, and the development and maintenance of such trust, as well as awareness of and respect for other people’s perspectives and expertise, were greatly facilitated by informal contact. This arose through co-location of work, incidental encounters, and opportunities for informal exchanges around the edges of meetings, or in social time in or near the workplace (typically over coffee or lunch).

Another important issue was the variable priority given to different outcomes of work and learning. Formal discussion of outcomes was often confined to periodic appraisals, conducted with varying degrees of professionalism. Often appraisers’ lack of reliable information about long-term outcomes gave short-term outcomes more influence than might otherwise be appropriate. Both formally and informally, some outcomes were given greater attention than others, which in turn affected the way in which workers deployed their time and effort. However, problems occurred when outcome priorities differed significantly from activity priorities. If the conflict could not be resolved, the most likely result was profound alienation.
Appendix II

Observational Vignette 6: N19 is shown how to set up a diamorphine pump by a senior

Field Note: 1145am: N19 is asked by the nurse in charge to set up a diamorphine pump for the patient in the side room. She says ‘Yes’ but confesses to me that she’s never done it before and so isn’t sure how to do it. She says she’ll ask someone who’s done it before to help her. She goes into the Treatment Room where a more experienced staff nurse, Sue is already preparing to set the pump up. N19 asks her to explain how to do it and Sue quite happily agrees. Sue has opened the Controlled Drugs (CD) cupboard and has the CD book open on the worktop in front of her at the page for recording diamorphine. She takes the boxes of diamorphine out of the cupboard and places them on the CD book. They count the number of ampoules out loud and check that this corresponds with the number recorded in the CD book. It does. Sue checks how much diamorphine they need for the prescription. ‘Right we want one ampoule’ and takes one from the box. She shows the ampoule to N19 and reads out loud the drug name, dose and expiry date. N19 says ‘Okay’ and Sue places the ampoule on a medicine tray. N19 records the number of ampoules that are going back in the CD cupboard in the CD book and checks this figure with Sue. Sue agrees that there is X number of ampoules in the box, she puts the ampoules back in the cupboard and locks it. Sue watches N19 write the date, time and drug dose in the CD book. Sue looks at the drug chart ‘Oh we also need to add cyclizine to the pump’. She has already got this ampoule in a separate medicine tray on the worktop. N19 asks ‘How do you draw up the drugs?’ Sue says ‘We’ll draw them up separately and them mix them together in a 50ml syringe...the diamorphine is going over 24 hours, so we want to reconstitute it to give the patient 1ml an hour’. N19 nods her head and says ‘Okay’. Sue asks N19 whether the drug is to go sub cut or IV. N19 checks the drug chart. ‘The prescription says sub cut’. Sue says ‘Okay, I’ll attach the butterfly after we’ve drawn the diamorphine up’. The pharmacist comes into the Treatment room ‘Have either of you seen Mr X’s drug chart?’ They both shake their heads and say ‘No’. Sue asks the pharmacist what the correct dose of phenytoin is because ‘...Apparently there was a problem with the dose that Mrs H had yesterday, the prescription was wrong ’ ‘I just wanted to check’. The pharmacist tells her, they discuss this for a few minutes and then the pharmacist leaves. N19 is quiet during this exchange. Once the pharmacist has gone, N19 asks Sue ‘How do you reconstitute the diamorphine, ‘cos it’s a powder?’ Sue says ‘You only need to dissolve it in a small amount of water’. N19 watches Sue prepare the diamorphine. Sue takes a 2ml syringe and attaches a blue needle to the end. She opens the ampoule of diamorphine and a 10ml plastic bottle of sterile water. She puts the needle inside the water bottle, inverts the bottle and draws up 1ml of water into the syringe. She shows N19 the amount she has drawn up and then squirts it into the ampoule of diamorphine. N19 watches what she is doing. Sue points out ‘Look, see how the diamorphine dissolves so quickly?’ N19 says ‘Hmm yeah’ and starts to draw up the cyclizine. She breaks the top off the ampoule, takes a 2ml syringe, attaches a blue needle to the end, inverts the ampoule and then withdraws the cyclizine. She places the ampoule in the tray along with the syringe. Sue then draws up the dissolved diamorphine into the same syringe as before and takes off the needle. There are bubbles in the syringe and she tries to get rid of them by holding the syringe and flicking it with her finger and tapping it on the edge of the worktop. The bubbles rise to the top of the syringe and disappear. When the bubbles have gone, she shows the syringe to N19 ‘Right, 1ml?’ ‘Yep, 1ml’ N19 writes up a yellow label to put on the 50ml syringe. She writes the patient’s name, the drug names, what they’re mixed with, the dose, the date and time of set up and the mode of administration. Sue shows N19 as she squirts the diamorphine into the 50ml syringe. She then puts the diamorphine ampoule in the sharps bin and asks N19 for another blue needle to draw up the rest of the water. N19 passes Sue the needle and watches her draw up the water from plastic bottles into the 50ml syringe. The nurse in charge comes into the Treatment Room and says she is going on her break. She hands over what’s going
on the ward to Sue whilst Sue draws up the water. N19 goes to find a syringe driver for the diamorphine pump. The nurse in charge says she wants to get some Oromorph for a patient that was due it at 10am. Sue says ‘Oh I’ll do it with N19 when we’ve done this’ and tells the nurse in charge to go on her break. The nurse in charge says ‘Thanks’ and leaves the room. N19 comes back with the pump. Sue shows N19 the amount of drug in the syringe ‘Right that’s 24mls’ ‘Okay’. N19 asks ‘Is it easier to draw up 48mls, ‘cos then it’ll go over 48 hours?’ Sue says ‘The patient would get the same dose, but this way you have less to draw up’. Sue attaches the IV line to the 50ml syringe and shows N19 how to prime it. She squirts the drug through until she can see it at the end of the line, then attaches the butterfly and squirts the drug through that until it’s at the end. She then clamps the line. The nurse in charge comes back in and tells Sue of further changes with the patients in the respiratory bay. N19 puts the yellow label on the 50ml syringe and asks ‘Should we do the Oromorph now?’ Sue says ‘No, we should do one at a time really’. Sue picks up the syringe, the patient’s drug chart and the CD book and N19 picks up the syringe driver. They go to the patient’s bedside. The patient’s family are present. Sue enters the room and explains to the family ‘I’m going to set up a pump that gives your dad a painkiller’. The family leave the room. This patient is dying, his breathing is very laboured and he’s barely conscious. Sue goes up to his bedside and says his name and then ‘I’m going to give you something to help with the pain and to stop you feeling sick,’ she says ‘But I have to put a needle in your tummy to do this.’ The patient doesn’t respond. N19 places the syringe driver on a chair by the patient’s bed, gets an electric cable for it and attaches it to the wall socket. Sue places the syringe in the syringe driver and clamps the syringe in place. They both put on aprons and gloves. They stand one on either side of the patient’s bed. N19 has the patient’s drug chart and Sue reads out aloud from his name band the patient’s name, hospital number and date of birth, N19 checks this with the information on his drug chart. The information on the wristband is unclear. Sue says they’ll cut that one off and get another one after they’ve set the pump up. Sue opens a packet of tegaderm and hands it to N19 while she takes the bedclothes down and exposes the patient’s abdomen. Sue switches on the syringe driver. The door is ajar. I offer to close it. Sue says not to worry as no-one can see. I can hear a health care assistant by the nurses’ station ordering 3 dinners of pie and mash from the kitchen. Sue takes the butterfly and takes off the tip, exposing the needle. She says ‘Just a sharp prick in your tummy now’ and sticks the needle in just beneath the patient’s skin. The patient cries out. N19 covers the butterfly with the tegaderm and Sue writes the date and time on it. She presses a button on the pump as N19 watches. Sue sets the infusion rate at ml per hour and checks that this is correct with N19. She then releases the clamp on the IV line and presses the start button twice to get the pump going. Sue covers the patient up again. They both sign the drug chart and the CD book and take their aprons and gloves off and wash their hands. A doctor stands at the doorway of the side room and asks N19 about a patient she is looking after. The patient has a sensitive problem and they talk in hushed voices. Sue and N19 leave the side room and go back into the Treatment room.
Appendix III

Observational Vignette 8: N38 catheterises a patient for the first time

Field Note: 1100am: N38 says she may have to catheterise a patient if she doesn’t pass urine. This is why she is looking at the Royal Marsden Clinical Procedures Book. N38 reads through the manual at the desk. She follows some of the text with a pen as she reads.

1125am: She closes the book and says she needs to catheterise this patient. She goes to tell the patient but she’s still on the phone. She decides to work out what she needs. ‘One of those’ she grabs a kidney dish on her way to the treatment room. The room is at the back of the ward, where there are store areas and cupboards with equipment in. There are lists of what’s in the cupboards on the front. She goes to these and then to the treatment room. A doctor asks if they have any large gloves. N38 points them out. She looks for a catheter but can’t find them. She goes to a small cupboard under a large table in the middle of the male bay of patients, which is labelled ‘urinary catheters’. She gets one and takes it to the treatment room, puts it on the bottom of a trolley and gathers the rest of the equipment she needs – KY jelly, a urine bag, a dressing pack, saline sachets x2, a 10ml syringe, an incontinence pad and gauze. She goes to the patient and explains that she needs to catheterise her. The patient says she feels like she needs to go to the loo. ‘Okay hold on and I’ll get you a jug’.

1130am: N38 gets a sterile jug for the patient to pass urine in and takes her to the toilet. She waits with her. The patient has no success. N38 says again that she will have to catheterise her. She escorts the patient back to her bed.

1135am: N38 goes to the desk and tells the coordinator Lee that she’s about to catheterise this patient. She says that she hasn’t done it before. Lee offers to help and N38 accepts.

N38 goes to the treatment room and another nurse comes in – this is N38’s preceptor. N38 explains that she’s going to have to catheterise this patient. ‘I didn’t say before because you looked busy…I’m about to do my first catheterisation’ She asks N38 ‘Are you happy to do it?’ They have a chat about it. N38 says she feels okay but nervous about doing it but she’s had a look at the Marsden book, which has helped. N38 says that the patient hasn’t peed since 5 this morning. ‘Do the doctors know?’ ‘Yes’ ‘What did they say?’ ‘If she doesn’t pee then catheterise’ ‘Okay...how is she?’ ‘She doesn’t seem bothered either way’ ‘Okay’ She says to call her if she needs a hand N38 takes the trolley to the patient and arranges the area. She moves an IV drip stand out of the way and moves the patient’s table to the end of the bed. She pulls the curtains round and says ‘I need you to lie on this [incontinence, pad]’. The patient is lying on the bed. ‘Another nurse is going to watch me do this is that okay?’ It’s fine with the patient. ‘I’m used to it’ N38 says she’ll be back in a minute ‘I’ll just go and find the other nurse’ The patient says she’s going to be sick. N38 grabs a kidney dish for her. N38’s other patient is in the loo. N38 goes to get another dish for the patient from the sluice. She comes back with a few dishes and puts gloves on. ‘If you want to be sick there are more bowls here’ The other patient comes back from the loo ‘I couldn’t see the towel with my name on’ N38 asks which loo she went in to. The patient says she took her own pen and wrote her name on the towel over the jug. ‘Okay that’s fine’. N38 waits for the coordinator to be free to supervise her. She looks nervous. She says that her hands are sweaty. The patient asks her to get a vase for her flowers when she’s free. N38 goes to fetch one from the sluice. She chats with her preceptor on her way via the desk. She comes back with the vase and puts gel on her hands. N38 goes in to see how the patient is behind the curtains. She asks if I can watch her do the catheter. She says
it’s fine. The patient asks why she’s feeling so sick. N38 says ‘You did have that morphine’.

1150am: The coordinator says she’s on her way so N38 prepares her equipment for the catheterisation. She opens the dressing pack on a blue towel, opening each corner at a time with the tray in the centre of the towel. She takes the yellow rubbish bag in the pack and smoothens out the corners with her hand inside the bag. She takes out the contents of the pack in the same way – gloves, gauze, the tray and towel. She attaches the bag to the side of the trolley. She adjusts the light over the bed, it doesn’t stay where she wants it over the patient and the light is too dim. She chats with the patient whilst she prepares the equipment. She asks about being re-catheterised, the patient has had it done before ‘How was it this morning?’ ‘It took 10 minutes, I could have done it myself’ ‘I’ll just lower your bed down’ N38 lays the bed flat and adjusts the incontinence pad underneath the patient. ‘Can you push yourself up the bed a bit?’ The patient asks about the fact she is bleeding slightly from her wound. N38 says it’s normal ‘I spoke to the doctor about it and he says it’s okay’ N38 cuts the top off a saline sachet and pours it into the tray. Lee comes in ‘Have you got an apron?’ ‘No’ She brings one in for N38, along with gloves for them both. She does N38’s apron up. N38 opens the syringe onto the trolley. She opens the KY jelly. Lee says ‘Always discard the first bit’. N38 squirts it into the yellow bag and then a dollop onto the dressing towel. ‘I hope I’ve got everything here Lee’ Lee asks N8 what size catheter she has. ’16, do you think that’s too big?’ ‘Yes I think you should get a 14’ N38 goes to change it.

1200pm: N38 comes back with the size 14 catheter. She puts gel on her hands and opens the outer layer of the pack. She goes to open the inner pack and Lee says ‘It’s easier if you leave it in the bag’ N38 leaves it half open on the sterile field on the trolley. N38 asks the patient to take her pants off and her pad. ‘Where do you want me?’ The patient looks very tired. ‘I’m just going to open your legs for you’ N38 gently pushes her knees down. N38 puts sterile gloves on which looks tricky because they’re stuck together and she has gel on her hands. ‘They won’t go in’ Lee says ‘Take your time’ ‘It’s my fingers that are the trouble’ N38 eventually gets them on and stands close to the patient with the trolley on her right by the bed. ‘Okay I’m going to separate your labia, yeah, keep your legs open for me...I’m going to wipe it with some gauze okay’ She prepares the gauze, dips it in the saline, squeezes off the excess. She holds the patient’s labia with her left hand and wipes once in a downward stroke from top to bottom with her right hand. She repeats this twice. She says to Lee ‘I’m going to put that in gel’ She takes the catheter and dips the tip in the KY jelly. ‘Okay I’m going to put this in Mel’ She looks for the right opening, feeling with her left hand. Lee points out where to aim. The patient says ‘It’ll be over on this side a bit because I think that’s where you’ll hit it’ Lee says ‘It’s just a matter of pushing in the catheter until the urine comes out at the end’ N38 has a go at pushing the catheter in. She stops when she thinks she’s gone in far enough and looks at Lee. Lee shakes her head. N38 tries again. The patient says ‘Can’t you get it?’ ‘No not at the moment’ N38 has another go. N38 stops and looks at what she’s doing from the left side of the patient. Lee is on the right. Someone tries to come in. Lee says ‘No’ and goes to pull the curtains round. N38 says ‘Just relax your legs again’ ‘Okay take your fingers, separate and identify the aperture’ ‘Okay start again’ Lee goes out to get another catheter ‘What size was it?’ ‘A 14′ N38 discards the old catheter and says ‘We’ll be as quick as we can’ to the patient. The patient offers to do it herself. N38 says ‘I can only see 1 big and 1 small hole’ Lee comes back with a new catheter. ‘Do you want me to do it or do you want to try again?’ ‘I’d like to try again’ Lee says ‘Okay just open the tip of the catheter so only the tip shows through...so it’s a clean procedure’ N38 struggles with a new pair of gloves.
1210pm: N38 puts more gauze in saline and re-wipes the patient. The yellow bag detaches from the trolley. She puts the tip of the catheter in the KY jelly. 'Now identify the 3 areas...you haven’t opened the area enough, open it up more...identify before you go in with the catheter, otherwise it’s a infection risk’ N38 does as Lee says. 'There’s a bit of resistance...are you alright?...I can’t see it’ Lee leaves to get a pair of gloves. N38 says ‘Sorry if this is uncomfortable’ The patient says ‘Are you sure you’re pushing enough in, I can’t feel it’ ‘We’re still trying to find the hole’ ‘I just take pot luck’ Lee washes her hands and comes back, she puts sterile gloves on. Lee has a go. She puts her sterile glove pack on the incontinence pad in front of the patient’s legs. She opens her legs, wipes the patient and identifies the apertures. N38 hands over the catheter to Lee and she dips it in the jelly. There’s a ‘Hello’ from behind the curtains ‘We’re a bit busy behind the curtains’ ‘I’ve just got to take the ECG machine round to B ward’ ‘Okay’ Lee is having trouble. ‘Do you have trouble catheterising yourself?’ ‘I’ve done it, I take pot luck’ There’s a lot of resistance. ‘Everything’s quite tight’ Lee stops. The patient gets up on the edge of the bed. She has a look at the catheter and says it’s too big. Lee asks N38 to look for a smaller size 10.

1225pm: N38 comes back ‘The smallest we have is a 12’ The patient suggests trying urology. Lee asks N38 to go down there and get an 8 or a 10. N38 leaves. She comes back with an ‘in/out one’ that doesn’t attach to a bag. ‘Could we do an in/out one?’ Lee says she’d rather they got a permanent one. 'Where did you try?’ ‘R ward’ They decide to leave it a while until they find a size 10. Lee leaves. ‘Thanks very much for your help Lee’ N38 makes the patient comfy, sorts out the bed and clears up the rubbish. Lee comes back with the bleep number of the incontinence advisor and tells N38 to ring her for a catheter. N38 takes the trolley to the treatment room and chats with Lee on the way. ‘Get the incontinences advisor to see her’ Lee says that whilst she was trying she could see that the top of her urethra was sore which may be due to trauma from her catheterising herself. ‘I don’t want her to do it herself, there was a lot of resistance there so I think we’ll wait’

1245pm: Lee asks ‘What did the incontinence nurse say?’ ‘She didn’t want to come up’ Lee seems surprised. ‘It’s just embarrassing when 2 of us have had a go’ Lee asks her what wards she’s tried. She suggests some more. N38 says the incontinence nurse is on annual leave and a urology sister is covering ‘She wasn’t particularly helpful, she says she has no access to equipment so she’s unable to get any’ N38 says she’ll try again. She goes back into the ward clerk’s office and rings another ward. Theatres are her last try and thankfully they have one so N38 goes to fetch it.

1300pm: N38 comes back from theatres, bit of a trek. She goes to the patient. ‘We’ve got a size 10, do you want to try again?’ She asks her other patient how her lunch went. ‘Okay’ ‘Have you has anymore to drink?’ ‘Yes’ ‘Can you remember how much?’ N38 records on the fluid chart. She checks the patient’s IV drip, counts the drips per minute. She asks about the menu. She goes back to her patient and checks her IV drip, counting the number of drips again in a minute with her stopwatch.

1315pm: N38 prepares the catheter equipment again and brings the trolley to her bed-space. ‘I’m going to try again’ She raises the bed higher. This time she’s going to be supervised by another nurse. N38 follows the same procedure as before with opening the dressing pack. She puts her hand inside the rubbish bag and takes out the rest of the items in the pack. She opens the gauze, syringe, KY jelly and saline. Sue suggests using a catheter pack. N38 says she didn’t know they had them. ‘Okay ask the patient to take her pants down’ ‘I’ve got none on...I feel sick’ N38 gives her a kidney dish. ‘Have you vomited yet?’ ‘I’ve nothing to bring up’ N38 puts her sterile gloves on again, still not easy. She makes a joke of it, she says she hasn’t dried her hands properly. ‘One more thing to do, is to prepare the catheter’ Sue instructs the patient ‘Okay if you do what you did before, open your legs and we’ll wipe with some gauze’ Sue gestures to N38 the way to wipe, one
downward stroke. 'Sorry' N38 whispers to Sue 'I can't see the hole' Sue shines her pen torch onto the area so N38 can see better. N38 dips the catheter in jelly and Sue holds the torch steady. 'Sorry' N38 pushes the catheter in. And urine comes out into the catheter inner bag. It's in! Sue says 'Okay put the receiver under the end to catch the urine' N38 takes off the catheter wrapper and puts it in the receiver. Sue chats to the patient as N38 gets the urinary bag ready. She opens the bag and puts more gloves on and attaches the end of the bag to the catheter opening. Sue holds the catheter in place. 'Okay get the syringe to blow it up' N38 gets the 10ml syringe of water and squirts it into the catheter. 'That's quite stiff' 'How does it feel down below?' 'Okay' 'Is there anything there [meaning urine]?' 'A little bit' N38 clears the rubbish away. They lower the bed and make the patient comfortable. N38 takes the trolley away to the sluice.