Work-role transition: From staff nurse to clinical nurse educator.

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Abstract

There is an imperative for health professionals today to maintain competence in clinical practice, which for registered nurses in New Zealand requires current experience of practice, continued professional development and education. In many organizations in New Zealand today, practice based clinical education for nurses is delivered by clinical nurse educators (CNEs). The purpose of this study was to explore the opinions and perceptions of CNEs as they transitioned from a staff nurse position to the CNE role, a designated senior position within the District Health Board (DHB) involved in this study.

The aim of the study was to describe the experiences of CNEs in their first year in the role to gain a clearer understanding of the knowledge and skills required to be successful in the role. This understanding will enable a smoother and more satisfactory transition into the role and provide targets for career development for nurses aspiring to become CNEs. Qualitative description, using a general inductive approach was the methodology chosen to underpin this study. A sample group of eight CNEs from a New Zealand DHB were interviewed about their experiences using a semi structured interviewing technique.

The results of the data analysis have been presented using Bridges (2003, 2004) transition theory as the theoretical framework. The data chapters are titled endings, neutral zone and beginnings. The main themes were; entering transition, getting started, chaos and turmoil, overwhelmed and opening doors. The themes present the feelings and perceptions of the CNEs using their own words. The CNEs experienced the journey through transition and discovered the role they had undertaken was much larger than expected. In addition information and shared understandings of the role were limited and orientation to the role, minimal. The CNEs experienced a variety of emotions and challenges while moving through this transition period. By sharing their stories and insights they have given the opportunity for learning to occur, which will enable improved succession planning, orientation and transition periods for future CNEs.

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Chapter 1: Introduction

1.1. Introduction

In New Zealand's District Health Boards (DHBs), the workload of the staff nurse[1] continues to evolve and increase (McCloskey & Diers, 2005). Concurrently there are increasing numbers of learners in the clinical setting; new graduates, nurses returning to practice, overseas nurses, student nurses and newly appointed nursing staff, who the staff nurse is expected to support or precept. As bed management responsibilities, highly dependent patients, increasingly complex treatment options, sub optimal skill mix and financial restrictions all impact on nursing time, it can be difficult to sustain the role of preceptor and teacher (Brennan & Hutt, 2001; Edmond, 2001; Orchard, 1999). Many DHBs have responded to the need to orientate nurses, manage clinical risk, provide ongoing practice education and meet the regulatory requirements of continuing competence, as required by the Nursing Council of New Zealand (NCNZ), by establishing Clinical Nurse Educator (CNE) roles embedded across the various specialty areas.

The Health Practitioners Competence Assurance Act (HPCAA, 2003) requires all registered health professionals in New Zealand to provide ongoing evidence of competence within a scope of practice as detailed by their regulatory body. This has led the nursing regulatory body (NCNZ) to request evidence of practice and education hours on a three yearly basis from each practising registered nurse in New Zealand. In a competitive recruitment market access to in-house education is a potential recruitment and retention strategy as nurses seek access to free education opportunities to meet continuing competence requirements for their annual practising certificates.

In light of the HPCAA (2003) there has been considerable national activity in DHBs to develop Professional Development and Recognition Programs (PDRPs) to facilitate competence assessment of registered nurses, enrolled nurses and nursing assistants. A number of DHBs have had PDRPs for many years based on Benner's (1984) model of situational skills acquisition applied to the nursing profession. There has also been some use of magnet principles, which relate to the recruitment and retention of nurses (McClure, Poulin, Sovie, & Wandelt, 1983). PDRPs require evidence of learning hours

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[1] Throughout the thesis the researcher will refer to registered nurses employed in non designated positions as staff nurses. Registered nurses in designated positions will be referred to as senior nurses, or a title specific to their role such as clinical nurse specialist.

and practice skills, linking professional development, performance management and competence assessment (Peach, 1995, 1999). In many DHBs CNEs are the leaders of the PDRPs and competence assessment, their key role being to link practice education with clinical need.

CNEs are often professionally isolated as there is usually only one CNE in a service. However, CNEs have much in common with their colleagues from different clinical specialties. An example of this commonality is their transition into a senior role, which can be demanding and complex regardless of nursing specialty. This study presents the experiences and perceptions of a group of CNEs as they moved into this diverse senior role. In this chapter the background to the study is explored through presenting the CNE role within an historical context. Researcher interest and study aims are also presented. The chapter concludes with an overview of the thesis. The significance of the study is presented in the following section.

1.2. Significance of the study

Continuing practice development and education is vitally important in the rapidly changing practice setting of healthcare (Evetts, 1999). The CNE role provides an avenue for DHBs in New Zealand to offer continuing practice development and education within the clinical setting. Clinical practice can be complex, stressful and fast paced, hence a deep understanding of the clinical context is vital for any education or resource role (Edmond, 2001). CNEs, as DHB employees, have clinical credibility and full organizational access. They are able to effect change in practice, are involved in decision making, performance management and policy development. The combination of organizational knowledge, networking and clinical expertise provides an expedient resource for the staff working in the clinical area (Cowin, 2003; Edmond, 2001). The CNE has a significant role to play in quality assurance activities, staff assessment, clinical practice development, risk management and support for individual staff members. All these components ultimately impact on patient outcomes and the provision of quality nursing care.

The CNE is a nationally designated leadership position within the DHB nursing structure. As nurses ascend through the nursing hierarchy, their responsibilities and the expectations of them become more intense and more complex, but frequently less clear

(Laborde, 2000; Porter-O'Grady 2003a). It is often the case that nurses who have performed well in clinical practice are expected to perform well in designated senior positions, for which they have often had no formal preparation (Wilson, 2005). It is clear that employees perform better when they and their managers have a deeper understanding of how their roles function (Ministerial Taskforce, 1998). Despite this diverse role existing in New Zealand's DHBs for a number of years there is a paucity of literature available to describe the role. This study will increase the understanding of the role for employers and CNEs themselves, leading to stronger planning for future roles, succession planning initiatives and comprehensive, tailored orientation programmes.

1.3. Researchers interest in the study

Interest in this research stemmed from personal experience as a CNE, and then as the professional leader of clinical nurse and midwife educators. I have gone through my own chaotic and vulnerable time when moving from a staff nurse position to my first senior nursing role. During that time, I read a quote from an article which resonated with me then and continued to have relevance as I moved into other senior roles. "Becoming a nurse educator is not an additive process; that is not a matter of adding the role of educator to that of nurse. It requires a change in knowledge, skills, behaviours and values to prepare for newly assimilated roles, settings and goals shared by new reference groups" (Infante, 1986, p. 94).

To establish a rationale for undertaking the study, I have referred back to a discussion with a number of CNEs from my own DHB who had either completed one year in the role or were just about to. CNE orientation, leadership and provision of toolbox skills to do the job, are a part of my role and responsibilities. These conversations were informal and occurred due to my role and type of interaction with CNEs, looking at how we could improve the orientation for new CNEs. We talked about how they felt moving into their new roles and how they had grown into them. I requested permission from the CNEs to use their words anonymously in the study as a point of introduction and rationale, they enthusiastically agreed. I grouped their responses into 4 categories, using their own words.

(1) Feelings upon starting in the role

- Feel completely de-skilled, standing on the edge of a cliff looking out onto the 'big picture.'

- I had a complete lack of understanding of the size and scope of it ... it's huge.
- I went from 'top of the heap' clinical expert/ support/ resource/ coach to novice CNE.
- It felt very lonely, but also like I was in the spotlight and having to prove myself.
- Surprised at the agendas people had for me, the expectations were overwhelming.
- You have to juggle. They want you to be setting up and running study days, writing policy and on the wards all at the same time.
- You feel guilty whatever you do, either if you're 'visible' or 'not visible'.

(2) Personal developments

- Always need to be accessible, always welcoming.
- Learning to stay neutral.
- How to coach and teach.
- Counselling skills/ mediator/ diplomacy.
- You need organizational knowledge and awareness really quickly ... networking is so important.
- Viewing your old colleagues through a different lens.
- Being relied on.
- Learning leadership skills, like decision making, self awareness and managing relationships.
- Getting used to 'being seen differently', behaviours change when you walk into their area.
- People have to trust you and you have to earn that.
- The first year is a massive learning curve. Can't believe how much I just didn't know.

(3) Tasks

- The computer skills–excel data-basing, email scheduling, power-point.
- Learning how to write using the quality template ... that was time consuming and stressful, and I didn't know I'd have to do that.
- Representing your service or even the DHB in various meetings, nobody tells you about that.
- What various 'must attend' meetings are for, where they fit, it took a while to work out.
- Staff assessment skills-or the communication skills to undertake assessment.

(4) The first year: the CNE's agreed on a timeline for their own development.

- 0-6mth- self-direction, finding out what the job is, feeling vulnerable.

- 6-9mth- starting to make sense of things, but overwhelmed.
- 9-12mth- starting to consolidate what you've learned, starting to 'do the job'.

In my capacity as the professional leader for this group I was aware of the inconsistency and ad hoc manner of CNE orientation. I continue to hold the opinion that orientation should not take a set period of time to suit the convenience of the organization, but rather, should be revisited and adjusted as often as the individual requires. I have encouraged nurses who are new to designated senior positions to maintain a journal in their first year as a tool to enable reflection. These reflections value and celebrate the completion of a journey, of which I have personal experience.

1.4. Research question and aims of the study

Question

- What are the perceptions and opinions of nurses as they transition from staff nurses into being clinical nurse educators?

Aims

- To describe the experiences of CNEs in their first year in the role.
- To develop a clearer understanding of skills and knowledge required to be a clinical nurse educator.
- To guide the development of a process to make this transition period more successful and satisfactory.
- To develop a more targeted approach to career development for people aspiring to the role of CNE.

1.5. Background

In order to present this study in context I have explored the development of the CNE role in New Zealand. As the CNE is a designated senior position it was important to put the evolution of the role into the historical, socio-political context of nursing leadership while being mindful of the requirements to provide post registration clinical education. Two main areas are presented, clinical education post registration and the impact of the health reforms on nursing in New Zealand.

1.6. Clinical education post registration.

There is a richness of information available describing the development of New Zealand nursing education, from hospital based training to the undergraduate degree programmes of today (Brown, Masters & Smith, 1994; Department of Health, 1986; NZNA, 1984; Orchard, 1999; Papps & Kilpatrick, 2002; Williams, 2000). The Carpenter report (Carpenter, 1971) recommended an alteration in registered nurse training, moving from hospital training to a polytechnic based course. In 1973 Christchurch and Wellington Polytechnics commenced nursing courses in response to the Carpenter recommendations. Over the subsequent years polytechnic based training continued to supplant hospital based training until the last hospital based school of nursing, Auckland, closed in 1990. Resistance to the loss of students as a workforce with their transfer to polytechnics was observed across New Zealand as nurses defended the system under which they had gained registration (Papps & Kilpatrick, 2002).

The loss of the student nurse workforce altered the staffing balance in the clinical environment. Difficulties in recruiting the correct mix of registered nurses, enrolled nurses and healthcare assistants to replace the student workforce, saw a decline in the numbers of senior nurses, registered and enrolled nurses (McCloskey & Diers, 2005). This decrease in numbers of registered nurses and enrolled nurses led to increased pressure on remaining staff to manage high workloads, preceptor new graduate nurses and support colleagues (Brown et al., 1994; Ministerial Taskforce, 1998; NZNO, 1995).

There is little written on the continuing practice education of registered nurses in New Zealand. Williams (2000) outlines the development of nursing career structures in New Zealand generally and the developments in pre and post registration nursing education. For example, as far back as 1965 nursing 'inservice education' positions were established to manage ongoing education and orientation of registered nurses. Their role was to ensure nurses in practice could refresh their skills. In later years, inservice departments ensured that nurses could safely return to practice and were also able to support new graduate nurses as they left the polytechnics. The courses offered by these departments did not result in qualifications towards career progression but, instead, kept nurses up to date in their particular field of interest (NZNA, 1984, 1987).

The NZNA review of inservice education (1987) detailed the development of inservice departments. They defined inservice education as a means of ensuring the nurse was more effective in the workplace. Organizations were obliged to provide this service and nurses were obliged to participate. The career structure for staff within inservice departments was outlined by the NZNA (1987). The expectation was that inservice staff would attain post registration diplomas or degrees in nursing, and the head of the department should have a post graduate qualification in nursing. The inservice educators were expected to be clinically current and have skills in policy development and knowledge of adult educational practices. Inservice departments realized nursing practice had changed as a result of workforce restructuring (NZNA, 1987) and that the need for ongoing education and orientation to new clinical environments, employer policies and procedures, was of paramount importance to maintain safety. The NZNA (1984, 1987) identified that most large organizations had an inservice department which needed to become central to an organization in order to cope with a changing work environment.

Despite being seen as central to nursing education in the 1980's the advent of the health reforms in the 1990s saw the demise of the inservice departments due to extensive budget cuts. Nursing was the largest workforce and its budget, including nursing education, was extensively trimmed (McCloskey & Diers, 2005). Nursing staff from inservice departments were redeployed or made redundant.

The loss of the hospital based schools of nursing had significant and irreversible impacts on the nursing hierarchy and the overall structure of nursing (Jacobs, 2003). Nurse leaders took the opportunity to seize the moment to be the driving force for their own future (Williams, 2000). For example as new graduates left the polytechnics and needed ongoing support nurse leaders sought to deliver education working alongside the registered and enrolled workforce in the clinical environment. In the mid eighties the first senior clinicians were appointed, a precursor to the clinical nurse specialists of today. In 1988 supervisor roles were removed and the first of the nurse specialist roles was introduced. Between 1991 and 1993, with burgeoning specialties and increasing clinical complexities, clinical nurse specialist and clinical nurse educator roles began to increase in number across New Zealand's hospitals (J. Peach, personal communication, October 4, 2006).

1.7. Health reforms

Health reform can be described as a reconfiguration of the health system at a national level (Bloom, 2000). In New Zealand health reforms were announced in July 1991 and aimed to introduce market competition into a publicly funded health system (Hornblow, 1997).The New Zealand health reforms looked at service costs, efficiency and quality of health service delivery, and were driven by political agenda's, increasing financial costs within the health care system, advances in technology, increasing consumer knowledge and expectations. The government of the time claimed that market tension would increase performance of the twenty three newly developed Crown Health Enterprises, which were expected to operate at a profit. This resulted in contract negotiations for services, budget cuts and increased user charges (Hornblow, 1997). Nursing services, being the largest within the organizations, attracted aggressive budget cuts, a phenomenon repeated in other parts of the world, such as North America (McCloskey & Diers, 2005; Tourangeau, 2003).

Inevitably, in reforming the health system, organizational staffing structures were challenged and changed. The reforms, aimed at controlling the spiraling cost of healthcare through market competition, had widespread and sometimes unpredicted consequences such as the decline in the quality of patient care as registered and enrolled nursing numbers dropped and nursing leadership at every level of the health system was lost (McCloskey & Diers, 2005). A decline in registered nurse staffing levels has since been internationally proved to be a leading cause of adverse patient outcomes, nurse job dissatisfaction and stress in the hospital setting (Aiken, Clarke, Sloane, Sochalski, & Silber, 2002; Cho, 2001; McCloskey & Diers, 2005).

The reforms not only focused on the cost of health care delivery but challenged traditional roles in hospital management. Historically the management system utilized by New Zealand's hospitals was a tripartite model; a doctor, a nurse and an administrator (Alexander, 2000). The development of the health care market led to a professional management model, which saw a number of doctors and nurses moving into management roles (Alexander, 2000; Peach, 1995). According to Peach (1995) many senior nurses were removed and managers introduced. However, some senior nurses opted to move into management roles. Williams (2000) suggests that many senior nurses did not have the skills or support to successfully move into management, or

struggled with the adjustment to the different demands of management roles (Kaissi, 2005) leading to some leaving the profession. Other senior nurses left to take employment in technical institutions as lecturers and tutors. Again Williams (2000) suggests many found this a difficult transition. Significant numbers of staff nurses, enrolled nurses and senior nurses left the profession altogether (Brown et al., 1994). According to Williams (2000) nurse leaders of the time are of the opinion that a generation of expert clinicians was lost. The Ministerial Taskforce, (1998) noted that nursing leadership had significant gaps, and in acknowledging the future global workforce issues in nursing, the Taskforce document recommended development of professional career pathways, increased access to further education, leadership development and increased understanding by employers of nursing roles.

The change of guard at the hospital management level had significant impact on nursing as a whole. In presenting a history of nursing at the time, Brown et al. (1994) note that this signalled a change in roles for charge nurses, from being responsible for the nursing care of the patients to recruitment and managing a budget. Conversely, the organization's senior nurse or chief nurse was seen in an advisory capacity only, often losing budgets completely, while the hospitals were run by generic managers (McCloskey & Diers, 2005).

In some instances, managers would have professional health backgrounds (clinician/managers) which impacted on decision making processes. Clinician/managers who felt able to knowledgeably balance clinical versus financial implications could and would make decisions without consulting clinicians, including the organization's chief nurse. However, many of the managers were business managers and conflict occurred as nurses' professional values and the business managers' commercial values collided (Alexander, 2000; Hornblow, 1997). Remaining nursing leaders felt de-valued and rather than having involvement in corporate and strategic decision making, they lost financial and strategic control of nursing (Ministerial Taskforce, 1998).

At this stage, nursing leadership was unable to regain the level of management and financial control it held prior to health reform (McCloskey & Diers, 2005). However, in recent times, opportunities for senior roles within nursing have increased. Workforce development pressures, such as changing consumer needs, technological advances,

and recruitment issues, have opened the door for new roles to evolve, such as; Nurse Consultant, Associate Directors of Nursing and the Nurse Practitioner. Nursing leadership has again seized the opportunity to develop career structures for nurses, and to shape its own future.

1.8. Organization of the thesis

Chapter one: Introduction

In chapter one the study is introduced and the context of the CNEs place in DHBs in New Zealand is described. The researcher's interest in the study is presented introducing the rationale for the study. The background to the study provides an historical context for the role in ongoing practice education, nursing leadership and the health reforms. An overview of the thesis completes the chapter.

Chapter two: Literature review

In chapter two, a critical review of the literature relevant to this study is presented. The role of the CNE and similar roles internationally begins the section; nursing leadership and succession planning are also presented. In keeping with the theoretical framework chosen for this study the literature on transition in nursing practice is reviewed along with an overview of literature on organizational socialization and orientation.

Chapter 3: Research process

In chapter three the research methodology and methods are presented, beginning with an overview of qualitative research, specifically qualitative description. The ethical issues and the approval process associated with the study are presented. The interview and sampling methods are detailed and an overview of the general inductive data analysis process, followed by a section on rigour and trustworthiness. The chapter concludes with an overview of the theoretical framework used to present the findings.

Chapter four: Endings

Chapter four begins the data presentation chapters. The first section reviews the endings stage of transition then the chapter is split into two themes, 'entering transition', and 'getting started'.

Chapter 5: Neutral zone

In chapter five, the data relating to the neutral zone phase of transition are presented. Beginning with a review of the neutral zone and then moving into the theme of 'chaos and turmoil' followed by the final theme, which relates to 'being overwhelmed'.

Chapter 6: Beginnings

In chapter six the data relating to the beginning phase of transition are presented. It starts with a review of the beginning stage of transition and then the theme of 'opening doors' is presented. This is the last of the data chapters.

Chapter 7: Discussion of findings.

In chapter seven the discussion generated by the study and the recommendations from the findings are presented. They are discussed within the context of nursing in DHBs in New Zealand and the literature reviewed for this study. The recommendations and limitations of the study are acknowledged and the concluding statement presented.

1.9. Summary

In this chapter an introduction to the CNE role was provided, situated in the rapidly changing and turbulent health environment of New Zealand's DHBs. The current spotlight on competence assessment following the introduction of the HPCAA (2003) has an increased focus on the provision of in-house education and professional development opportunities. This study is significant as the CNE role plays an important part in providing competence assessment, quality assurance, risk management and practice education within DHBs. The researcher's experiences in the CNE role sets the scene for the basis of the study.

The development of the CNE role was placed into an historical context by reviewing the development of nursing education and inservice education departments in New Zealand. Changes in student education, removal of the student workforce, and the health reforms of the 1990's, resulting in economic constraints and altered management structures, had significant impact on nursing. In the following chapter a literature review is presented, which includes literature about the CNE role, succession planning and leadership, concluding with a review of the literature on transition and organizational socialization.

Chapter 2: Literature review

2.1. Introduction

In the previous chapter information was presented on how, over time, nursing has changed due to health reforms, educational developments and workforce issues. In this chapter the literature on the role of the CNE, succession planning for leadership, organizational socialization and transition are presented. There has been extensive research and writing internationally, on the education of student nurses and the experiences of lecturers and tutors in the clinical setting. However, little has been written about ongoing clinical practice education for staff nurses, or the CNEs who deliver this educational need, particularly within the DHBs in New Zealand.

To fully understand the role of the CNE, a literature review of the role was undertaken. Minichiello, Sullivan, Greenwood and Axford (2004) describe literature reviews as painting a picture of the study subject using words. It enables the researcher to find out current research, thinking, views and theories on a subject. The literature search also enables the researcher to find out how much is known about a subject. In the case of the CNE, very little has been written, which gives strength to the significance of the present study. The literature review also allows the researcher to look at what type of research has been conducted on the subject previously, and which research has proved most effective or useful.

The literature currently available in New Zealand and internationally on CNEs or similar roles is reviewed in this chapter. It also contains a review of published works on succession planning for nursing leadership. The final section focuses on organizational socialization and transition, moving into new roles and new organizations which is the focus for this particular study. The first section begins with a description of the research literature criteria and search process.

2.2. Literature criteria.

The aim of this literature review was to critically review the published works on the topics identified. The search criteria for the CNE role took into account the different titles used internationally, such as practice development nurse, used in the United Kingdom. The

intention was to limit the search to practice education roles dealing with post registration nurses in practice and not to include the role of lecturer or tutor supporting student nurses. However due to the shortage of research dealing specifically with post-registration practice development roles, the search was expanded to include research on nurse lecturer roles perceived as being relevant to the current study.

Articles were obtained using searches of CINAHL, Psychinfo, Business Source Premier, Google scholar, Medscape and Medline databases. Books and opinion articles were used to support the literature where required. Minichiello et al. (2004) noted that a literature review can use various types of literature, not just research studies, and use the terms "... theoretical literature, scholarly non-research literature and scholarly literature" (p. 12). The literature review for the present study included research, articles and publications dated from 1980 to 2006, enabling the researcher to understand how the concepts of organizational socialization and transition were generated.

2.3. Clinical Nurse Educator role

There is an imperative for professionals working in the health setting to maintain continuing professional development throughout their work life, as health is one of the most rapidly changing of all work environments (Evetts, 1999; Siehoff, 2003). In New Zealand, focus on continued education and competence of the registered nurse and enrolled nurse workforce started with the Nursing Council of New Zealand's Post Registration Education Framework (2001), which followed the Ministerial Taskforce recommendations (1998). Focus has continued to increase since the advent of the HPCAA (2003). The pressures of technology, workforce limitations, increasing cultural diversity and consumer knowledge, place a high demand on the nursing profession (Aiken, Clarke, Cheung, Sloane, & Silber, 2003). A number of authors advocate the need for lifelong learning in nursing, or continued practice development, linking it to improved patient outcomes, as well as to the ongoing job satisfaction of registered nurses (Considine & Hood, 2000; Haines & Coad, 2001; Perry, 1995; Wildman, Weale, Rodney, & Pritchard, 1999). Despite the supportive claims of value and potential improved patient outcomes linked with increased education, there is little written about clinically based practice education for post registration nurses, not only in New Zealand but internationally (Siehoff, 2003).

Manning and Peach (2002) described the process of ongoing education and practice support currently used within a large New Zealand DHB. They identified that New Zealand health organizations require an increase in the capability of nurses to accommodate rapidly expanding services and advances in technology. This observation is mirrored in the United Kingdom (Haines & Coad, 2001; Holloway, 2000) and Australia (Considine & Hood, 2000). Manning and Peach (2002) acknowledged that many nurses were not in a position, either financially or professionally, to access formal tertiary education and in fact, many simply did not have the intention or inclination to do so. This observation is supported by Hogston (1995) and Spence (2004). Despite this the DHB had to provide education to ensure an acceptable standard of care and as a clinical risk management strategy.

A learning framework linked with a Professional Development and Recognition Programme (PDRP) was developed to effectively structure educational delivery. This learning framework was managed by CNEs, who worked alongside nurses in practice, and were able to identify staff learning needs. Close collaboration with charge nurses then enabled targeted approaches to clinical coaching and in-house education. Manning and Peach (2002) presented this article as a report on an education system and though it has no research foundation, it reinforced the actions and rationale of DHBs in employing CNEs to improve access to clinical education, a similar situation seen internationally (Considine & Hood, 2000; Edmond, 2001; Haines & Coad, 2001; Mateo & Fahje, 1998).

Ervin (2005) promoted the use of clinical nurse specialists to coach and support nurses in practice. She defined coaching as "… a relationship for the purpose of building skills" (p. 296). In reviewing the article, written in the United States, it would appear the clinical nurse specialist holds a role somewhere between the CNE and the nurse specialist in New Zealand. This role carries a patient case load, but with an increased staff education portfolio, with the intent of supporting the utilization of evidence based practice. The author noted that nurses often did not have the time or skills to critically review research and the CNS role could assist nurses to improve their knowledge. Nurse specialist roles in New Zealand would certainly offer coaching and support for nurses, however the strategic direction and responsibility for education would sit with the CNE. Though

Ervin's (2005) article is not focused specifically on the CNE role, it does highlight the international need for ongoing coaching and support for post registration nurses.

Clinical coaching and the need to support nurses in the New Zealand practice setting is presented by Manning, Palmer and Yonekura (2003). This article presents a personal perspective relating to the size and 'scope' of a CNE role within a large medical service. The incumbent CNE described the role as being much larger than one full time equivalent (FTE). Subsequently the employment of two part time experienced staff nurses (1FTE) in the new role of clinical coach was made to support the work of the CNE in the clinical area. The new role also offered opportunities for career advancement and was seen as a succession planning initiative for CNE roles. It began to lay the foundations of understanding a senior role by giving clinical coaches the opportunity to work in close collaboration with CNEs and charge nurses to address education and practice deficits within the clinical setting. This article only offered a description of what was happening and lacked a research foundation, however it reflects the size and diversity of CNE roles, showing that it is not only a teaching and clinical role but has involvement in service innovation, role development and service strategy (McCormack & Garbett, 2003; Mateo & Fahje, 1998).

Lambert and Glacken (2005) presented a review of clinical education facilitators, describing the role as providing support for students in the clinical setting. The rationale for the role was the need to support staff nurses in preceptoring students. The role is described as being complex, needing strong communication, interpersonal skills and increased role clarity similar to that of the practice developers described by McCormack and Garbett (2003). The article supported an increased focus on clinical practice for students and it concluded with a suggestion that this role could be developed to support staff nurses in practice to help them maintain and update knowledge. In effect they were describing a CNE. Such a suggestion, presented as a new idea either shows a limited review of the literature or alternatively reflected the lack of literature available on the CNE role.

An example of nurses in practice profiling the impact of their roles is provided by Haines and Coad (2001), who presented an evaluation of a CNE role in a British hospital. The role was based in an intensive care unit and was expected to provide additional

knowledge and professional development for nurses, both within the unit and to ward based staff. Ward staff were being expected to manage increasing numbers of clinically complex and highly dependent patients. The increasing pressure on ward based nurses and the advances in technology in a rapidly changing clinical setting were significantly improved by the effective combining of educational and practice support in both environments. The authors reported that needs based learning, staff rotation and development of practice skills have all resulted in improved patient outcomes and led to further role developments. This article provided strong evidence for an increase in CNE roles, resulting in benefits in patient outcomes and an increase in career opportunities for nurses.

Brennan and Hutt (2001) detailed their experiences as a new graduate educator and a return to practice educator in an English hospital trust. Each role was created to support students, staff nurses and their preceptors in clinical practice. They identified that the increasing numbers of learners in the clinical areas were causing strain on the staff, which is not an uncommon phenomenon (Considine & Hood, 2000; Lambert & Glacken, 2005; Orchard, 1999). These two CNE roles were set up to try and redress the imbalance. The roles worked across many services and the CNE perceived the need to prove credibility in these areas, which was stressful for them. Clinical confidence and credibility is an area that is addressed in a number of articles (Clifford, 1999; Dyson, 2000; McCormack & Garbett, 2003). Brennan and Hutt (2001) proposed their criteria for successful roles included recent relevant clinical practice experience and they suggested that secondment into roles such as these would develop nurse's interest in education and leadership positions.

Clifford (1999) presented a small scale qualitative study on the role of the nurse teacher. Though it does not relate specifically to the CNE role there are similarities in how the nurse teacher and CNEs manage the dual aspects of their roles, clinical versus classroom. Clifford described how the teachers felt about their work, the role ambiguity and lack of role clarity, resulting in poor management of the role. The teachers felt guilty that they were not sufficiently visiting the ward areas, usually due to paperwork and classroom responsibilities, meaning they were not available to their students. Conversely, they also felt uncomfortable in the clinical areas, at times not "fitting in" (p. 181). The competing facets of the role can create feelings of guilt for not being present

or visible and not achieving deadlines. According to Clifford (1999), role conflict is common and would be exacerbated if the educator did not feel comfortable or credible in the clinical setting, creating a sense of job dissatisfaction.

Cowin (2002), in an opinion column, discussed the feeling of taking a clinical load as a nurse educator and being seen as a "real nurse" (p. 40), after a number of years working in the educator position. Cowin described the anxiety and panic induced by wondering what the staff would think of her and if she would be credible and able to cope back on the floor. Despite the fact she is clinically available daily and teaches in clinical practice, the skills required to manage an allocation of patients and coordinate a shift are different to moving in and out of the clinical setting in a support role. Though this is not research it does echo the research findings of Clifford (1999) and the need for educators to feel and be seen as clinically credible. It is worth noting that Kouzes and Posner (1995) rated credibility extremely highly as a leadership characteristic.

The subject of being seen as credible is described by Dyson (2000) who reported on a study of nurse lecturers in New Zealand, supporting clinical preceptors. She stated that the lecturers felt they would gain a more positive response from clinical staff if they were seen to be "credible and visible" (p. 20). Being seen as credible meant helping out on the wards, or, as described by one person, "hovering" (p. 20). Being present on the wards was felt to increase the familiarity between the lecturer and the staff, to encourage conversation and ultimately to foster trust. However, the study finished with the conclusion that lecturers remain outside the clinical team and are viewed as having minimal status in the clinical area. The study focused on support for preceptors with student nurses, however the constant negotiation to be accepted by staff nurses, reinforces the notion that a resident CNE, with organizational credibility and clinical expertise would be preferable to staff nurses supporting students.

According to McCormack and Garbett (2003), credibility is seen as crucial to the success of practice developers. They presented research conducted using focus groups, telephone interviews and cognitive mapping processes with large numbers of practice development nurse roles. The research showed the complexity and ambiguity of a practice development role, the potential for it to overlap with other senior roles and the resulting confusion and lack of role clarity. The research focused on attributes needed

for the role of practice developer, such as; being a counselor, a sounding board, being seen as neutral or a safe person, having organizational awareness and the ability to develop a complex social network. They suggested that any practice development role must be a subject expert, but more specifically must "... have a deep understanding of the practice context in which they work" (p. 324).

Mateo and Fahje (2003) defined the characteristics of successful staff educators as being change agents, leaders, managers, having political savvy, being respected as a clinical expert and possessing advanced communication skills. They addressed the issues of sustaining expertise, maintaining visibility, working long hours and feeling overwhelmed. The article focused on professional attributes and tips on communication skills, ending with a strong message that these roles need mentorship to flourish and maintain energy. This is a concise and relevant piece of work which further reinforces the need to study the perceptions and feelings of educators new to a leadership role.

Cowin (2003) presented an opinion article which discussed the complex networking and understanding of the practice context, suggesting that a CNE's knowledge of the organization and how to get things done cannot only make their job easier, but can impact on the staff they interact with, and subsequently expedite treatment for the patients. This opinion is expanded on by Mallett, Cathmoir, Hughes and Whitby (1997), who presented the results of a pilot study, conducted as a survey, into the role of practice development nurse in the United Kingdom. The findings presented an array of role expectations and responsibilities which showed the multifaceted nature of practice development or clinical nurse education roles. The differences seen in the roles across the UK reflected the impact of organizational need, ability of the current incumbent and need of the nursing staff in the area. The authors argued that these roles must be managed carefully to avoid overloading. By absorbing new responsibilities the real reason for the role being in place, which is the teaching and practice support of nurses in the clinical area, is lost.

The availability of the resident CNE is supported by Edmond (2001), who presented a potentially provocative paper suggesting that the current situation in clinical practice of preceptors and mentors being unavailable is unsustainable and will not keep pace with the demands and changes in clinical practice. She suggested that with an increasing

focus on academic achievement, practical education has been neglected, to the detriment of the profession. The author accurately relates the workload of staff nurses, functioning as preceptors and mentors, as well as attempting to carry a clinical load. Orchard's (1999) research showed that the role of staff nurse in New Zealand as preceptor to nursing students has conflicting demands. The role is often given to staff nurses without consultation, training or resources and though staff nurses often reported they enjoy precepting, it can often mean students are not given the attention and support they require.

Wellard, Rolls and Ferguson (1995) conducted a study where clinical educators were utilized to teach undergraduate students in an Australian pre-registration course. The study found the CNEs relied heavily on their clinical knowledge and had little understanding of curriculum based learning or clinical teaching methods. The authors suggested that the clinical educators required support and should have had a relevant tertiary qualification. Edmond (2001) suggested that staff nurses acting as preceptors or clinical educators supporting students should be given the opportunity to be seconded to a university, or work in a jointly funded role between an employer and a tertiary education provider. Joint positions have been used in New Zealand, often for educators supporting undergraduate students in practice, or new graduate staff nurses in a formal entry to practice programme. The management of a joint position is complex, needing to balance the expectations of two employers. Combined with the already complex nurse educator role, the educator must quickly achieve role clarity and role mastery to avoid confusion, role ambiguity and subsequent dissatisfaction (Clifford, 1999; Lambert & Glacken, 2005).

The clinical support of students is only one area in which staff nurses are expected to give clinical education and support, it can extend to new staff, new graduate nurses and return to practice nurses which, though not requiring curriculum based learning, do require tailored precepting. The role of the CNE in supporting the clinical area can have a significant impact on the staff nurse workforce and in supporting preceptors. Considine and Hood (2000) presented a study looking at the impact of employment of a CNE into an Australian emergency department. They asserted that it can be unrealistic for nurses working in an emergency department to not only increase their own knowledge, and provide a high standard of nursing care, but to also supervise or precept another nurse.

They suggested that a supernumery person, such as a CNE, with clinical expertise and a deep understanding of the practice setting is vital to fulfill this role. This strongly reflects the situation described by Manning and Peach (2002) where CNEs were embedded in specialties to work alongside nurses ensuring clinical education and safe practice.

Employers in many of these studies, have recognized the need for ongoing education in nursing practice and sought the most accessible way for all nurses to benefit. Rather than expecting all staff to access post graduate education, the education comes into the clinical setting and is presented in a way that is seen as credible and relevant to the adult learner. Nurses can work part time, full time or casual, as well as having dependants, financial burdens, time constraints and other commitments and are sometimes just not currently interested in accessing post graduate education (Barriball & While, 1996; Hogston, 1995; Penlington, 2006). This does not undervalue post-graduate education in any way, but the appointment of a CNE to provide education in the clinical setting is a pragmatic and cost effective way of dealing with the realities of patient safety, continued professional development and maintenance of competence.

In summary there are consistent themes across the articles relating to the CNE or practice development role and they are the need to be able to network, to have a deep understanding of the clinical setting and to be seen as credible. Titles vary from country to country; staff development educator, practice development nurse, education facilitator and CNE. Whatever the title, the role is diverse, often larger and more complex than first thought. Though most findings are consistent internationally, from the United Kingdom, Australia and New Zealand, there are differences in how the role has evolved depending on the organization and the CNEs themselves. One consistent message is; the role of CNE or similar does need to exist, due to the increasing focus on ensuring competence in practice for all nurses in the most rapidly changing of all professional environments. In the next section succession planning and leadership development for senior nursing roles, such as the CNE are reviewed.

2.4. Succession planning and leadership development

Workforce development has recently come to the fore in healthcare as the international shortage of doctors, nurses and midwives reaches crisis point. Though there are many facets to workforce development strategies, one key component is succession planning

for leadership (Bolton & Roy, 2004; Byham & Nelson, 1999). In New Zealand the Health Workforce Advisory Committee (2003) has encouraged the development of leadership and management capabilities at all levels, to ensure career development is available and the workforce sustainable. According to Byham and Nelson (1999) the pool of leadership candidates is reducing, while the expectation on leaders increases. Succession planning and leadership development are both ways to potentially ease the journey of transition into leadership (Kelly & Mathews, 2001). As the worldwide nursing shortage continues, organizations need to ensure potential high achievers are encouraged, supported, mentored and rewarded with proactive succession planning into designated leadership roles such as CNE.

McConnell (2006) discussed succession planning and rather than mention leadership, he uses the term "key positions" (p. 91). This acknowledges that not all succession planning will relate specifically to leaders, in fact manager roles, nursing roles or any designated position may be filled with someone who is not necessarily perceived as a leader, but who is performing well in their role and will need a successor. This literature review will now look at succession planning and leadership specifically as the CNE position is a designated leadership position and successful educators need to perform and be seen as leaders (Mateo & Fahje, 1998).

Redman (2006) noted increasing interest in succession planning over the last five years, but also a lack of research. This matches the findings of this literature review. The topic of succession planning for leadership is widely covered by high level managers and leaders in opinion articles (Bonczek & Woodard, 2006; Byham & Nelson, 1999; Garman & Tyler, 2006; Hader, 2004; Sherrod, 2006), but there is virtually no research available, particularly in relation to succession planning in nursing. Redman (2006) advocated the use of succession planning not only in health organizations generally, but specifically in nursing, education and academic faculties. He identified the considerable transition required for an individual to move into a management or leadership role, though he strongly supported the use of formal programmes, there is also the suggestion that leadership skills are often learned by watching and doing rather than through educational preparation. There is no doubt that role modeling is a key to the development of new leaders. However, formal academic programmes offer a greater depth of understanding related to leadership, "… tertiary programmes can provide insight

and theoretical framework to compliment your natural ability" (Peach, 1997, p. 17). A mixture of formal academic education and informal mentorship and role modeling from current leaders provides opportunities for a more rounded view of leadership.

Nurses who excel and take on extra responsibility need to see rewards for their efforts (Bolton & Roy, 2004). The use of PDRPs in New Zealand is increasing and combined with the industrial multi–employer collective agreements (DHB/NZNO, 2004), a level of practice allowance for nurses achieving at level four, clinical expert and leader, offers some financial reward for involvement in leadership activities (Peach, 1995). McGoldrick, Menschner and Pollock (2001) captured the essence of moving into leadership positions as "… requiring a change in perception of the nurse's work from that of a 'job' to full acceptance of the 'professional' status of the role" (p. 17). Bolton and Roy (2004) related the importance of performance reviews and setting goals enabling the steady acquisition of relevant knowledge, which is all accessible via PDRPs. This all depends on nurses being able to access and engage in a PDRP programme. Alternatives to PDRPs include, post-graduate leadership courses, available nationally, and access to professional nursing organizations such as the College of Nurses Aotearoa (NZ) which can offer mentorship and leadership networks. Many large DHBs also provide management and leadership development programmes available to all professions.

There is no-one more important to the retention and ongoing development of nurses than effective nursing leaders (Bonczek & Woodward, 2006; Corning, 2002; Tourangeau, 2003). However, leadership in nursing must change its focus to accommodate the dramatic changes in health and the nursing workforce over the last two decades and for the future employment of the next generation of nursing leaders (Kupperschmidt, 1998; Porter-O'Grady, 2003a, 2003b; Sherman, 2005). In the knowledge economy of today, nursing staff, whose skills are sought internationally will choose an employer who can deliver both the financial rewards and the intrinsic job satisfaction ((Porter-O'Grady, 2003a; Thomas, 2000).

Hader (2004), in an editorial column talks candidly about succession planning and reinforces the need for mentorship and early leadership preparation. He promoted the idea of current leaders using those with potential to support their role, involving them and teaching them how to function as leaders in a supported way. Kelly and Mathews (2001)

suggested that transition into new roles can be improved by preparation and advanced knowledge, supporting the process of succession planning. The opportunity for a career pathway and a supported entry into a leadership position is one way nursing leaders can offer an incentive to current and future employees.

Internationally, succession planning is virtually non-existent in nursing (Bolton & Roy, 2004; Bonczek & Woodard, 2006). Current national focus is on recruitment and retention of nurses. The DHBs that are seen to be undertaking succession planning, supporting new role innovations and education initiatives, will enhance their ability to recruit as nurses choose employers who can offer them career development opportunities. This inevitably requires a commitment of time and money (Cassie, 2006b). Bonczek and Woodward (2006) assert that organizations with financial constraints should view the development of leaders as a smart investment rather than an added expense.

Smeltzer (2002) discussed succession planning, not just to replace ones own role, but to train and mentor potential leaders to fill all positions within healthcare, suggesting succession planning is part of the job of a nurse leader. Individual mentoring is recommended by sharing experiences on a day by day basis, role modeling problem solving, decision making processes and consequences. Smeltzer also recommended that succession planning starts with recruitment, to employ leaders who see succession planning as part of their role. This opinion is shared by Garman and Tyler (2006) in a short opinion piece about high level leadership in health. They suggest that leadership positions should be succession planned while the incumbent is still in position, an opinion shared by McConnell (2006). Though this risks offending the present leader, it deals with unanticipated resignations. Consequently, job descriptions need to be kept up to date and in aligned with an organizational strategy, vision and values. Succession planning does not just involve current leaders, but should be a team approach involving managers and human resources personnel. However, according to McConnell (2006), the whole process must be driven from the top in a consistent way and "... for every management job that exists, there should be a plan for filling it the next time" (p. 95).

There can be a tendency to see high performers or clinical experts as having leadership potential, but clinical expertise does not always indicate leadership ability, (Bolton & Roy, 2004; Cousins, 2004; Sherrod, 2006; Wilson, 2005). Bolton and Roy (2004) suggested

viewing potential leaders differently by assessing their emotional intelligence and their willingness to take on leadership and education opportunities. Conversely, they also suggested that some managers can be reluctant to promote high achieving clinicians to management or leadership roles. They prefer to keep excellent staff in the clinical environment, or managers may simply prefer to develop leadership capability in their areas rather than see nurses having to move away to other roles to realize their potential.

Sherman (2005) presented a qualitative research study on the development of nursing leaders, using focus groups to ask nurses if they would consider taking up a leadership role and what influenced their decisions. This research focused on roles such as the charge nurse manager with budgetary responsibility. Participants felt that leadership or management roles were stressful and held negative factors such as working longer hours than staff nurses but receiving basic pay, therefore earning less than the staff they managed. This problem persists in New Zealand as the pay differential has continued to decrease between designated senior roles and the staff nurse role.

Further results from Sherman's (2005) leadership research also saw participants express concern that in moving into a senior role they may not get the support and mentorship they felt they needed. Mentorship into new senior roles is consistently seen as being vital (Bolton & Roy, 2004; Corning, 2002; Hader, 2004; Kouzes & Posner, 1995; Peach, 1997; Redman, 2006; Schumacher & Meleis, 1994). Interestingly, Sherman's (2005) report suggested that current senior nurses may be sabotaging any succession planning efforts by conveying a negative attitude towards their roles. Substantial discussion was stimulated when Sherman (2005) presented this to a group of current nurse leaders, who then reflected on how little they talked to their staff about how much they enjoyed their work.

The differing needs of today's workforce were investigated by Sherman (2005) who introduced the different work ethics and attitudes of the baby-boomer generation as opposed to generation X or Y. Redman (2006) reported that currently as many as four generations of nurses could be working together. The next generations of nurses who are moving towards leadership roles not only require different pay and conditions to accept that level of responsibility, but will potentially need roles redesigned to fit their

requirements, their values and beliefs. Internationally, the healthcare industry urgently has to start thinking about innovative ways to recruit and retain the next generation of nurse leaders (Kupperschmidt, 1998).

Corning (2002) presented an article on a small scale study undertaken in the United States. Corning asked what skills were required to work in nursing leadership, how leadership skills are learned, and what leadership characteristics make a successful nurse leader. Data were gained by analyzing job descriptions, assessing leadership styles and the personal interests of the nursing leaders. Analysis showed nursing leadership positions to be extremely complex and indicated that "soft skills" (p. 374), are a key to success. They are listed as ten competencies; employee development/coaching, teamwork, self management, interpersonal skills, empathy, planning with flexibility, decision making, management skills, futuristic thinking and ability to negotiate. Interestingly, Cranwell-Ward, Bossons and Gover (2004) recommended avoiding terms like soft-skills when referring to mentorship and coaching, suggesting managers do not respond well to this terminology. Following data collection in Corning's (2002) study, further discussion with the nurse leaders indicated that virtually none of these skills are included in leadership training or orientation programmes and quite simply cannot be taught in a classroom. The position that these skills must be learned experientially is supported by Redman (2006).

Corning's (2002) study highlighted the often sub optimal recruitment processes for nursing leaders due to the lack of focus on an applicants "soft skills" (p. 374) as listed above. Corning (2002) stated "All too often, hiring decisions are made on the basis of a 'gut reaction', with less consideration than goes into capital acquisitions with lesser financial and organizational consequences" (p. 375). It was recommended that a selection tool or inventory of skills be used in recruitment and interview, as the cost of recruiting the wrong person far outweighs a robust but potentially lengthier process to ensure appropriate selection.

Upenieks (2002) presented a qualitative research study about what constitutes successful nursing leadership. The aims of the study were to find effective leadership traits for acute inpatient settings and the components an organization needs to support the role of a nurse leader. The study focused on high level nursing leadership positions

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which hold budgetary responsibilities. This study was included as it is a contemporary view of nursing leadership with some findings on leadership competencies which could be generically applied. Results showed that nursing leaders themselves felt that access to resources, information and opportunities supported a productive and successful work environment. They presented a leadership view that included business acumen balanced against the needs of the clinical nursing staff with an overriding passion for nursing and an ability to articulate this in any forum.

Upenieks (2002) pointed out that nursing leaders felt they had significant informal power within their organizations. "This type of power is gained through credibility. Informal power is the power of people; people who want to do it for you, want to do it well, and want to get there the same way you want to get there. That's power" (Upenieks, 2002, p. 626). This sort of informal power is developed through relationship building, collaboration and networking. The effective nurse leader knows who to pay attention to in order to get the job done. This could be described as "political savvy" (Mateo & Fahje, 1998, p. 169), or reading the environment. Mateo and Fahje (1998) suggested that staff educators need these skills to get the job done, to accomplish goals and to know the right time to act in the political climate. The ability to use emotional intelligence will enhance a leader's ability to motivate. Wasylyshyn, Gronsky and Haas (2006) asserted that increased emotional intelligence and capability is needed for leaders to ensure stability and growth of organizations in the global workforce market. Upenieks (2002) described nursing leaders as requiring "… critical thinking skills, varied expertise and knowledge, and extraordinary interpersonal capabilities" (p. 622). This array of requirements to perform in leadership positions requires significant preparation and personal development (McGoldrick et al., 2001).

Tourangeau (2003) presented a report on a programme of leadership development, undertaken using current nursing leaders from Canada. The programme consisted of a five day residency programme and three months later another full weekend. The programme was modeled on a conceptual framework, based on the Kouzes and Posner (1995) leadership competencies; challenging the process, inspiring a shared vision, enabling others to act, modeling the way and encouraging the heart. Feedback from peers working with the leaders who undertook the programme reported substantial increases in leadership behaviours post course. The study concluded that leadership

ability can be significantly improved by education interventions, though it did show that the leaders themselves struggled to see any improvement in their own leadership practices.

Peach (1997) also used the five leadership competencies of Kouzes and Posner (1995), when reporting on preparation for leadership within nursing in the New Zealand environment. She asserted that preparation for leadership is variable and that coaching, mentorship and feedback are vital to establish and maintain oneself in a leadership position. She related not only the skills needed to be a leader but also the personal implications of taking up a designated leadership role. The article, unlike many others offers a series of suggestions for "self-care as a leader" (p. 16), for example; maintenance of and attention to personal relationships, setting professional boundaries, and seeking supportive collegial resources. This type of input and support to potential or new leaders is vital to manage their expectations.

Cohen (2005) also talked about self care for new leaders, specifically the difficulty faced by those promoted into senior roles from within the organization and the impact this has on established friendships. Peach (1997) referred to this under the heading of "boundaries" (p. 16), but didn't go into detail about how to manage these difficulties. Cohen (2005) offered some tips on easing the shift in status, such as clarifying the new role and its boundaries to the staff, handling potential conflicts early and explaining why socializing with staff is not longer appropriate. The author suggested that though these conversations may be difficult, they can prevent future disillusionment and disappointment caused by the negative comments and behaviours often seen following a change.

Leadership development and succession planning are both ways of potentially easing the transition into senior roles. Preparation for a new role requires planning, understanding and an ability to do the job. Succession planning offers the opportunity to role model leadership, performance and role responsibilities, so any potential candidate has an improved understanding of the role they will be undertaking. The issues inherent in transition into new roles are discussed in the next section.

2.5. Organizational socialization and transition in nursing practice

In this section the available literature on work-role transition, orientation and organizational socialization is examined. In presenting an overview of transition in nursing Schumacher and Meleis (1994) described transition as a normal part of life and any change process. During transition emotional and physical well-being can be challenged, as transition surfaces multiple wide-ranging emotions, such as fear of failure, loss and disconnectedness (Kelly & Mathews, 2001; Schumacher & Meleis, 1994). Schumacher and Meleis (1994) reinforced the need for a level of planning before and during a transition asserting that preparedness enables a smoother transition. This applies to work-role transition, understanding a new role, being supported in preparation for the change and having the appropriate information to make decisions.

Kelly and Mathews (2001) presented a study reviewing the transition of registered nurses in their first role as a nurse practitioner in the United States. This study dealt with the issues of moving into a leadership role, grieving for a team, finding things were not as expected and, most importantly, moving from expert back to novice leading to feelings of insecurity and uncertainty. The authors found that, though most of the participants had now been a nurse practitioner for a while, they still lacked confidence at times. However, all the participants agreed that the first year was by far the hardest to cope with. Brown and Olshansky (1997) confirmed that while novice nurse practitioners experience significant anxiety in their first year they also experienced significant personal and professional growth, later realizing that despite early doubts their expertise and solid knowledge base allowed them to competently complete their first year as a nurse practitioner.

Heitz, Steiner and Burman (2004) also investigated the transition of registered nurses to nurse practitioners. They looked specifically at the transition through a nurse practitioner education programme, encountering evidence of personal sacrifice in commitment to the education process. This study incorporated the extrinsic factors impacting on transition such as family commitments, part time jobs and loss of privacy. The relationship with physicians was also an issue leaving participants feeling intimidated and isolated, resulting in feelings of inadequacy, also seen in the study by Brown and Olshansky (1997). Heitz et al. (2004) suggested that further research may need to be done into education and career transitions to investigate the impact of gender issues, such as

women with young children and other perceived sacrifices which may be more specific to women than men.

According to Bridges (1980, 1987, 2003, 2004), transition is present in all aspect of ones life, including transition in a work setting. Bridges presented a transition framework in a series of populist books. The framework defined three phases in the journey of transition, 'endings', 'neutral zone' and 'beginnings'. The framework is seen and used in nursing texts (Brown & Olshansky, 1997; Harrington & Terry, 2003; Schumacher & Meleis, 1994; Wells, Barnard, Mason, Ames, & Minnen, 1998) to describe work-role transitions and the transition from student to staff nurse. For example, Harrington and Terry (2003) described a transition framework directed at new graduate nurses who have exhibited signs of stress on moving into a role which has new expectations and professional responsibilities.

Infante (1986) incorporated the use of transition, though not in a formal framework, identifying that the journey from nurse to nurse educator takes time and mentorship. "The gradual transition from nurse to nurse educator progresses as the process and the value systems of both roles take shape within the students self–image" (Infante, 1986, p. 96). Infante indicated that moving forward requires an understanding of the past. She also found a high level of role confusion and stress in the early stages of the new role and suggested that it could be alleviated somewhat with more formal preparation for transition, as supported by Schumacher and Meleis (1994).

Louis (1982) wrote about transition and career planning as a result of a five year study of MBA graduates and their subsequent career and lifestyle choices. The study recommended that transition management be covered as part of any career development process. The author acknowledged that transition can be overwhelming and difficult and offered some steps to achieving the ideal transition, such as; acknowledging transition, the feeling of being overwhelmed, the contrasts between the old job and the new, analyzing the potential problems a newcomer is likely to meet and planning ahead. An important focus, not often noted by other authors was to review the performance of the previous incumbent, what they did well and what their reputation was. A review of the tasks of transition is required, learning the vernacular, locating networks, building role identity and relationships and to locate oneself in the

organization. Louis's (1982) work laid the foundation for the work of Louis, Posner and Powell (1983), and Hsiung and Hsieh (2003) as well as sitting comfortably in the frameworks of Wanous (1992) and Bridges (2003, 2004).

An organizational socialization framework for newcomers is presented by Wanous (1992). This framework was used in the study by Glen and Waddington (1998), to describe the transition from staff nurse to clinical nurse specialist. There are four stages of socialization identified in the model;

- Stage one; confronting and accepting organizational reality.
- Stage two; achieving role clarity.
- Stage three; locating oneself in the organizational context.
- Stage four; detecting signposts of successful socialization.

Wanous (1992) offered a comprehensive overview of the tasks related to orientation and the associated feelings during this phase, specifically associated with organizational newcomers rather than internal transfers. In Wanous and Reichers (2000) it is noted that there is still very little written about orientation for internal transfers.

Wanous and Reichers (2000) made a clear distinction between orientation and socialization. Orientation is a defined period of coordinated events which occur after entry to an organization consisting of a small number of staff. Socialization affects all employees, across organizational boundaries, including initial entry, hierarchical (lower to higher levels), functional (one job to another) and inclusional (from periphery to the core of power). This distinction is important, as it shows transition and change at many points, affecting staff in numerous ways and at a variety of levels. These are challenges inherent in the transition to a new leadership position such as the CNE role which involves moving from a lower grade to a higher grade, moving job and moving closer to organizational decision makers and decision making. When viewed in this light, newcomers to an organization, dealing with the combined effects of socialization and environmental orientation, may find the transition from novice to role mastery, overwhelming.

Klein and Weaver (2000) presented research on the content of orientation programmes. They recommend that formal orientation programmes provide information on three main areas; the broader organization, information about the job and the immediate work

environment. Wanous and Reichers (2000) promoted the use of realistic information at orientation. They suggested that normal orientation contains information on the environment and expectations, whereas realistic orientation may include what to expect during the transition, in the form of disappointment and how things may improve or change with increased experience. This, they argued would normalize feelings of dissatisfaction and stress while preparing the newcomer emotionally for potential challenges. This is not dissimilar to the advice of Louis (1982) who suggested planning ahead to address how a newcomer could deal with potential problems. The opportunity to develop programmes relating to transition is a positive way of normalizing feelings on transfer to new roles.

Hsiung and Hsieh (2003) hypothesized that newcomer socialization would be improved by standardizing job descriptions and improving role clarity. This study was undertaken in Taiwan using a large number of newly employed nurses in ten public hospitals. They suggested that a short formal orientation about the organization is generally not enough to get the newcomer through their first year in the job. There must be significant experiential learning, which will be enhanced by standardized roles. Ragsdale and Mueller (2005) asserted that an organized orientation programme, specifically for nursing has the potential to reduce staff turnover and though preparation for a new role does improve transition (Schumacher & Meleis, 1994), this needs to be combined with ongoing socialization in the work area. Hsiung and Hsieh (2003) also made the observation that newcomers to an organization also need to be proactive and to take some personal responsibility for finding information, not everything can be included in an orientation. They did however warn that this method cannot be relied on. Some employees may not take a proactive stance, while others may gain inaccurate information or be misinformed. Orientation and more specifically socialization needs to be a longer lasting, individual process (Klein & Weaver, 2000), enhanced by the use of mentorship and support (Bass, Rabbett & Siskind, 1993; Wells, Erickson & Spinella, 1996).

Bass et al. (1993) used Benner's (1984) model of situational skills acquisition to describe the transition of a staff nurse into a clinical nurse specialist (CNS). The CNS role is not dissimilar to the CNE role. It can be an isolated role, often involved in clinical practice education and is a designated senior position. In the study, the concept of working long

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hours to establish oneself in the role is introduced, to be seen as visibly busy and to demonstrate worth. This need to prove oneself can be linked with imposter phenomenon, or the more likely, transient identity confusion, common in transition (Huffstutler & Varnell, 2006), but is also often linked with expanding roles and being identified to take on new projects. Senior roles such as CNS and CNE can be seen as having available time, to be used on projects which are not necessarily part of the role (Mallett et al., 1997). The ability to say 'no' to enable to prioritizing of workloads can be a challenge as the new CNS wants to be accepted, to fit in. As roles develop and boundaries become blurred the senior nurse must maintain control over their work (Cutts, 1999; Glen & Waddington, 1998), however, nursing roles are continually defined and manipulated by others. This has the effect of making the workload requirements exceed the contracted hours and to confuse the role boundaries (Glen & Waddington, 1998) thus exacerbating the feeling of vulnerability and frustration common in the neutral zone.

Bamford and Gibson (2000) in a study into nurse specialist roles noted the history of ad hoc development of senior nursing roles in the United Kingdom, without clear job descriptions, titles or direction. This is a similar situation to the New Zealand health environment post health reforms. The research findings indicated that CNS roles would benefit from the application of a continuum of role development. The work of Benner (1984) is again used to establish a baseline for the continuum, to clearly describe expected practice at each stage of development. The work of Benner (1984) is a common theme in writing on transition in nursing. It deals well with the situational skills acquisition aspect of transition from not knowing the new environment to mastery of the environment. However, it does not deal with the move from expert back to novice or the emotional side of transition. For example, the distress of an ending, the chaotic feelings of the neutral zone, the vision and hope of the beginnings phase. Bridges' (2003, 2004) transition framework compliments the situational skill acquisition model used by Benner (1984), as it provides insight, hope and a sense of normality to senior nurses who feel deskilled (Bamford & Gibson, 2000) and often like imposters in their new settings (Huffstutler & Varnell, 2006; Kets de Vries, 2005).

2.6. Summary

In this chapter literature relating to succession planning, leadership development, transition, organizational socialization and the CNE role were reviewed. A lack of research related to the CNE role was identified strengthening the rationale for this research study. The area of succession planning for leadership in nursing identified the need for increased focus on leadership skills and proactive identification of high performers. A summary of the main points of each of the three sections will now be presented.

Though international variations of the title were used, research and literature on the role of the CNE remains limited. However, the consistent message from all the literature reviewed was that the CNE role can make a significant impact on staff nurses in the form of practice education. The CNE was found to be a credible clinical practitioner, who can work alongside and be accepted by staff nurses. The ability to network and to have a deep understanding of the practice environment was a key component in the success of the role. Though roles are diverse, there are similarities in role, function and perceptions of the CNEs themselves, whether they work in New Zealand, Australia, the United States or the United Kingdom.

Succession planning and leadership in nursing explored how nursing leaders are prepared. A consistent message throughout the literature was that succession planning must be consistent and continuous. However, the articles described an international lack of succession planning for leadership roles in health. If predicted generational changes become a reality the demands of future nurse leaders will require recruitment and selection processes to change to focus on different sets of skills. Leadership roles in nursing were identified as becoming increasingly complex, requiring extraordinary abilities in interpersonal relationships and emotional intelligence. Ultimately, the need for self care as a leader was identified, including mentorship, a concept that is comprehensively supported by the literature.

Role transition and organizational socialization were presented in the final section. Role transition can be overwhelming and complex. Contrasts between new and old identities can create turmoil; however the literature strongly suggests that a comprehensive and considered orientation and socialization process can impact positively on work-role

transition. Role transition was reviewed with acknowledgment to the theories relating the organizational socialization. The differences between orientation and socialization were clarified. In the following chapter the research methodology used for this study, the ethical considerations, sampling process and method of data analysis are presented.

Chapter 3: Research process

3.1. Introduction

In this chapter an overview of the methodology and methods that underpin the present study is provided. A qualitative descriptive methodology was chosen. Semi structured interviews were conducted to collect data from the participant group and a general inductive approach was used for data analysis. The questions used in the interviews are presented, along with the rationale for participant selection criteria. Ethical considerations for the study are addressed, and the theoretical framework used to underpin the present research is presented. The chapter begins with an introduction to qualitative research methodology.

3.2. Research methodology

Minichiello et al. (2004) described the meaning of the word research as "... to search again or to examine carefully ... its purpose is to validate and/or refine existing knowledge and to generate new knowledge" (p. 4). To undertake research the researcher must negotiate a plethora of methods and methodologies, being directed by the aim of the study or the issue to be addressed (Crotty, 1998). The methodology utilized in the current study is qualitative research. Denzin and Lincoln (2000, p. 3) defined qualitative research as "... a situated activity that locates the observer in the world. It consists of a set of interpretive, material practices that make the world visible". Sandelowski (2004, p. 1371) supported this view, stating that "... qualitative research findings offer a window through which to view aspects of life that would have remained unknown." There are numerous qualitative methods including ethnography, phenomenology and grounded theory. More recently the use of qualitative description has enabled researchers to explain phenomena using a naturalistic approach.

The aim of this study was to gain an understanding of human experience and perceptions. Naturalistic enquiry is effective in qualitative studies and behavioural research, where the subject will be studied in as natural a state as possible, enabling insight into behaviour, thoughts and feelings (Sandelowski, 2000). Naturalistic enquiry laid the foundations for qualitative description as described by Sandelowski (2000). According to Guba and Lincoln (1994), qualitative data can "... provide rich insight into

human behavior" (p. 106). The identified methodology for this study is qualitative description, using the methods of semi structured interviews and a general inductive approach for data analysis.

Descriptive research is non-experimental and is used in qualitative and quantitative studies to observe, portray, and describe characteristics of phenomena or groups (Polit & Hungler, 1997). Qualitative descriptive studies can "… produce truly transformative knowledge" (Sandelowski, 2004, p. 1382). This study seeks to understand feelings and perceptions of nurses who have similar experiences, with the ultimate outcome of taking action to improve the experience for the future. Sandelowski (2000) suggested that descriptive studies should present a particular event or situation in the best way to be understood by the audience for which it was intended. This requires data to be presented in a manner accessible to the audience enabling the reader to view the experiences in a new, accessible way.

According to Minichiello et al. (2004), qualitative studies are not a direct presentation of the data, but are a form of report, constructed by the researcher to best deliver the information to the reader. Bridges (2003, 2004) transition theory was chosen as the theoretical framework for the report for this study. The chosen framework offers a pragmatic, logical and relevant way to view the findings, while linking them to the transition the participants experienced.

Nurses have always learned from stories and experiences of others (Smeltzer & Vlasses, 2003). Nursing leadership and organizational management can often remain unaware of these stories focusing on productivity and output. However, in a time of nursing shortage and eroded leadership, listening to the perceptions and experiences of others can help us reflect on the past and gather evidence to then shape the future of nursing. Using the methodology of qualitative description and the method of semi structured interviewing enabled a foundation of sharing stories and perceptions to offer a rich source of evidence for future learning from the study findings.

3.3. Ethical issues
In this section the ethical considerations for this study are presented. Polit and Hungler (1997) presented three major ethical principles to be considered in any research as

beneficence, respect for human dignity and justice. These principles are used to address ethical issues in the present study.

Beneficence.

- *Freedom from harm:* In asking the participants to answer questions there is the potential to cause distress as people reveal potentially sensitive information. Though the interviews were carefully thought through, I observed the participants for signs of distress and emotion during the interview. Confirmation that the participants wanted to continue talking was sought if any concern was raised. As the DHB involved offers free counseling services I had the ability to offer support and counseling, if required, following the interview.

- *Freedom from exploitation:* The participants were fully informed of the study and that information from the study would not be used against them in any way. They were encouraged to ask questions prior to signing the consent form to ensure they had a full understanding of their participatory requirements.

- *Risk/benefit ratio:* It is important that the risk of taking part in a research study does not outweigh the benefits of the study. The risk to the participants in this study would be related to disclosing personal information, fear of repercussions and the potential emotional distress from engaging in introspection. The risks in this study were minimized by the guarantee of privacy, confidentiality and the informed consent process.

Respect for human dignity

- *Right to self determination;* The participants in this study were given the right to decide to participate. All participants were provided with an information sheet (Appendix 1), by a third party and asked to contact the researcher if they wished participate in the study. There was no power dynamic as the participants were not from the DHB I worked in, and were not known to me.

- *Right to full disclosure;* the nature of the study was fully described to the participant group. The right not to take part, to withdraw from the study and to have the tape switched off at any time was included in the consent process (Appendix 2).

- *Informed consent;* on meeting each of the participants a preamble or further explaination of the study was given to support the information sheet and the consent form was explained. Drever (2003) supported this process, suggesting that a verbal

preamble will remind participants what the interview is about, enabling the interviewer to offer more detail than in the first contact. On initial contact limited information is given, to avoid participants preparing answers or discussing too much with other potential participants. A preamble not only reminds participants of what the interview is about, but clears up any misconceptions or concerns they may have. Consent was gained and the consent forms signed by the participants.

- *Principle of respect*; the collection and use of all information from this study was fully explained to the participants, no covert data or information was gathered.

Principle of justice

- *Right to fair treatment;* participants in this study were treated fairly and equitably, they were offered the right to non participation, to withdraw up to two weeks after the collection of information, to have the tape switched off.

- *Right to privacy;* The study required the participants and their employer to be anonymous. The participants all gave pseudonyms of their choice for the transcript and report. All references to workplace and colleagues were altered or excluded. Audio tapes and transcribing were stored in a locked filing cabinet, to which only the researcher holds a key. Audio tapes were destroyed at the end of the study. Transcripts and password protected computer files are to be kept for a period of ten years and will then be destroyed by the researcher.

3.4. Ethical approval

Ethical approval was sought from Massey University Human Ethics Committee (MUHEC) as well as the Regional X National Ethics Committee. The Maori ethics committee from the participants' DHB and the Maori ethics committee from the researcher's DHB were consulted during the development phase of the study. This early consultation ensured the study processes were appropriate and obligations under the Treaty of Waitangi were undertaken with regard to Maori involvement in the study and if any participant identified as Maori or wished to be interviewed in Te Reo, the relevant organizations would support the process. Finally, the participating DHB required the ethics submission to be heard in a clinical board forum and to be approved by the DHB clinical board members.

3.5. Sampling process

In qualitative research, sampling techniques enable the researcher to select the most appropriate participants for the study question. The most appropriate form of sampling technique was identified as purposive sampling, a method recommended by Sandelowski (2000) for use in qualitative descriptive studies. This method is useful when there is a limited or small group or population of interest, such as this study. Minichiello et al. (2004) described purposive sampling as a decision by the researcher, about which participants will give the information required for the study. According to Sandelowski (2000 p. 338) "... the ultimate goal of purposeful sampling is to obtain cases deemed information-rich".

In this study, the participants were a purposive sample of eight CNEs from a pool of approximately thirty. Minichiello et al. (2004) also suggested that for a qualitative study where an in-depth understanding of experiences and their description is required, as few as six participants may be necessary. The study has a clearly defined sample group with the obvious primary criteria of needing to be a CNE; this immediately indicated a limited sample, as even the largest DHBs have only a small number of CNE roles.

The prospective participants were notified of the study by a third party, independent of the researcher, who provided them with an information sheet. This invited the nurse educators to contact the researcher directly, either by phone or email to indicate if they were interested in participating in the study. Once a participant made contact, this was followed up by a phone call to organize a venue and time for interview. The first four participants volunteered within a week, the final four took three to four weeks to come forward. Most of the participants were enthusiastic about the study, though one or two were slightly apprehensive, having never taken part in research before.

3.6. Data collection

Interviews were scheduled at a time and venue chosen by the participant, with most choosing to meet away from their clinical areas. At the interview, and after introductions, the intentions of the study and confidentiality requirements were addressed. The consent form was provided to the participant, with reminders that the interview would be taped, that the tape could be switched off if requested and that an interpreter could be accessed if required. The option to withdraw from the study up to two weeks post

interview was reinforced, as stated on the consent form. The consent form was signed. Before commencing the interview, each of the participants were asked to choose a pseudonym for the study, a name which they could recognize but would not be known to others. This was used on transcription and in the written report to ensure anonymity. Further questions prior to the interview commencing were answered.

The interviews took between 45 minutes and one hour, however they were scheduled for two hours to ensure time was available to meet, move to the venue, which was chosen by the interviewee, and to allow for introductions or any unforeseen delays. Following the interview, the tape cassette and tape box were labeled; the recording tag on the cassette was removed to prevent any changes to the tape recording. Transcription was completed entirely by the researcher. Tapes and transcriptions were stored in a locked filing cabinet.

In this study, transcripts were not returned to the participants for checking of accuracy. The decision not to return transcripts is supported by both Burnard (1991) and Angen (2000). For example, Angen (2000) believes that on reading returned transcripts, participants may have changed their minds, or feel uncomfortable about what they said during the interview phase of data collection. The return of transcripts can therefore lead to confusion rather than confirmation among respondents. Audio tapes were destroyed at completion of the study. Transcripts are to be kept for a period of ten years.

Inclusion criteria
- A registered nurse working as a clinical nurse educator.
- In their first senior nursing role and within their first six months to two years as a clinical nurse educator.
- Employed four days per week to full time as the sole clinical nurse educator for an identified clinical area.
- Employed for a specific clinical area or service.

Exclusion criteria
Participants must not:
- Be jointly employed by a tertiary education provider.
- Be a Waitemata DHB employee.

- Work less than four days per week or in a job share role.
- Have had previous experience in a senior designated position, e.g. charge nurse, clinical nurse specialist or educator.
- Be employed solely to train either mandatory skills such as Cardio Pulmonary Resuscitation (CPR), or leadership development courses.
- Be employed in the role less than six months.

Inclusion and exclusion criteria were set to ensure each participant was experiencing a full range of responsibilities in the role, not sharing responsibilities or only undertaking a portion of the role due to very part-time status. The inclusion criteria which required the CNE participant be in their role for at least six months, proved initially problematic for the researcher, as it caused the sample to be limited to five CNE participants. On discussion with the research supervisor it was deemed appropriate that an additional three CNEs, who were between three and five weeks of meeting the six month deadline, could be included.

Ultimately, the experiences of the newer CNEs reflected their stage in the transition process, and though they did not have a strong presence in the 'beginnings' phase of transition, they did feature consistently in the 'endings' and the 'neutral zone' as they were concurrently experiencing those phases of transition. A full explaination of transition is provided on page 47. Ultimately, the inclusion of the newer CNEs did not jeopardise the study, but enriched it by reinforcing the statements made by the other participants who had to recall memories. It also supported the accuracy of the transition framework used in this study.

3.7. Semi structured interviewing

A semi structured interview process was selected for this study to fit with the intent of the research method. Participants were given the opportunity to voice how they felt about their experiences with minimal interference from the researcher. The use of semi structured interviewing means the researcher has a general structure for the interview, and will generate a set of main questions to be asked in the interview (Drever, 2003). A selection of open ended questions was developed for the interview, these were chosen to assist with the flow of the interview, and were adapted, changed or missed altogether if the item had been covered by another answer. Subtle sequencing and structure of

questions gave the opportunity to revisit important memories which by the end of the interview were more able to be recalled in context.

Sample questions were:

- Tell me what attracted you to the CNE job.
- What is your vision for the role? a) Clinical b) Personal.
- Before you got the position, what did you think was involved in being a CNE?
- Tell me about your first impressions of the role.
- What was the hardest thing you had to learn?
- If you had an orientation, what were its main components?
- What would you have liked in your orientation?
- Who do you get professional support and development from?
- What leadership competencies do you believe are required for this role?
- How would you describe the importance of networking for this role?
- How do you manage the periods of time when your role is less visible to the clinical staff you support?
- Describe how you perceive the staff understand your role.
- Do you feel you are outside the team? If so, how does this make you feel?
- How do you feel if things go wrong within your service? Such as errors or complaints.
- How did you personally cope with the demands of the role when you first started and has that changed?
- What do you now think would have been important to know about the job before you applied?
- Think back to the day you saw the advert for this role, if you knew then what you know now, what would you do?

The interviews were tape recorded, with no notes taken to avoid distraction and to permit the researcher to focus on exactly what the participants were saying. As they answered the questions, it was useful at times to probe further into a particular area to clarify what they meant or were referring to. Drever (2003) reviewed the use of prompts and probe questions: Prompts are used to jog a memory or encourage more explanation, whereas probe questions are used to clarify or extend an answer. Prompts and probes were used in the present study to enable a more detailed description. However, by the end of each

interview their use was limited as the interviewees were independently remembering valuable feelings, memories and perceptions.

The interviews were enjoyable and interesting; all of the participants were generous and candid in their information sharing, as they connected with the aim of the study and were enthusiastic to share their experiences. Drever (2003, p. 9) suggested that interviewing can be "... an intensive and rewarding social experience." As a first time interviewer, I felt privileged that the participants felt able to freely share some of their most vulnerable, anxious and rewarding moments and memories.

3.8. Data analysis

An inductive approach was used in this study. Inductive approaches are used when the researcher seeks to identify themes through analysis of the data. Thorne (2000) suggested that in general, an inductive method will use the data to generate ideas. Conversely, the deductive approach requires the researcher to present a theory, a hypothesis and then collect the data to prove or disprove the hypothesis. Thomas' (2003) general inductive approach was utilized to sort and organize the data. This approach was described by Thomas (2003) as a "... convenient and efficient way of analyzing qualitative data" (p. 1). This method served the purpose of condensing the large amount of data, establishing links between the research aims and the findings.

The data analysis process should result in, between three and eight main themes (Thomas, 2003). In this study there were five main themes, described by Thomas (2003) as top level categories, within the five main themes were nine sub-categories;

- Entering transition,
  - o Thinking back
  - o Went in blind
- Getting started,
  - o Orientation/ disorientation
  - o More than expected
- Chaos and turmoil,
  - o Communicating in a new way
  - o Finding support
- Overwhelmed,

- o   Learning to negotiate intra role conflict
- o   Stress levels
- Opening doors,
  - o   Adjustment, reflections and new identities

Each main theme was named to represent the feelings and perceptions within it, such as 'chaos and turmoil', as the CNEs tried to make sense of their experiences. The naming of each sub category reflected the particular data content, for instance, 'thinking back' contained the initial reflections on why the CNEs had applied for their positions. Fortuitously, the themes and sub categories fitted into the theoretical framework underpinning the study as described on page 47.

3.9. Coding process.

Coding is an analytical process of condensing transcripts or raw data into relevant categories. The method utilized in this study followed the guidelines outlined by Thomas (2003) and Burnard (1991). The process required the creation of categories, linking text into a summary format, establishing links with the aims of the study, then linking into the chosen theoretical framework. The process is detailed in the next section.

The tape recording was listened to and transcribed by the researcher within a short time of the interview. During transcription increased attention could be paid to the use of words, intonation and deeper meanings. Burnard (1991) described this as being "Immersed in the data" (p. 462). Transcripts were typed onto A4 paper. Each transcript was read and re-read, while listening to the tape recordings. Categories were identified from each interview then written on a table in columns and boxes under each participant's name. The recurring phrases were colour coded as suggested by Burnard (1991) then grouped together, first on paper using a highlighter, then on the computer. Some data fitted into more than one category initially, which saw some category boxes containing two or more colours, Thomas (2003) described this as overlapping coding. Once the colours and categories were sorted and reduced, they were grouped again by colour; for example table 1, is a section of the green category; 'initial interest'.

Table. 1. Example of category development.

name	Lynair	Zoë	Chloe	Bobbie	Emily
Anal-ysis	Enjoyed teaching, tended to run education session as an RN (p1)	Always enjoyed teaching in clinical area as an RN (p1)	Had thought wanted career in that direction-initially hesitant (p1)	Already doing education as a Staff nurse-enjoyed teaching (p1)	Enjoyed precepting + teaching prepared hugely for interview – very excited (p1)
text	"Within my previous job as a … I tended to step up to the mark to do the education for the nurses because for a period of time there was no educator"	"I felt as though I'd found my niche, really enjoyed the education side of things and saw the roles like CNE or clinical nurse consultant at the penultimate kind of achievement, so I guess I kind of got interested then."	"Ok clinical nurse education has been something that I have in the past in terms of thinking about my career is where I've kind of wanted to go towards but not right then but this job came up"	"I had a role as a staff nurse which incorporated a lot of education. There was no nurse educator in …and it was expected in the unit that one person took on the role of doing education and that was sort of my role so when I came to here I wanted to expand that role a big more."	"I came here to work and just worked in the unit as a staff nurse and very quickly sort of came to be doing preceptorship here as well, really enjoyed it …. I was thinking to myself 'oh I'd actually really fancy doing that job', just purely because I love teaching, I like the whole education side of things.

Colouring the segments of text, both on the coding sheets and the transcripts made data very easy to track, and created a visual representation of the themes. Some text was not coded as it was not relevant or was the result of the participants natural speech pattern, such as; 'like you know, I kind of, you know actually thought', which may sound reasonable during conversation, but on paper becomes unintelligible (Burnard, 1991). Each colour represented a category, such as; 'No sense of history; jeopardizing performance management' and 'perceptions of what I thought it was', which would later be absorbed into a theme. Following the development of categories and themes, each phrase or section of conversation was reviewed for its relevance and inclusion in the chapter. According to Thomas (2003) themes and categories can be presented using a model or framework. In this study the themes were divided into three chapters, representing the phases of a theoretical framework; Bridges transition theory (2003, 2004). The chapters in this study are named 'endings', 'neutral zone' and 'beginnings'.

3.10. Rigour and trustworthiness

With regard to trustworthiness, Lincoln and Guba (1985) simply asked, "Are the findings of the study worth paying attention to and worth taking account of?" (p. 290). Koch and

Harrington (1998) suggested three categories for addressing trustworthiness; these are credibility, fittingness and auditability. These three categories are addressed in relation to this study.

Credibility

Credibility suggests faithfulness to the data (Koch & Harrington, 1998). The method of general inductive data analysis used in this study (Thomas, 2003) offers three methods of assessing trustworthiness and credibility of data; independent coding, coding consistency checks and stakeholder checks. This study used two methods adapted from Thomas' (2003) method. The first was a form of independent coding, as the categories were reviewed by the research supervisor for accuracy to establish that the information came from the original data. The second was stakeholder checks, which assessed both credibility and fittingness. The stakeholders in this study were CNEs from the researcher's DHB. Credibility will also be established with the dissemination of the research results.

Fittingness

Fittingness can be described as the data fitting into a context other than the one in which they were generated (Koch & Harrington 1998). Stakeholder checks were used to enable comment on the findings and conclusions by someone with expertise or interest in the study question, in this case CNEs from the researcher's DHB. The stakeholders were presented with the main categories and sub categories. Stakeholder checking proved to be a surprisingly powerful way of endorsing the study. The CNEs identified so strongly with the perceptions, thoughts and words of the research participants that one stakeholder, for example, was moved to tears by the similarity of her experiences to what she was seeing. Thorne, Reimer Kirkham and O'Flynn-Magee (2004), humorously referred to this emotional response as "lachrymal validity" (p. 17). However, they continue by suggesting that the best descriptions will illuminate the thinking of those with expertise in the field, in this case the stakeholders, who were working as CNEs and by reviewing the findings of the study, saw their past experiences through a new lens. As CNEs are part of the target audience for this research, these reactions suggested that the data accurately and credibly described the shared experiences of current CNEs working in not only different clinical settings but entirely different organizations.

Auditability

Auditability is achieved when the research method and decision making process could be followed by another researcher and when the decisions made by the researcher are transparent. Morse, Barrett, Mayan, Olson and Spiers (2002), stated, "... audit trails may be kept as proof of the decision made throughout the project, but they do not identify the quality of those decisions, or the responsiveness and sensitivity of the investigator to data" (p.7). In the current study, the research methodology, methods, data collection, interview technique and data analysis are clearly detailed in the report within this chapter.

3.11. Theoretical framework

The theoretical framework, underpinning the present research, is Bridges (2003, 2004) transition framework. Dr. William Bridges, PhD., was a professor of literature prior to becoming an executive development consultant helping organizations and individuals deal with the processes of transition, reorganization and leadership change. He still continues this work, having published numerous populist books and being cited in several nursing texts (Brown & Olshansky, 1997; Harrington & Terry, 2003; Schumacher & Meleis, 1994; Wells et al., 1998).

Bridge's (2003, 2004) transition framework acknowledges that in any change there is also a personal journey of transition, which enables a person to merge the old self with the new self and assists in coming to terms with a new situation. Change is defined as situational, the new job, work or family structure. Transition is defined as psychological, an internal process that people must go through to accept change. The framework is based on the application of three phases; endings, neutral zone and beginnings. This framework has been identified as appropriate for this study due to its clarity, simplicity and pragmatic approach, not only to the organizational socialization process, but the personal journey inherent in locating oneself in a new place in an organization. The framework is used in this study to present the data, with each of the chapters representing a phase in the transition framework.

The present study focuses on the shift from being a staff nurse working within a supportive, collegial environment, managing an allocated workload to being in an isolated senior position requiring self motivation with emphasis on personal leadership

skills, often with little management understanding or support. This transition can induce feelings of distress and anxiety, as the reality of the shift begins to set in (Huffstutler & Varnell, 2006). Bridges (2003, 2004) has used a framework that deals with feelings and perceptions, giving the opportunity to concisely articulate transition.

Transition

The three stages of Bridges (2004) transition or personal development chronology are endings, neutral zone and beginnings, visually portrayed in Figure 1. (See p. 49). The first section of transition is an ending, described in the next section.

Endings

Bridges (2003) believed that all transitions begin with an ending or a letting go of old references, relationships and ways of being. Endings are linked with a grieving process, a natural sequence of emotions we all experience such as anger, bargaining, anxiety, sadness, disorientation and depression. Bridges suggested that many organizations never plan for the impact endings will have as people move into new roles, tending to focus on change management rather than transition management. As well as a grieving process there is the feeling of disengagement; breaking away from old systems and orders which have reinforced and supported behaviors, such as a supportive team environment.

Transition may start with a feeling of disenchantment. People may be disappointed or feel that they have lost interest in what was once sufficient. This can be exhibited by displays of hostility, stress and sometimes just bland acceptance (Kouzes & Posner, 1995). There is a mourning process or dismantling, where the old world and the old identity need to be taken apart, where it is still possible to see and feel the old identity, but it doesn't fit with the new order so needs to be unpacked. This can lead to feelings of disidentification, or not being sure who you are, feeling lost. Harrington and Terry (2003) suggested that an old identity can interfere with transition as it is challenging to let go of what and who you were. This can be hard when a person's role and title are perceived as particularly important to the person's identity. Kouzes and Posner (1995) suggested this loss of identity can cause people to feel immobilized, unable to decide what to do next.
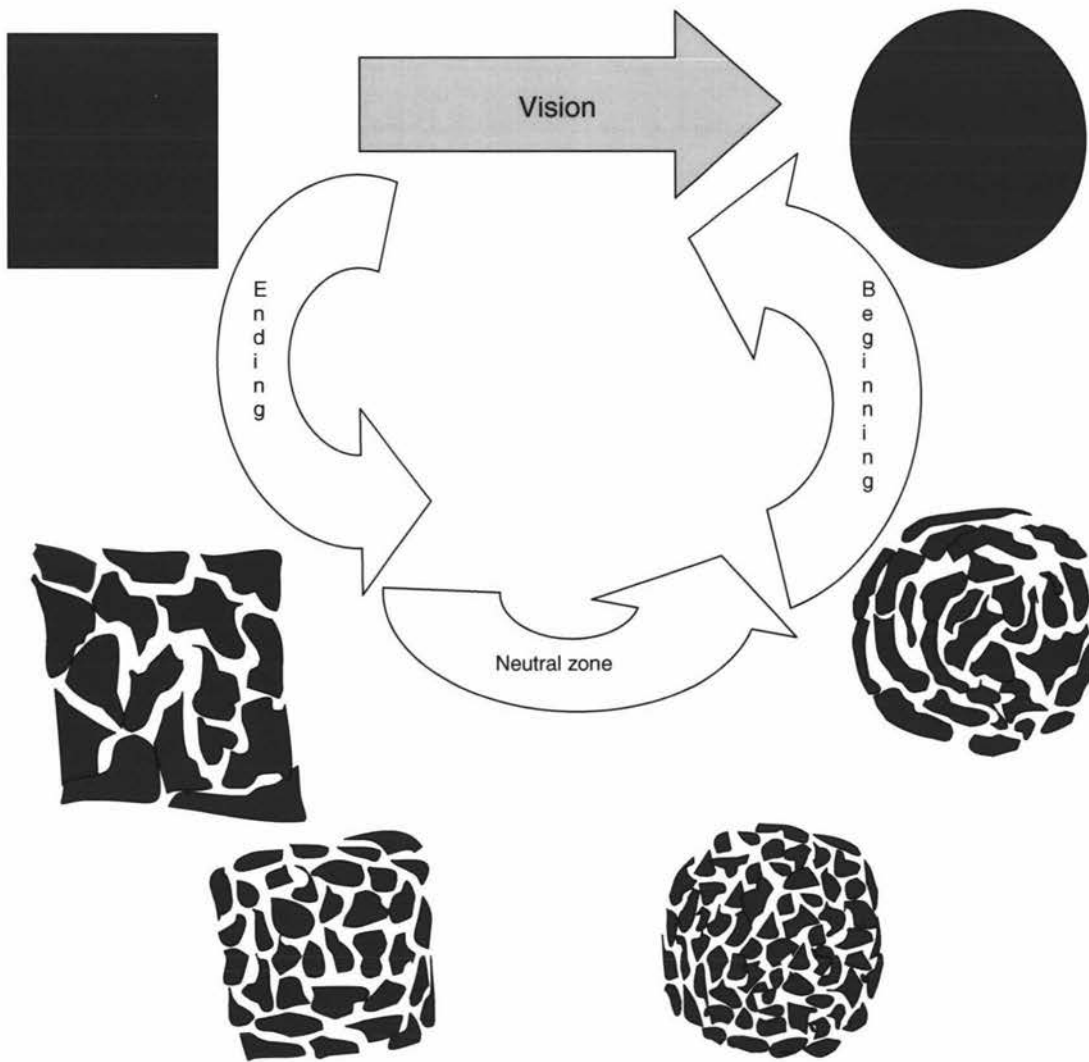
Figure: 1. Visual representation of the phases of transition (Bridges, 2003, p.41)

Disorientation creates a sense of loss and confusion, everything has changed and nothing feels the same. In nursing this can create a feeling of being 'de-skilled', transition anxiety or even imposter phenomenon where a person feels incompetent or fake (Huffstutler & Varnell, 2006; Kets de Vries, 2005; Vance, 2002). Huffstutler and Varnell (2006) view this as a normal temporary process. This can be seen in both endings and the neutral zone.

Neutral Zone

The neutral zone is the time between the ending and the beginning, a no-mans land, a confusing and chaotic period. It is a positive and negative time, certainly ambiguous.

Harrington and Terry (2003, p. 49) described the neutral zone as surrender, renewal, recharging, redirection and a change in perspective. Bridges (2003) depicted the whole broken into pieces, disintegration (see figure 1. p. 49) and as a time where anything can happen, people are unsure and feel vulnerable. If a person prematurely leaves a job, because it's not what they expected, they may not have adjusted to their new role at this point and are actually experiencing the chaotic neutral zone.

Brown and Olshansky (1997) used the anthropological term liminalty to describe being in limbo or the straddling of two identities. Often, though people feel lost and unsure, it can be a time of great reflection, thinking things through and contemplation. Huffstutler and Varnell (2006) suggested people who have the ability to reflect on the situation will progress more successfully through transition. The neutral zone also has the function of recharging, discovery and redirection. If managed well it can create energy, enthusiasm and "… new opportunities which inevitably arise in times of tremendous change" (Kouzes & Posner, 1995, p. 79).

Beginnings

Bridges (2003) described beginnings as involving, "New understandings, new values, new attitudes and new identities" (p. 58). Harrington and Terry (2003) called it a "… loop in the life journey, reintegrating the new identity and the old identity" (p. 49). Infante (1986) talked about the merging of value systems of two roles, the old and the new taking shape in a new image, which using Figure 1 (p. 49) fits with Bridges (2003) transition model. Schumacher and Meleis (1994) suggested that role mastery is an indicator of a healthy transition, the ability to see possibilities for the future and to experience control is indicative of someone comfortable with a role.

3.12. Summary.

The research methodology and method used to answer the research question was described in this chapter. Qualitative descriptive methodology was selected as best suited to address the aims of the study. Qualitative description presents the findings of the study using the words of the participants, allowing perceptions and feelings of the participants to be articulated.

Ethical considerations were presented and ethical approval gained from Regional X National Ethics Committee and the Massey University Human Ethics Committee. Eight CNEs were recruited using purposive sampling. Inclusion and exclusion criteria meant the sample would be small and potentially may not make the eight required. Dispensations were made for three participants who fell between three and five weeks short of the minimum inclusion timeframe.

Semi structured interviewing was used to collect the data, which was then analysed using a general inductive approach. Categories evolved and were refined to provide five main themes; entering transition, getting started, chaos and turmoil, overwhelmed and opening doors. Within the five main themes were nine categories. Each theme fits into one of the three chapters, based on the transition framework used in this study. The emerging themes were checked using a form of independent coding and also utilized stakeholder checks. The themes are placed into data chapters titled, "endings", "neutral zone" and "beginnings", to place them within the framework selected for this study. The themes are presented using the words of the participants. The next chapter is the first of the three data chapters and begins with themes fitting under the heading of 'endings.'

Chapter 4: Endings

4.1. Introduction

In chapter three the research process was presented, detailing the research methodology as well as the interview processes. Data gathered from the participant interviews were analyzed using a general inductive approach (Thomas, 2003), resulting in the development of categories and subsequent themes of commonality. The themes are presented in the next three chapters using the transition framework (refer to chapter. 3, p. 46). Throughout the data chapters each category will be introduced using a quote from a participant in the study. Each quote has been selected to present a snapshot of the data contained in each category. The following three chapters are titled, endings, neutral zone and beginnings.

In this chapter the initial endings phase of transition will be described, with the data being presented in two themes. The first theme is titled, 'entering transition', which has the two categories of, 'thinking back' and 'went in blind'. The second and last theme in this chapter is titled, 'getting started', which has two categories, 'orientation or disorientation' and 'more than expected'. The chapter begins with a review of the endings phase of transition.

4.2. Transition: Endings phase.

The initial phase of transition is titled 'endings' (Bridges, 2004). The beginning of a journey or transition is referred to as an ending. This ending phase attends to the feelings of grief and loss as a person changes their relationships and familiar places for something new. The entry to transition can be a difficult time with feelings of disengagement, disidentification, disenchantment and disorientation (Harrington & Terry, 2003). The first theme 'entering transition' identifies how the participants felt about moving onto a CNE role.

Entering transition

4.3. Thinking back

> **Frances:** *In my time on the wards ... one of my favourite jobs was actually supervising and precepting students and new grads so I always really liked that and you know, enjoyed making their time on the ward a happy time and being able to support them (p. 1).*

The participants all indicated general interest in practice education prior to applying for the CNE position. Interest and experience ranged from taking on a practice education role as a staff nurse, to enjoying precepting and orientating new staff. Most of the participants recollected a feeling of readiness for this career change, having achieved success and a level of comfort in their roles as staff nurses. Some identified this independently, others were encouraged by senior staff that recognized their abilities and potential, and some were encouraged by senior colleagues before they felt ready for the move. Making a planned transition is energizing and exciting, but requires preparation, including emotional readiness and control (Mateo, Newton & Wells, 1997). Unplanned transition can cause anxiety, disbelief and shock. The participants describe a mixture of transition experiences including those that were planned and unplanned as well as all points in between.

Lynair was preparing for a change, she felt the skills she saw among her colleagues needed attention and there was no educator to support any further learning. She felt disenchanted with the practice she was seeing and felt ready for a challenge.

> **Lynair:** *Within my previous job I tended to step up to the mark to do the education for the nurses because for a period of time there was no educator. I actually went to wound conferences and did presentations. I think I was actually just preparing myself for this role and I had concerns because I saw clinical practice out there that I didn't actually think was of a high standard (p. 1).*

Lynair had started to expand her role, disconnecting from the staff nurse position and indicating she was ready for a career shift. She spent some time adjusting her education to fit this next stage in her career. Bobbie also had positive memories of her role as a

staff nurse undertaking practice education and wanted to expand on her old role, feeling ready to take on more responsibility. Like Lynair there was no clinical educator in the service where she worked previously and she had 'stepped up' to take on extra responsibility.

> *Bobbie: I had a role as a staff nurse which incorporated a lot of education. There was no nurse educator … and it was expected in the unit that one person took on the role of doing education and that was sort of my role so when I came to here I wanted to expand that role a bit more (p. 1).*

Bobbie had experienced some aspects of the CNE role, but had no CNE role models, as the clinical nurse education position was not available in her area. Zoë indicated she was seeing people in the CNE role as role models and aspired to be like them. Like Lynair and Bobbie, she had felt comfortable taking on practice education as an extra responsibility, but had also had experience of working with a CNE in her area.

> *Zoë: I went overseas, did my OE working predominantly in [clinical specialty] and just doing the OE thing really, came back to my old hospital that I worked at and started working in [clinical specialty] and it was then I felt as though I'd found my niche, really enjoyed the education side of things and saw the roles like CNE or clinical nurse [specialty title] at the penultimate kind of achievement, so I guess I kind of got interested then (p. 1).*

Emily had also seen CNEs in her work area, and had also enjoyed the precepting and education side of nursing. She felt ready for a career shift, feeling enthusiastic and energized at the opportunity.

> *Emily: I came here to work and just worked in the unit as a staff nurse and very quickly sort of came to be doing preceptorship here as well, really enjoyed it, really enjoyed the unit … I was thinking to myself 'oh I'd actually really fancy doing that job', just purely because I love teaching, I like the whole education side of things, I knew that I'd probably be pretty good at it because I was interested in it (p. 1).*

Lynair, Zoë, Bobbie and Emily had taken the opportunity as it had arisen; they had prepared for the role and felt positively about their readiness to move on. Their colleagues Chloe and Barb were initially reluctant about moving into a CNE role.

Chloe was happy in her staff nurse role but was identified by her manager and the previous CNE, as someone with potential, able to achieve. This could be seen as succession planning, but the urgency with which the role needed to be filled, meant Chloe had little time to prepare, she felt pressured and subsequently she initially struggled with the role; having been encouraged before she perceived she was ready.

> *Chloe: Ok clinical nurse education has been something that I have in the past …
> in terms of thinking about my career, is where I've kind of wanted to go towards,
> but not right then but this job came up … I wasn't convinced for quite a while but
> in the end I decided I would go for it (p. 1).*

Barb's experience of being selected for the role was similar to Chloe. Barb was one of the participants who was slightly short of the 6 month inclusion criteria, she demonstrated many of the characteristics of 'endings' and 'neutral zone' (Bridges, 2003, 2004), such as anxiety and lack of confidence. Two of the three participants who fell short of the six month inclusion criteria were the most unsure of their success in the role. Barb in particular, had to struggle to identify why she wanted the role, her demeanor and tone, along with words like 'persistence' identified feelings of being preemptively disengaged from her familiar old role.

> *Barb: What happened was my charge nurse and the CNE that was here
> previously encouraged me to do it, so it was their encouragement and
> persistence really that got me in position, and I mean I identified that I enjoyed
> sharing knowledge with other staff, new staff, preceptoring new staff members
> you know, that was an area that I enjoyed. So it [the CNE role] wasn't something
> that I craved from the beginning (p. 1).*

Chloe and Barb, though they had been encouraged to make the move to the CNE role, had not felt wholly ready to make a career move at this stage and to some extent showed a sense of disengagement and reluctance to take up the new role.

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Conversely, though she hadn't prepared for the role, Frances was enthusiastic and had enjoyed the precepting and education of new staff as a staff nurse. She had also been encouraged by the senior staff to apply for the CNE role, but felt as it was in a familiar area, where she had credibility and a sense of comfort, that she could handle a new challenge.

> *Frances: In my time on the wards ... one of my favourite jobs was actually supervising and precepting students and new grads so I always really liked that and you know, enjoyed making their time on the ward a happy time and being able to support them (p. 1).*

Frances saw the role as an opportunity to provide the clinical support and education she had enjoyed as a preceptor. This interest in preceptorship and clinically based teaching was something the participants all had in common, however their readiness for a role shift and relevant leadership abilities were mixed. Succession planning appeared ad hoc at best, with a sense of urgency for roles to be filled as previous incumbents left or went on maternity leave. Bolton and Roy (2004) are of the opinion that succession planning is not occurring in health organizations and that recruitment of candidates for key positions does not occur until the position becomes vacant. The experiences of the participants in this study confirm that this remains an issue. The next section presents data on the participants' understanding of the role prior to appointment compared to the reality they found once in position.

4.4. Went in blind

> *Bobbie: I didn't have very many clear expectations of what the role would involve, I sort of thought I would go in there and shake things up, get some education on board and get things going a little bit (p. 1).*

Though the participants had all experienced a practice education component to their staff nurse roles, such as preceptorship, they were unaware, on applying for the CNE role, what it actually entailed. As indicated in the previous section, a number of the participants had not experienced working with a CNE in their previous work settings and

so had nothing to compare their new role to. In seeking information on the role to prepare for application and interview, they were met with differing levels of support.

Lynair gave a description which is commonplace in health, the development of new positions without fully understanding how it will work or merge with other roles. This means managers and human resource departments are often unable to give detailed descriptions of roles, compounding the anxieties of applicants who are simultaneously experiencing transition.

> *Lynair: Nobody could really tell me what the job entailed but I just said 'oh I could do that, whatever it was I'm sure I could do it.' … I was told nothing. You get given a job description and there is a perception that you'll have an understanding of what you'll have to do to fulfill the scope of that role (p. 2).*

Lynair indicated that although she received a job description, it didn't give her the full story about the role. However, Lynair did at least receive a job description. Lila came from another organization and got even less information on the job she was applying for.

> *Lila: I would have loved to have had a job description, I was told it's available it'll be sent with your [documents] but it didn't arrive with my whatever, documents and I would have loved to have seen you know what's involved and things like that (p. 6).*

Job standardization reduces the stress of transition to new roles, or at least moderates the effect (Hsiung & Hsieh, 2003). With different perspectives of the role, a standardized job description can offer some guidelines and consistency to potential applicants.

Other participants talked about how they had viewed the CNE role when they were staff nurses. Chloe worked with a CNE and felt she understood a little about the role.

> *Chloe: I think as a staff nurse, focus on my world view if you like was pretty isolated to the unit and to staff nursing so what I saw the role as was probably related to providing education and to providing support clinically yes, that's*

probably the main two things to provide education and to provide that clinical educational support (p. 2).

This view is not uncommon, as this is the visible side of the role, the helping and coaching component that is seen by staff while in the clinical area. Frances described her experience of CNE's in the past, as a senior staff nurse in the area she felt she had little contact or need for the CNE.

> *Frances: I know there was one CNE per area and the ward we were on was quite isolated so we didn't really see a lot of the CNE physically and at that stage I never really had any [idea]. It was only just when I had to do my portfolio or something to hand it in, I wouldn't really have any requirement to see them so I wasn't really sure, but I knew that they certainly were involved in you know, supporting new grads. Not so much the students, but also new staff, portfolios, organizing study days. Yes, that was a little small square that I had them in, and now of course I realize that it's a lot more than that, yes (p. 2).*

Emily had also worked with a CNE as a senior staff nurse and describes how she had seen only a small part of the CNE role and in reality had no concept of what the role entailed.

> *Emily: When the other CNE was here I had no idea what she did, absolutely no idea, knew nothing about what she did apart from she did my IV test and would make sure you did an annual update day and stuff like that, and if you wanted to do a course then you went to see her, but like had no idea about the magnitude of her job (p. 7).*

Zoë related similar understandings and expands on how she started to see the role was bigger than she ever anticipated.

> *Zoë: Guess I went in a bit blind really … I knew it was about orientation of new staff, I knew it was about, we've got a modular programme in our department, it's about marking those and it was about being a leader in the department but the*

further into the role I've gotten you see how big it is, and I mean it's not just about education (p. 2).

Zoë identified the role as more than just being an educator and providing education. She had been attracted to the role as she enjoyed education and had no indication the role would include anything else. For others, the more formal side of the role is a new experience. The involvement in policy development and justification for study days surprises Barb;

> *Barb: I wasn't aware that it [the CNE role] was so much involved in being a policy developer or the study days and I mean that's probably naivety because out on the ward you attend study days that would be just laid out for you don't really know that you have to negotiate and fight for its existence and maintain it and there's a lot of work involved (p. 1).*

Barb was starting to see the need to be able to negotiate, influence and articulate clinical education needs. She saw the difference between the expectations of staff nurses, attending study days without thinking how the day is organized, paid for and facilitated. This was the start of new understandings for Barb on how the organization functions at a different level; she is experiencing transition and socialization across hierarchical and inclusional barriers. Hierarchical, as she has moved from a lower level to a higher level. Inclusional, as she moves closer to the place where power is held and decisions are made (Wanous & Reichers, 2000).

Lila had expected the role to be a predominantly formal teaching role, expecting to have to lead the study days. In a similar way to Barb, Lila was surprised by the role the CNE takes in quality and risk management in the form of policy development and use.

> *Lila: Yes the role was supporting and teaching nurses and in my perception I was thinking more like doing presentations and teaching those kinds of things but when it came to a reality I realized you need to have all these policies and everything just in your head (p. 1).*

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Lila moved into the role with preconceived ideas, she had no job description to give her any guidance and only a passion for education and teaching. She saw the role offering her the opportunity to do the things she had enjoyed most in her previous roles, but in reality the job was not as she expected. Kelly and Mathews (2001) suggested that this discrepancy between expectation and reality surfaces many emotions, "... especially a sense of insecurity and disequilibrium" (p. 157). Lila and the other participants required significant support to prepare them for their new roles. The next section looks at the orientation they received.

Getting started

4.5. Orientation or disorientation?

> **Bobbie:** *My orientation was pretty much 'there's your office go for it' (p. 2).*

Socialization to a new role is vital in delivering the knowledge the person needs to undertake the role and to give them the skills to do the role (Wanous, 1992). The participants in the present study received minimal orientation. One of the main issues was, not only are staff nurses unaware of the size and complexities of this role, so are the managers who employ the clinical educators. Subsequently, the orientations were either non-existent or did not capture the complexities of the role enough to adequately prepare the CNE, either for the tasks or the leadership responsibilities required.

Designated senior roles were described as complex and requiring significant skills. Tailoring an orientation programme to a senior nursing role, which will have significant impact on clinical practice across a specific service, would minimize the initial transition anxiety. Chloe described her orientation.

> **Chloe:** *It was minimal, there was also the job description and some kind of an online orientation thing but it wasn't, it didn't really work in with the role, it didn't really fit ... yeah (p. 5).*

Lila was not only new to the role, but to the organization. She felt there was no guidance and explained how the role was something she had to learn for herself.

> *Lila: Very brief, its kind of an individual kind of a role that you learn everything and you don't have a role model (p. 2).*

The effects of transition are predictable, as the new staff member actually grieves their old role, relationships and networks, the positive, welcoming into a new role is vital to allay feelings of fear, loss and disorientation (Wells et al., 1998). Lynair related an experience where, after having to ask for an appraisal with a manager, the conversation turned to things other than her new role.

> *Lynair: I mean I was given an orientation booklet I didn't actually think this was very good. I don't think we adhered to the guidelines within the orientation booklet either. I had to actually ask for a three months performance review and I thought that was a complete waste of time because I think we actually sat there and talked about her children rather than anything relating to work (p. 3).*

A number of the participants were dismissive of orientation, recalling anxiety and in some cases anger at their perception of being left to get on with it. Bobbie articulated a feeling of being de-skilled and disorientated.

> *Bobbie: My orientation was pretty much 'there's your office go for it'. I was given a preceptor who was a very nice person but not particularly accessible … I didn't have an actual orientation programme. There weren't set things I had to do at set times, I feel I haven't had clarity of my role explained, yes its pretty much find out as you go along. Silly things like how to book venues, I hadn't a clue until it came to book a venue and it's like, who do I ask? And had to seek that from someone else, and I think that should be covered in a period of orientation, all those simple things. As a nurse educator you've got to book venues, you've got to find equipment, you've got to know how to co-ordinate study days and what have you, especially as a new educator, those things weren't explained until it came to a point where I had to have it explained because it was imminent (p. 2, 3).*

Emily not only felt lost, but the time that was spent on orientation she felt was misused or wasted while her predecessor cleared out her office.

Emily: Didn't really have an orientation, when I got the position I started it a week before the CNE who went on her maternity leave, so we spent a lot of that week basically clearing this room out because you know there was at least twenty years of rubbish in here (p. 4).

Emily's experience resulted in her being in a state of disorientation, trying to make sense of things.

Emily: [I was] trying to make head or tail of was I was supposed to be doing because there was no real structure in place there was no real structures for you know, how often are you meant to be doing these things (p. 4).

Emily felt the best thing which could have occurred was useful time with her predecessor.

Emily: I would have benefited from longer time with the existing CNE to actually get that information that was all in her head and get it in a logical order ... whether it was on my computer or on paper so I knew what I was doing ... So, to actually identify those areas that are needed and be able to go and be taught how to do it properly, rather than be struggling for half a day to do something that takes someone else half an hour (p. 6).

Other participants echoed Emily's feelings, that the best source of information would have been their predecessor. Lack of this person to talk to meant information on how to do the job and about staff issues was lost.

Lynair: I think it would've been good to be able to orientate with the previous CNE for the area. I have actually rung the previous CNE once, because I know her, just getting that feedback, again some of that's around the dynamics of individuals. But just some of the day to day running stuff. It would've been good to have actually had her notes and all her staff files just put onto my computer so that I could access them and read what she had written about people previous to see whether the same behavior is still going on or if there were issues about anything specific like clinical practice that I could've actually been privy to those

notes and been able to follow up on some of the stuff that she'd actually started (p. 3, 4).

Lynair is expressing frustration; feeling disaffected because the information she needed to start performing in the role was not available to her. Skills and knowledge that could have prevented time wasting were not passed on, learning new systems and searching for information resulted in a lot of work being repeated. The passing on of skills and information can also mean the newcomer feels able to perform in the role earlier, increasing a sense of fitting in and organizational acceptance. Bobbie also had issues when organizational knowledge was lost with the departure of the previous CNE.

> **Bobbie:** *I would have obviously have had some time with my predecessor to go through the office basically and see what was what, where she was up to with education what was on the plan, how you did things like book study days, how you managed your time that kind of thing … we have got staff performance issues at the moment within my unit and I would have to look through a filing cabinet full of incident reports to find out if these people had been implicated before which would be extremely time consuming and difficult (p. 3).*

Bobbie described her frustration with trying to learn simple functions expected of any CNE. Her initial anxiety in the role was compounded by frustration, feeling unable to work the system and to perform to the standard she would have expected of herself. Employees with higher levels of job autonomy, able to make decisions and get on with the work are less stressed and more satisfied in their work (Thompson & Prottas, 2005). This frustration can be avoided by passing on the knowledge and skills to do the job in a structured orientation, handover or even in a succession planning process. Chloe described how she would like to handover to someone taking over the role, suggesting a week with the next CNE would not be sufficient.

> **Chloe:** *I guess if I was to hand over to someone else I think having a week, or I don't know if a weeks long enough but at least some time with whoever was going to take over to go through things (p. 5).*

The participants became disenchanted as they discovered the beliefs they held about the role when they applied, were no longer real. The job was not what they expected and the orientation period was not planned enough to lessen the anxiety of transition. The departure of the last CNE resulted in information and organizational knowledge being lost. As the participants continued to orientate, they also found the role was much larger than they had imagined. The next section looks at the size and expectations of the role.

4.6. More than expected

>*Bobbie: I didn't quite realize the amount of paperwork and other responsibilities (p. 1).*

There are a number of reasons why roles were larger than expected or have extra responsibilities. Often people do not fully understand what they are applying for and are unable to get a real sense of the role from the employer. The 'went in blind' section, discussed how managers may not be completely sure what the new role can contribute. Some extra responsibilities develop due to the skills of the person who has taken over the role, for example a CNE with a particular interest such as wound management, may increase the focus in the service on wound care, which means they are also used by other services for their knowledge in the area of wound management; consequently the role stretches to accommodate the growth (Mallett et al., 1997). Participants in this study described numerous additions to the basic CNE role, from generic DHB expectations and service representation at meetings to absorbing a counseling or pastoral responsibility.

Counseling or pastoral duties in a CNE role are commonplace. The CNE role is viewed as a neutral position, supporting the registered nursing staff and the charge nurses, a part of the role that requires significant interpersonal skills (Upenieks, 2002).

>*Zoë: People trust you enough to come in blurt their life story out in front of you, so I go ok I've got the nurse educator role and I'm a counselor too (p. 3).*

As well as supporting the staff, not only in a clinical support sense but with personal issues, the CNEs have to contend with intra-team conflicts.

> *Lynair: Yes it's bigger than I thought it would be for sure, a lot bigger yeah, but some of that's because I generated that because there's no-one else to do it. I mean problems with dynamics within teams and areas of conflict and bullying and stuff like that. I seem to have to deal with that because there's nobody else to do it (p. 2).*

Lynair described how she coped with issues that in reality should be dealt with by a manager. She accepted that she chose to take on the responsibility of the extra work, as she felt no-one else was dealing with it. However, dealing with staff conflict is not the role of the CNE who needs to remain in a neutral position.

Generic responsibilities were a frustration for a number of the CNEs who on initial application thought the role was for a particular service, in a clinical setting where they felt comfortable. Generic components such as meetings and Professional Development and Recognition Programme (PDRP) portfolio responsibilities were often not something they had considered.

> *Emily: But it was the whole expectations of you ... when I was looking to do this role I had no idea. I thought it was just going to be an educator for the unit, teaching and educating the staff here, which is fine but there's this whole host of other things that you're meant to be involved with as well which I had no idea about (p. 2).*

The generic responsibilities came as a surprise to Emily, but Bobbie felt they were impacting on her ability to manage her core responsibilities.

> *Bobbie: I've really, really struggled with that because 30% of the component of my job is generic so that's a day and a half so it sort of doesn't leave very much time left to do the paperwork that's involved in your role or the other things that maybe involved in your role (p. 2).*

Barb felt like responsibilities outside of her area are taking her away from the staff she is employed to support.

Barb: A lot of meetings, planning meetings, which sometimes don't seem to bear much output or outcome, the outcome doesn't seem to be achieved and probably a lot of things that take me away from the ward (p. 1).

Attendance at meetings was a consistent issue through all the interviews. The CNEs felt that they were seen as having available time, and used to represent the service, at times they didn't really understand why.

Emily: I mean there's working parties for Africa on every single thing you can imagine and its like oh, there's problems with this lets make a working party for it and lets have 10 meetings to discuss it and get no-where and then have to sit down and start from scratch again and that is really frustrating for me really frustrating (p. 3).

Emily and Zoë felt frustrated by the amount of time taken up in meetings.

Zoë: Huge, crazy, what are all these meeting? ... The number of meetings it's probably that's one of the things that I didn't realize that there would be so many meetings (p. 12).

Frances felt overwhelmed, at this early stage in her new position, the meetings and expectations seemed more than she could cope with.

Frances: You're in meetings constantly like we had the education [meeting] session the other day and honestly I was just sitting there thinking 'Oh my god how am I going to cope with that?'.... But yes its information overload I think (p. 2, 3).

Chloe started to understand the complexities of the role and why decisions and projects can seem to take an endless amount of time. She started to understand that in order to succeed she needs to have networks to get things done.

> *Chloe: I realized how complex the role was and how I didn't know the networks, I didn't know the processes, I didn't know the expectations of how long something could take (p. 3).*

The participants have described pastoral responsibilities, project work, meetings and portfolios; which they perceived results in a lot of extra work, but Bobbie's experience was an even greater shock.

> *Bobbie: It wasn't made clear to me when I applied for my position that I would be running a post-graduate course, that was dropped on me at the end of my first week. I might have thought a little bit differently about it had I known that (p. 8).*

There is no doubt that you cannot orientate a new person to everything, some learning must be situational, experiential and unique to clinical areas (Corning, 2002). However, many of the experiences articulated by the participants are core expectations of a designated senior role in health; the need to be in a counseling role, attend meetings and holding generic responsibilities are all part of CNE roles (Mateo & Fahje, 1998). The presentation of this as extra work may be erroneous, however the CNEs were not informed of these responsibilities prior to application, so their expectation of the role was often founded on minimal information. The components of the role described in this section are in reality, quite predictable and able to be part of a job description and included in an orientation.

4.7. Summary

In this chapter the data on the participants' initial interest in becoming CNEs was presented. They had all, without exception, previously enjoyed a practice education component to their staff nurse role. However, they soon realized that the CNE role was much more diverse than expected. They had applied for the role without much information to guide their decision and once in the role had received minimal, if any orientation.

Initially the participants were reasonably positive about the transition to a CNE role. However, they found preparation for recruitment into the roles was sub-optimal. The participants had minimal understanding of the role they had applied for and were not

offered a strong orientation and socialization process. Following orientation it became clear to the participants that the role was significantly larger and more complex than they had anticipated and they felt lost and isolated as their predecessors left little behind. They have exhibited the feelings of loss as they moved from an expert staff nurse to a novice senior nurse, creating feelings of disorientation, frustration, disenchantment and being de-skilled.

In the next chapter the neutral zone of transition is presented. The neutral zone is an ambiguous and chaotic time with positive and negative feelings, as previously described on page 49. The participants relate how they are beginning to form relationships and are adjusting their expectations. The first theme presents the data on interpersonal and personal management.

Chapter 5: Neutral zone

5.1. Introduction

In chapter four the data on endings, the first part of transition were presented. The participants described their expectations of the roles they had applied for and their feelings as the role emerged as bigger than they expected, often with little direction or role clarity to guide their development. Orientation programmes and socialization processes were felt to be sub-optimal by all the participants, with the most valuable information leaving with the previous role holder. In this chapter neutral zone feelings are explored. The themes in this chapter are titled 'chaos and turmoil', and 'overwhelmed'. The first theme 'chaos and turmoil' presents the conflict that can arise when moving into a new role, as well as a sense of confusion as the participants continue the journey from novice back to expert. The second theme 'overwhelmed', presents the CNE's attempts to manage role boundaries and the stress that accompanied their work-role transition. The chapter begins with a review of the neutral zone.

5.2. Neutral zone

The title 'neutral zone' was chosen by Bridges (2003) to describe a time of being in limbo. It is the time between the ending and the beginning, a no-mans land, a confusing and chaotic period. It is a positive and negative time, certainly ambiguous. Bridges (2003) depicted the whole broken into pieces, where repatterning occurs (see figure.1. p. 49). The initial theme is titled 'chaos and turmoil', reflecting the feelings associated with this phase.

Chaos and turmoil
5.3. Communicating in a new way

> **Zoë:** It is also about your stepping into this senior role now and your buddies on the floor, it's really hard to maintain friendships, but be a leader as well, do you know what I mean, you're kind of taking a step outside that clique (p. 3).

The neutral zone can affect self confidence and self esteem, and is a time of conflicting messages and ambiguity. There is a tendency for old or unresolved issues to re-emerge

and potentially get worse (Bridges, 2004). Dealing with conflict as a senior nurse is one of the more difficult challenges and can override any positive feelings about the job. One CNE talked about her experiences dealing with old colleagues, she felt undermined and though she was now senior to them, she had a perception she was being bullied.

> *Lynair: Something that's been really interesting for me is the dynamics that I've received from my senior colleagues who I used to work with and there's been bullying and I've actually had to [pause] … there's been two nurses in particular because I worked with them for 10 years and I was on the same level as them and now I suppose I'm senior to them now I'm not their boss but I do their clinical assessments and things. There has been some bullying to the degree of undermining what I say and what I do, and setting me up to fail and some people saying that I said things and I didn't say them just to set me up to fail. I think that's been, I would say that's been the most difficult out of anything that we've talked about today but I think that's because of where I came from, working with these girls (p. 8).*

The ability to deal with conflict is an important skill, however dealing with additional conflict such as bullying can add another dimension to the already vulnerable neutral zone.

The majority of participants had moved within the organization, working in the specialty, establishing credibility and then applying for a senior role. For example Zoë, who described the burden of being seen to 'fit in' and to have the skills and knowledge to manage. Zoë described the importance of being viewed in the right light by the organization.

> *Zoë: I think if you don't have your credibility you're not going to succeed. No you're not going to succeed, that's why I often think people coming from outside, a different organization, into this organization and into a senior role straight away how much more difficult it would be (p. 9).*

In fact, there was a participant who had moved to the DHB from another organization and had also experienced the communication and credibility problems Zoë referred to.

Lila: I saw myself as working in a different DHB that's kind of a strange ... like I'm a stranger, I have to be friendly and introduce myself they need to know me I have to allow time for that (p. 6).

Lila saw the responsibility for relationship building to be hers, not the staff or the other senior nurses in her area.

The more common theme about relationships was about having to learn to deal with old friends in a new way

Zoë: You find yourself in such a quandary, oh I still want to be buddies with my buddies on the floor because I really like them, but there's certain things I'm going to be told that I can't let on that I know anything about to other people and that can be quite difficult and your kind of caught in this ethical situation where you've got your buddies, that you were quite close with on the floor saying oh that damn nurse 'ra ra ra' kind of thing and you know what's going on over here, but you can't actually say anything (p. 9).

Having to make the adjustments needed to become the leader of old colleagues can prove awkward for all involved (Cohen, 2005). It is common practice in nursing to promote from within, this enables organizational knowledge to be maintained and for the employer to be seen to value the work of those within the organization, however, it has the effect of changing the dynamics in the group to make people feel initially uncomfortable.

Emily: Right at the start having to think about writing letters to chivvy them up and get them [portfolio's] handed in and everything and it was like 'oh god I've got to write a letter to her' and she was a really good friend and now here I am writing them a letter saying hand it in 'or else' type of thing, that made me feel really uncomfortable at the start (p. 8).

Communicating with old friends in a new way and distancing oneself from daily conversations can be difficult as you try and establish yourself within the norms of a new organization or at a new level.

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Bobbie: I don't feel completely outside the team but you are … you're a senior member of staff you're not one of the girls on the floor (p. 6).

The reference group for daily interactions is forced to change. There is a need to find new colleagues and relationships. To do this there is a need to be able to communicate, and in the neutral zone the CNEs have often found themselves caught between loosing their old reference group and yet being unable to articulate or engage confidently at a new level. Chloe related not only to meetings but to writing emails and using language that would elicit a response.

Chloe: I think part of the big learning is learning to relate to people without offending people and how to change your language, simple things like instead of writing someone an email that says 'can you look this over and get back to me if there's any changes on the policy' or whatever and then not hearing back for a week and wondering should I email them again (p. 10).

Emily was more direct in relation to meetings, spending considerable time wondering, not only how to engage but how she fitted into the picture.

Emily: I mean I'm not a shy person by nature but I probably spent a lot of my first 6 months just really just sitting and observing because I needed to work out for myself where I was in the whole grand scheme of things, and there's no-one to actually tell you about it (p. 3).

Emily was able to look back on her experience from a place of confidence. Barb hadn't reached that place and still felt anxious about how to engage and communicate in a new forum, identifying that she may have needed to attend education on managing effective meetings.

Barb: I'm probably not there yet. No, because that's an area I need to develop, effective meetings, there's a study day I can't remember what it's called but … it's an art, no I haven't got this down at all (p. 8).

Corning (2002) described people skills, negotiating and communicating, as 'soft skills' which are vital in leadership positions. On moving into designated senior roles, the participants are at different stages in their ability to communicate with old colleagues or in new ways. Though many will naturally develop the ability to work through these issues, some will require mentorship and support to increase their confidence. The next section presents data on finding mentorship and support.

5.4. Finding support

Barb: I mean, the bottom line you have to seek your own support really and also identify those people you know are available to support you (p. 3).

One way of coping with communication and finding a way through the neutral zone is by finding a mentor and using networking skills. Literature on transition, leadership and succession planning comprehensively supports the concept of mentorship (Allen, 1998; Bolton & Roy, 2004; Corning, 2002; Hader, 2004; Kouzes & Posner, 1995; Peach, 1997; Schumacher & Meleis, 1994).

Chloe: There's a couple of the other CNEs that I've gone to over the time but its probably more, yes professional guidance in terms of 'this is the situation how do you think I should deal with it' and that's been really good they've always been really open to 'yes sure what can we do? How can we address it'? So there's certainly been a couple of people there, in terms of mentorship (p. 6).

Some of the CNEs managed to find their own support network.

Emily: You know one of the girls who'd started a little bit before me ... so she'd got onto like the next phase ... and she was like 'oh yes its really good but I'm still finding like this bothers me and a bit troublesome but now I'm sort of moving on and you'll find you know that this hospital here is absolutely great for this' and I'll be like 'oh but I need to do that'. So it's just that whole networking and sharing of information was fantastic. Made you feel a lot more confident in your ability (p. 6).

The networks were a variety of people, from previous managers, to professional leaders and other CNEs.

> *Lynair: I have I suppose three people, the nurse that I talked about before ... she's really much on her own as well so we buddy up together and we would see each other every day and I think if there's areas of concern we'll actually phone or email or actually find each other and talk about it. Our previous clinical nurse [specialty title] has agreed to do clinical supervision for both of us but she said ... and that's together, but she will actually see us on a one to one if we actually need it and she's very much available. Then I have my previous service manager who I got on very well with who has I think a very similar philosophy about how we can improve the ... service, so I suppose because we're akin to similar thoughts we tend to run things off at each other so I suppose I've got the 3 people (p. 4).*

Whichever person was used for support, the CNEs all identified they needed mentorship, someone on the end of the phone to bounce ideas off, to ask questions without feeling uncomfortable and to compare progress notes with. In achieving role clarity the new person must see the congruence between their performance and the organizations expectations of performance (Wanous, 1992).

> *Emily: It probably needed to be more formal in that it needed definitely regular even weekly catch ups, just even to chew the fat for half an hour, just getting someone to say to you look its ok that's fine that's what's going to happen would have been great (p. 11).*

An effort had been made within the DHB to provide a preceptorship arrangement for the new CNEs. This had mixed results.

> *Barb: The support network is getting a little shaky, so I still have my preceptor who I contact, but you have to I mean, the bottom line you have to seek your own support really and also identify those people you know are available to support you (p. 3).*

Formal preceptorship has had its drawbacks, not necessarily because of the person, but because of the working hours and contact issues.

> **Lynair:** *My preceptor has been fine but she's not full time and she's not contactable really. Yeah, I mean I suppose if I ever needed any support and I felt I was out of my depth then I certainly could ring her (p. 3).*

Some of the participants felt the CNE group meetings and networks were of benefit, enabling them to learn how to do the work, especially in a role where the boundaries can be flexible.

> **Barb:** *You still need to reach out to the bigger group for help in my case often … I've memorized the phone number if I need to ask for help they are usually little detail things not major things but they [CNEs] need to be on the other end of the phone (p. 4).*

The CNE meetings gave the participants a chance to get to know each other, to meet with people in a similar situation, who could identify with their concerns and worries. However, some found the meetings gave them a sense of what they had to strive for.

> **Lila:** *It's [CNE group] very important in terms of support and learning they are great because they have been on the road for such a long time and I have heaps to learn from them and I just think my god they are so confident and things like that so I think oh when am I going to be like that and yesterday somebody told me 'it took me a good three years for me to be really you know, able to put my shoulders behind and walk' I thought 'oh my God that long' (p. 7)!*

Some CNEs were at the stage where external networking at conferences and between DHB's had become important.

> **Zoë:** *I sit on the national committee and that's been fantastic to take that little bit of a step outside … and just to start networking with those kind of people when I'm trying to bring in you know, better procedures, better protocols etc etc. so that's been invaluable to do that (p. 9).*

The CNEs, whichever method of support they chose, all agreed that networking was a vital part of succeeding in the role, both initially and long term. The outcome of mentorship and a support network is to help to assist in being able to locate oneself within the context of the new work setting (Wanous, 1992). The ability to 'fit in' reduces the pressure of intra-role conflict and role confusion, presented in the next section.

Overwhelmed

5.5. Learning to negotiate, intra–role conflict

> **Frances:** *You get roped into doing things and that's not really what you're supposed to be doing (p. 3).*

Intra-role conflict is a term used by Glen and Waddington (1998) to describe what occurs when people have different agendas for what the role holder should do. Stages of socialization will inevitably include conflict at some level as role clarity evolves. According to Wanous (1992), there is frequently conflict as a person finds the difference between personal values and needs and the organizational agenda.

> **Zoë:** *I feel as though, I don't know if it was an all of a sudden thing or if it was one of those things that just crept up. I'm expected to do 30% outside my department ... like I'm not really interested in it and it's probably like just a frustration to be told not asked, to be told that you've got to do 30% generic (p. 8).*

Establishing role clarity can be challenging, as agendas for the CNE can be more assertively promoted during the first few months when the new CNE is more easily manipulated.

> **Zoë:** *And then the charge nurse might ring up and say ' can you cover for lunch breaks on the floor' and you're like 'yep no worries' and then you hang up the phone and you kind of resent it a wee bit, because you go, well so are you going to come in and do my work (p. 12)?*

Learning to negotiate these relationships is a key part of fitting in to the organization and defining the interpersonal role between both colleagues and managers (Wanous, 1992).

> **Bobbie:** *I just feel the biggest hurdle of it really is knowing where your role begins and ends and being able to implement that, when you've got all these different forces pulling on your attention and on your time (p. 8).*

Bobbie made an effort to be clear about her expectations and that of others by setting up a service level agreement in regard to her role. Though a good idea in principle, she had problems completing it, presumably as it was not a priority for, or in the interests of, the parties it included.

> **Bobbie:** *One step I went to do was to do a service level agreement so we all got together and we looked at what their expectations were, what my role entailed now and see how we can marry the two up and sort of make a collective agreement that, this is my role boundaries, but we've not actually finished that process yet, I've not, I need to say that people haven't been that enthusiastic about completing it, apart from me (p. 6).*

A number of CNEs felt that their role was undervalued as they perceived they were used by others, often to the detriment of their own work.

> **Zoë:** *CNEs time is seen as disposable you might have a stack of work this high sitting on your desk that you have to get done within say in the next two weeks and for me that's stressful (p. 12).*

Wanous (1992) described the phenomenon of co-optation of individual newcomers. The new person is seemingly offered a choice, but in reality the only option is the organizationally favourable one. For instance, a senior colleague asking the CNE if they will help on the clinical area to relieve meal breaks when the CNE has deadlines to complete work which is office based.

> **Emily:** *It's infuriating though that if you've got, like you might have a planning day or something. So you're out for a whole day and then the following day you might*

be teaching … for half the day and then you've got meetings for the other half of the day. So, that's two days out … that you're nowhere near the unit and then you come back, and there's like you know a whole desk full of messages and emails and the doctors saying, 'Well, why weren't you at teaching on Wednesday?' and all that sort of thing and that's frustrating because there's just never enough time (p. 7).

The lack of understanding comes not just from managers and other disciplines but from the staff in the clinical area.

Barb: But if you say you have a meeting for this reason which is going to take this amount of time to achieve this, for example a policy, which maybe just ends up two pages, and all the hours you put in to achieve just a two page procedure it's really hard for them to see that, so you can't really, I don't think you can, because if they want to see you physically there and you're not there at that particular time when they want you, any excuse is not going to be good enough, well not excuse but you know. 'I wanted you to help me, where were you?' … 'Well I was at a meeting for something' (p. 5).

Barb talked about a common misunderstanding which if left unresolved can become problematic. The times when the CNE is not visible, the staff can and will, presume the CNE is not busy, this is common in roles with periods of low visibility (Felstead, Jewson & Walters, 2003). This is something the CNEs themselves have talked about, the realization that as staff nurses they themselves had no understanding what their predecessors actually did.

Bobbie: I think that people do understand that you are there to provide education but they really don't understand that you are there to facilitate education, they think you are there to stand and lecture them continually (p. 5).

The lack of understanding of the CNE role is not to undervalue, it is simply that staff do not get exposed to the complexities of the role until they become CNEs themselves.

Chloe: There was a real expectation that a clinical nurse educator is clinically focused and that means being on the floor a lot. So during that six months it was a bit of a transition between over being on the floor and meeting those expectations and kind of slowly pulling back a little bit from that and I think lately more people probably noticing that I'm not on the floor as much and that would also be for clinical, you know if they were short staffed, that would also be like I would do a clinical shift occasionally, so it was trying to work out how to balance that and when I could say no, when it was reasonable to say no ... (p. 3).

Chloe was starting to gain confidence, to say 'no', however there was still the balance between clinical and office work. Frances talked about the need to work clinically when the area is short staffed.

Frances: So you are really torn actually because you really do because you sort of think well God, maybe I should, but if you make a habit of that then it becomes part of the culture doesn't it (p. 3).

While Frances worked out the dichotomy of the role, she is also personally striving to realize her potential. Cooptation (Wanous, 1992) means that if Frances or any other CNE makes the collegially acceptable choice and leaves their own work, they can be setting a precedent for the future. This can prove difficult to manage during the early stages of role socialization as role clarity is often not achieved at this stage. The neutral zone holds positives as well as the chaotic negatives.

Frances: No they don't, they don't really understand, they actually think that we sort of yes, they don't really have any comprehension and I'm still getting to grips with it myself, because you've got so many fingers in so many pies and its not just, I mean not for me particularly at the moment but I know my colleague there, you know she's just everywhere man, she's just, you know I don't know how she does it to be quite honest. I think oh gosh I'd hope to be like that one day but yes she's on committees out there ... but they're all very relevant you know they're all just part of the role (p. 4).

Frances articulated the complex nature of this role, its diverse nature and flexible boundaries that can seem overwhelming for a novice CNE. Lila is also a novice CNE, who has moved in from a new organization. She is struggling to find where she fits and as she struggles to confirm her role boundaries, the staff also struggle with what Clifford (1999) describes as the role responsibilities thus making it difficult for Lila to gain confidence.

> *Lila:* That's right, that makes also the other people perceive the position as a little bit different because this position is a little bit spread out and I heard a couple of things, people saying, 'you're not actually under my team or on the roster' and people saying, 'Oh, you say you have meetings and you're going to meetings but we don't know what you are doing'. Or probably, no one has said anything to me but from the expressions or some comments I understand 'oh, we exactly don't know what you're involved with' you know that kind of role confusion is there (p. 3).

It felt to Lila like she must justify what she did, where she is and what work she is undertaking. She had yet to establish a trusting relationship with the staff she supports. She felt that when she worked late and had made a significant contribution, her presence was not valued.

> *Lila:* Its sometimes very difficult, for example you stay behind, for example you have a new grad, she has to do a medication test or something and you stay behind and I'll do that at four-thirty that's fine and you do it and stay and the other day we had a [cardiac arrest]. I went home at seven o'clock that night and no-one else knew and no-one knows that the CNE was a supportive person or she was round there (p. 7).

This statement from Lila was one of the last things she said in the interview, she had been positive throughout the interview but also reserved, towards the end she started to relax a little, once this happened, she started to relay some less positive views and experiences.

Lila: As a staff nurse you would feel that you just give, give, give, and you feel so drained and you think, well if I become an educator that won't be that type of giving role you're not going to be drained and it's going to be more positive, but its not the case. Its exhausting because also you have to juggle if you're doing things and people perceive, oh you have nothing else to do, you're just sitting in front of the computer and having a nice time but its really not (p. 8).

Lila's words express many of the characteristics of the neutral zone. This is not the job she expected and she appears to be in a slightly hostile environment where she feels the nurses are questioning her whereabouts. This is undoubtedly a source of stress for her as she is frustrated, upset, disappointed, confused and vulnerable. The CNE role has high discretion, it is self directed to a large extent. High discretion roles need to be managed carefully as they can be adversely affected by the team or the organization, as with high discretion, comes potential role overload, where the demands of the job are in excess of the ability of the role holder or for the role holder to prioritize work which is not visible, causing confusion and questioning of productivity (Felstead et al., 2003; Glen & Waddington, 1998). The CNE role has caused Lila to experience anxiety and stress which could affect her ability to perform, a common theme in both the neutral zone and the endings phase of transition. Data on stress is presented in the next section.

5.6. Stress levels

Barb: I would stay here hours and hours and hours, oh gosh, just incredible … and just thinking I should have done better and I should have finished this by this time and probably unrealistic expectations of myself (p. 6).

Working long hours was a common issue for the CNEs when they started the role. They all exhibited commitment to the role and the organization, wanting to achieve in their roles and establish themselves. Lynair recounted her initial experience of working exceptionally long hours.

Lynair: When I first started I was doing sometimes six or 7 days, I'd take work home, I'd do it at night and I'd still be doing it at eleven o'clock at night and on the weekend (p. 7).

Lynair felt she was now making progress and starting to manage her hours better. Whereas in reality, even with reduced hours, Lynair was still taking work home and working ten hour days.

> **Lynair:** *I think I was trying to be everything to everyone. I was trying to sort every problem. I'm not doing that now. I sometimes take work home but I'm not here at work till seven or 8 o'clock, I tend to finish about five and I tend to start at about half past 7 (p. 7).*

Establishing oneself in a new role, working long hours, being seen as busy and being present are ways of demonstrating worth and establishing credibility and identity in a new role or organization (Bass et al., 1993). Zoë has found the long hours have created a stress for her.

> **Zoë:** *It was just getting crazy I was taking work home at night and it was just too stressful (p. 6).*

Chloe began to show physical signs of stress

> **Chloe:** *I got really stressed out I was working late, I lost weight so I guess you could say I didn't really cope that well initially for the few months where I mean, were just quite, quite full on (p. 7).*

As well as working long hours the CNEs felt another change in their situation, working regular hours Monday to Friday brought some unforeseen issues.

> **Bobbie:** *I started at half past seven and left at 4 what do I do if someone comes to my office at two minutes to 4? Now, my manager says that in all fairness I should say, look I'm just about to go home can we continue this tomorrow, I really struggle with that and that's my issue that's definitely my issue (p. 10).*

Bobbie was starting to negotiate and bargain with herself and her manager, working out what her expectations versus that of her manager and the staff would be. She needed to set some boundaries and establish her priorities.

Frances brought up an issue which called for significant personal adjustment, impacting on her ability to cope.

> ***Frances:*** *I was stressed I must say for the first couple of months just because I, and the transition too from rostered shifts to Monday to Friday, people just don't realize you know they go 'oh, I wish I could work Monday to Friday.' I say well, actually it's very tiring, I honestly went from insomnia to narcolepsy just about, you know. That in itself is quite a transition and I was only point nine [0.9 FTE] too, so it's chewed up one of my days off and two days a week off is just not enough. That's probably been the hugest adjustment I've had to make (p. 6).*

Though Frances made light of the issue, the reality was that her physical health and wellbeing were affected by transition and subsequent stress, a phenomenon described by Bridges, (2003). Zoë described similar issues; she was exhausted, with the change in sleeping, shift and work patterns.

> ***Zoë:*** *The hardest thing I found, was going from doing three 12 hour shifts a week to five days Monday-Friday, That was really hard, working full time Monday to Friday and like I always thought I had it bad because I had to do the occasional set of night duties or work a weekend or work on a public holiday but I actually had four days off and working Monday to Friday is exhausting and that is probably the biggest, that was my biggest stressor and for the first twelve to 18 months, I was trying to think of ways where I could work you know, four 10 hour days and I could have an extra day off or can I start later, can I start at eleven and work until 7 (p. 11).*

The CNEs initially thought Monday to Friday regular hours were an easier option than shift patterns. However, changing from one to the other seems to have significantly increased levels of tiredness and stress levels.

Barb was not only working long hours, she felt she may not be performing as she should, her expectations of her own performance were very high.

*Barb: I would stay here hours and hours and hours, oh gosh, just incredible ...
and just thinking I should have done better and I should have finished this by this
time and probably unrealistic expectations of myself (p. 6).*

The need to be seen to perform was a high priority for the new CNEs and caused them
to be stressed about their performance.

*Emily: Overwhelmed, definitely and also you just felt really deskilled because
yes it was an area, I mean I'm pretty quick on picking up on things I mean if
someone tells me something then that's fine I'll run with it but to constantly be
finding out these things or that you've missed this you've missed that it just
makes you feel like you're really not doing a very good job, completely de-skills
you (p. 4).*

Emily felt completely de-skilled, a previously expert staff nurse, moving to the role of
novice CNE brought her unexpected hurdles, which she felt unprepared for. This was
compounded for Bobbie, who moved from an external organization into this role.

*Bobbie: One point to make is when you come into this role new or from another
place is that there's a great expectation that you know all the policies and
procedures, that you know how everything works, how the organization works,
who to contact for different things, and that a massive learning issue that when
you start in the job, I found that one of the biggest things, people would come to
me and say 'what do I do with this?' and I'd never seen it before (p. 8).*

Bobbie thought that nurses expect that as the CNE she would know everything. Having
the confidence to manage this situation is something that comes with time, however in
the early stages the CNE may feel like a fake or imposter as they move through
transitional identity confusion (Huffstutler & Varnell, 2006). Though they are qualified and
completely able to do the job, there is a temporary feeling of inadequacy. Lila tried to
compensate for this by constantly checking policy on things she knows really well.

*Lila: A little bit yes, anxious about things like before I help or do anything with the
nurses I need to know exactly what I am doing, so I have to familiarize with the*

policies and even if anything comes up now, for example … you know the standard policy and aseptic technique and everything else, but still you feel like double checking the policy whether we have the same policy, its in my mind I have been doing it for year, but still (p. 5).

Self evaluation of performance at this stage of transition can be very harsh, people generally finding they are their own harshest critic (Brown & Olshansky, 1997). Barb was uncertain if she was achieving in the role and articulated her difficulty in assessing her effectiveness.

> **Barb:** *I had a sense that I'm not doing this right or I'm doing something wrong or unlike the ward work at the end of the day the tasks have been achieved … but at the end of the day in our work you can't really say well I've achieved this have you or haven't you, have they responded to the education has your clinical teaching explanation been helpful? I don't know how to assess that, my input into their practice has been beneficial or not, I don't know how you gauge that. I have no idea (p. 4).*

The participants had moved into a role which is self motivated, from a role which was a part of a structured team with a designated leader. Guidance on what to do and when to do it had largely been removed. Glen and Waddington (1998) used the term "job discretion" (p. 285) to describe the activities of acting independently, setting work targets, choosing when to do each job and who to deal with. Frances found this initially difficult to come to terms with.

> **Frances:** *Well, it was really bizarre because you sort of come from that very structured, it is quite a structured position the staff nurse you know. You come in, in the morning, come in and make sure all your patients are tickety boo and then go and do your meds then check your IV's, all very much in that way and you always knew that the charge nurse was going to come along and tell you what to do and stuff like that. But in this position when I first came I found it a bit difficult because of that unstructured stuff where I thought, oh well what do we do now? You know, and it was like that in the first few weeks, I really yes, didn't know what was going on at all to be quite honest, and so its quite a strange transition from*

staff nurse to senior nurse because it's a whole different ball game you are totally responsible for your day and you've got to organize yourself, you've got to plan and you've got to manage everything by yourself basically (p. 1).

Chloe talked about her time management in this self directed role and related feelings of being overwhelmed.

Chloe: I still find I'll always find that I'll write a list one week and then the next week it like I've done one thing on that list, because there's a hundred other things that have come up and been addressed. So I do really feel like most of the time I'm on the back foot (p. 8).

High discretion in a role can be negatively affected by the team and organization (Glen & Waddington, 1998). However, Chloe found this challenging as she would procrastinate and ultimately make things worse.

Chloe: Personally that's been a challenge as well because I procrastinate and you know, I forget about things and why I have to have my lists and remember things when I wake up in the middle of the night and I can't do anything about it, so whereas from a staff nurse handing over to someone and knowing right well I've done everything I can do and whatever's left well that's for someone else to do, yes that ongoing responsibility as well and I think that was part of the big stress in that first 6 months was that I couldn't just hand over and forget about it and come in and start anew the next day it was still there, so yes (p. 10).

Worrying about her performance, waking up at night worrying about things that she forgot to do at work are all signs of role stress. People in the neutral zone can be confused and in flux, with loss of confidence and increased stress. However, this is a time of great learning and personal development, which can eventually lead to role success (Bridges, 2003). Some of the participants had a sense that they had some way to go before they could match the role success of their predecessors.

Zoë: I felt as though there were huge boots to fill and it was almost overwhelming stepping into her role in that she was incredibly intelligent, incredibly, she knew

everything, she was one of those people who you felt as though you didn't really want to mention anything to her because she might just spout of a whole lot of information that you've got no idea about (p. 15).

Zoë described her predecessor as someone who she perceived as highly capable but also slightly intimidating due to her depth of knowledge. A CNE does need deep understanding of the clinical area. However, the most effective CNEs have the ability to share, to work alongside and to coach, enabling nurses to provide good care rather than just delivering information.

Barb appeared to have low self esteem when she described her abilities to carry out this role in comparison to a highly proficient predecessor. This feeling of low self esteem and being unable to carry out the role are common features of transient role confusion (Brown & Olshansky, 1997).

> **Barb:** *I can't be like the CNE that was before who was really terrific but I can still support my colleagues in an education role and learn how to do that better. Although I still think there's a lot of very experienced people out there who would be better at it than I am, but here we are (p. 9).*

Though Barb felt she couldn't be like her predecessor, she still saw the value in supporting her colleagues until she developed more confidence in her abilities. Bobbie was more pragmatic. Though she knew she wouldn't do the same job as her predecessor, she was of the opinion that she didn't need to.

> **Bobbie:** *It's always hard to follow on from someone else who's got a long history and my predecessor did have a long history, she had a very long history within this role within the area of practice that I'm servicing. We're very, very different people in the way that we approach things and there always is an expectation that you're going to step into a role and just carry on (p. 6).*

Bobbie felt some confidence in her abilities and was starting to see things could change under her leadership. She was starting to exhibit characteristics of the beginnings phase of transition.

5.7. Summary

In this chapter the experiences of the participants, once they had started in their new CNE role, are presented. The first theme 'chaos and turmoil' started with the inevitable interpersonal conflict associated with an adjustment to a new role or new organization. The participants in this case had to deal with finding their way in a new organization or fitting in at a new level with old colleagues. Either situation can bring its difficulties as described by the participants.

Finding support and networks was an area where the participants had been required to find their own way to meet their personal needs, some within their own group, and others through external organizations. For a number of reasons the attempts by the employer to organize preceptorship for the new CNE had been unsuccessful. However, the consistent message was that talking to others in the same or similar roles gave the CNEs a sense that they were experiencing normal feelings and that networking was important to them.

The intra-role conflict described the participant's unanticipated need to negotiate and manage their roles while accommodating or managing other people's agenda's. The key to success in this was linked to the CNE's own role clarity, the more understanding they had of their role, the more successfully they could negotiate with others.

Stress levels were identified as a main area of concern for the CNEs, long hours and high expectations were expected stressors, however, the participants also divulged the physical impact of a role shift which could affect many shift workers, the movement from rostered shifts to regular hours. They had expected this to be a positive aspect of the role change. Conversely they found adjusting sleep patterns and lifestyle to be problematic. Finally the need to prove oneself in the role was a great stressor, being able to match the abilities of their predecessor. In the next chapter the beginnings phase of transition, the move into the new identity and the end of the transition journey is presented. The chapter starts with a description of beginnings.

Chapter 6: Beginnings

6.1. Introduction

In chapter five, data were presented on the neutral zone, the second stage of transition. The participants described their experiences in negotiating their role, understanding the boundaries, finding support and mentorship and how the stress of the role had impacted on them. In this chapter the beginnings phase of transition is presented (as described below and in chapter 3). The participants are beginning to see a future, planning to make changes and move towards combining the old identity with the new, absorbing new knowledge and seeing the future through a different lens. Lila and Barb are not strongly present in this section of the data; they had been in their roles the shortest amount of time and had not, through their interviews, shown strong signs of reaching a beginning in their transition. The theme in this chapter is 'opening doors', with the category of 'adjustments, reflections and new identities'. This chapter begins with a description of beginnings.

6.2. Beginnings

Bridges (2003) described beginnings, the final stage of transition, as developing "… new understandings, new values, new attitudes and new identities" (p. 58). Harrington and Terry (2003) called the beginnings phase a "… loop in the life journey, reintegrating the new identity and the old identity" (p. 49). Schumacher and Meleis (1994) suggested that role mastery is an indicator of a healthy transition, the ability to see possibilities for the future and to experience control indicative of someone comfortable with a role.

Opening Doors

6.3. Adjustments, reflections and new identities

> *Zoë: You've got to have balance in your life and I think when I first started my balance was all work, no play and now I'm just trying to even it up (p. 11).*

The participants were all asked what their vision was for the role of CNE. The CNEs who had been in the role a longer period of time not only had vision, but had made some discoveries about themselves and the organization they work for.

Emily: You get a better understanding of the big picture because you are party to more of the management sort of things that go on. You know as a staff nurse you don't get invited to the management, the service management meetings here, so you don't know, well, I knew probably 25% of what was going on in this unit, but thought I knew everything when I was out there and I didn't at all. You know, you become the CNE, you get invited to the management meetings and meetings they have with other service managers and your input is valuable and I spent the first year with my mouth open, thinking 'God I never knew that was going on where did that spring from, I didn't realize we had this, that or the other' (p. 10).

Emily has made the role shift, from a staff nurse experiencing the daily activities in her clinical area, to a senior nurse, viewing the organization at a different level. She has spent over a year absorbing the differences, becoming comfortable with the changes. What came as a shock initially has now become comfortable and she used this knowledge to effect changes she saw as important, in a forum which two years ago, she didn't even know existed. She saw that her expertise was valued and sought by managers at this level. Mutual acceptance can impact on the feeling of being intrinsically motivated in the work you do. This is a valuable tool in retention strategies for senior nurses; recognize their expertise, seek their input, value their opinions and experience.

Emily's experience was echoed by Chloe, who had started to become politically aware, which according to Mateo and Fahje (1998) is vital.

Chloe: I think the politics of roles, not just mine but everyone else's and how they interrelate and how they work or don't work and how sometimes you just can't do anything about them (p. 4).

Fitting into the organization at a new level requires absorption of new values and new groups of people to interact with.

Chloe: I think any senior role would have its own challenge but I guess a lot of the politics and everything that you learn, or that I've learned so far in this role would definitely put me in a good starting base, yes, good start in another senior role, because you see how other people manage things and you see how

managers work and different styles and you learn whether you want to take that on board or whether that's something you don't actually want to do so ... yes I think its definitely, I guess going into any senior role would help prepare you for another senior role as opposed to from a staff nurse, it's a lot smaller a step (p. 9).

The step to becoming a senior nurse from being a staff nurse is summarized by Frances. Though she had only been in the role a short time Frances had developed significant insight into where she was headed and is the only one of the three participants who fell short of the inclusion criteria, to be represented in this chapter. This is an indicator that though the phases are the same, transition timeframes cannot be predicted, they will be individual to each person. Frances had been encouraged to move into this role by colleagues and family who saw her potential before she did. She had felt over-comfortable where she was, needed to stretch and grow, but felt reluctant to change having a sense of the effort she would have to put in.

Frances: I mean just going from staff nurse to senior nurse is different types of being, in just those two roles, its very much you know, on the ward, oh well we'll just get our work done and make sure the patients are comfortable and that but there's a lot you can get away with ... you can really get away with not taking a huge amount of responsibility for yourself, if you know what I mean, like your progression in anyway, you can actually just flop along and carry on with what you are doing, but in this job you can't, you've got to be seen to be having a headache (p. 7).

Frances had seen the difference in 'ways of being' as a staff nurse and a senior nurse, she was enjoying the role and adapting to new challenges. Zoë, had also enjoyed her move to the senior role, however she relates here how she has had to make significant changes in her time management from when she started the role.

Zoë: I guess now I rarely take work home, put it that way. I have come to accept that sometimes now you just need to leave it till the next day and you need to go home, the same as working late into the night you might have got there at 7 o'clock in the morning and still be there at 6.30, 7 o'clock at night. You've just got

to give it up, you've got to go and I think there's that balance, you know, you've got to have balance in your life and I think when I first started my balance was all work, no play and now I'm just trying to even it up so it's yes I go to work I go to work from 8 until 4 I put my pen down and I go home at the end of the day (p. 11).

Resolution of the work/life balance is a significant part of placing oneself in organizational context (Wanous, 1992). There is a need for CNEs to take time to re-energize, to be able to delegate and to value the team (Mateo & Fahje, 1998). In the beginnings phase, you can view things from a different perspective. The person who has gone through the journey can start to see what is important, what can wait, to prioritize confidently.

*   **Bobbie:** I'm much better now, I'm sort of learning to say no to some things and to negotiate other things. I think negotiation is a big issue. You do a lot of negotiation (p. 6).*

Bobbie simply states something that can be one of the hardest things to achieve, especially for nurses it would seem; learning to say 'no' (Bass et al., 1993). Bobbie has moved though the beginnings part of the transition journey and, while the same person she was when she started her journey, she now has new information and views that allow her to say no. The personal journey inherent in transition into a new role is also evident in Chloe's statement.

*   **Chloe:** Think its definitely been a learning experience and I've gained a huge amount from it and most of that learning did occur in the first six months, so since September or so last year it's been a far more positive experience (p. 9).*

Chloe had been in the role almost two years and was getting ready to move onto new challenges. She looks back and understands the journey she has just experienced, and would wish to change it for the next person to come into the role, for them to have a more positive experience.

Chloe: My vision would be to get the role to a stage where someone can come in and take over without having to go through what I went through (p. 1).

Emily has also recognized her progress in the role and a new sense of control, she has absorbed the role, and has reached the stage of beginnings where she can look back and see that when she started she had no experience of the role she had to perform.

Emily: Taken me quite a while to I think just to get in to the whole role and I knew that there was lots of areas, when I first started that I was completely lacking in you know (p. 2).

Zoë has made some progress in her leadership and decision making styles.

Zoë: What I've probably learned over the two years is to actually stand back a little bit and look at all the different options, don't rush into one option because it looks like it's the best (p. 14).

And with increased self awareness and control

Zoë: I have I've learned about my personality I've learned about what I excel in and what I don't. I've tried to and it's a work in progress I don't think I'll ever be perfect but I've tried to address things like conflict management (p. 3).

At the start of the interview Lynair's vision was clear; she was focused entirely on the patient and clinical need.

Lynair: I actually just want the clients to receive the best possible care but it's also about the growth of the nurses as well and then me encouraging them to learn and for their professional development (p. 1).

Lynair had begun to strategize how she could effect change in her service, by being seen to support the staff while taking opportunities to assess them in practice. She had developed an awareness of where she fits in the team and how she could interact to

make the best out of each situation. There was a feeling of mutual acceptance as she had reached a point of successful socialization (Wanous, 1992).

> *Lynair:* I've done that on the odd occasion... when I know there's really limited staff I'll go and do a morning... to help ease their load. And there's a couple of good benefits from that I can actually see what their clinical practice is and I can read notes and look and try and see the rationale for why they are doing what they are doing with wound care and stuff like that (p. 6).

The participants in the study had all made significant progress in transition. Though the participants have shown varying levels of progress in the beginnings phase of transition to this point they were all describing the normal characteristics, feelings and perceptions inherent in the phases of transition.

6.4. Summary

In this chapter, data on the beginnings phase of transition were presented. The participants have spent some time in the role and have started to see the potential for the role, gaining enough confidence in their abilities to start making plans for the future. The statements made by the participants are more positive and self reflective as they learn, not only the skills to do the job effectively, but about their personal development needs. This concludes the presentation of data and themes. The next chapter contains a discussion of findings.

Chapter 7: Discussion

7.1. Introduction

The aim of this study was to answer the question: What are the perceptions and opinions of nurses as they transition from staff nurse into being a CNE? The research methodology utilized to investigate this question was qualitative description, using a general inductive approach for analyzing the data. In chapters four, five and six the themes which developed from the analysis of the data were presented, using the theoretical framework of transition (Bridges, 2003, 2004). Data were presented using the words of the study participants. This chapter includes a general summary of the findings, followed by a discussion of the data in relation to the literature. The chapter concludes with recommendations, limitations of the study and a concluding statement.

7.2. Summary of the findings

Data were presented in three chapters, representing the three phases of transition, endings, neutral zone and beginnings. The summary of findings is presented using the same format.

Endings

The CNEs reported why they originally wanted to apply for the CNE role, feeling this was an area they would really enjoy. The CNEs all had a teaching component in their previous roles, most had been preceptors and felt positive about supporting colleagues in clinical practice. The participants had struggled to find out any information on the role prior to application. One participant had still not seen a job description after being in the role for over 12 months. Orientation periods were discussed by all the participants and were, in general, considered sub optimal. Participants were asked what they would have liked in an orientation. Structured orientation programmes were not identified as particularly useful, due to the perceived diversity of the role. All the participants felt that the most beneficial orientation would have been spending time working alongside their predecessor to allow for a fuller understanding the role.

A consistent finding was the participants' sense of feeling surprised and overwhelmed at the size of the role. They used words like 'huge', 'magnitude', 'enormous' and 'complex' to describe the size of the job. On reflection, they realized they had no idea the role would be so big or how it would be structured. Invariably, they became overwhelmed and

stressed. Organizational expectations in the form of generic role responsibilities and engagement in meetings, was often an area of disillusionment for the participants. The role contained a significant portion of generic work, an expectation of any CNE role. However, the majority of CNEs felt this was extra work, not relevant to them, intruded upon their clinical time and affected their ability to complete their workload.

Neutral Zone

The move into the CNE role for some of the participants meant taking up a leadership position in an area where they had been a member of staff. They talked about the separation from friends, re forming old relationships with people they once worked alongside. For a couple of participants the organization, as well as the role was new, the sense of loneliness and the expectation that, as a CNE they would know everything was stressful.

To manage the transition into the new role the CNEs had found support networks and mentors. For some, regular CNE meetings were invaluable where for others external networking with CNEs from other DHBs had proved important. Mentorship and support was sourced from a number of places such as, previous managers, as well as CNEs in other services. The preceptorship method of support had not been wholly effective for this group. They had found the allocation of a preceptor cumbersome, trying to coordinate times and availability.

Role clarity was a problem for the CNEs as they struggled with competing agendas. They sensed they were viewed as having available time and were asked to carry out work that was not their own. They had occasional problems balancing clinical work with office based work. If they were not visible on the clinical areas, they perceived that the staff and colleagues presumed they were not busy. They felt that the nurses they support didn't understand the CNE role and believed the staff and their senior colleagues didn't fully value the role as they were not aware of its size and responsibilities.

Feeling overwhelmed, the stress levels were significant for the participants during their first year. They talked about taking work home, working extremely long hours, feeling that they needed to know everything and if they didn't complete a project or task, it

would cause their work to mount up. Some of the CNEs described physical symptoms of stress, extreme tiredness, weight loss and waking up during the night worrying. A sense of being unable to match the performance of a predecessor was mentioned by some, however, they were often comparing themselves to a person who had made a successful transition and had mastery of the role.

Beginnings.

Not all the participants featured strongly in this section, as some were newer to the role and had not yet reached a place of seeing how they may develop into their role and how this might lead on to other career opportunities. However, those who had been on the journey of transition for longer, showed a sense of achievement. Some described how they were able to strategize, to ensure their work was completed while still being seen to support the staff. An increasing sense of political astuteness was noted in the words of over half of the participants, seeing the bigger picture.

Life balance was returning for many, they were increasingly able to competently and knowledgeably make decisions around their priorities, enabling them to go home on time more often and for some, an increasing ability and confidence to say 'no'. Participants reported how the last year or two had resulted in significant personal growth, a sense of understanding more about their leadership role, their tolerances and self awareness. The next section discusses the data findings in relation to the literature on CNEs, succession planning for leadership, transition and socialization.

7.3. Discussion.

The findings of the study were presented in the data chapters, and will now be discussed in relation the literature and the aims of the study. Key issues arose, with these issues further investigated and described in the following sections.

Identifying potential

This study identified that the participants particularly enjoyed precepting and supporting their colleagues, prior to application for their CNE roles. The identification of committed and effective preceptors, or those undertaking personal education, is one way of identifying potential candidates for the CNE role and a first step to succession planning for leadership (Bolton & Roy, 2004). Succession planning is seen as vitally important for

recruiting and retaining quality leaders but is poorly developed in healthcare (Bolton & Roy, 2004; Bonczek & Woodard, 2006; Hader, 2004; McConnell, 2006; Redman, 2006; Sherrod, 2006; Smeltzer, 2002). As issues around workforce development in New Zealand grow, succession planning for leadership will need to be adopted by DHBs to stabilize and grow the workforce.

Recruitment

Recruitment into senior nurse positions is currently a national issue, partly due to the lack of pay differential between a staff nurse and senior nurse; and partly due to registered nursing workforce perceptions of the variety and scale of leadership, management and professional responsibilities taken on by a senior nurse (Sherman, 2005). The continued lack of financial recognition for roles, particularly those based in education and professional development, means that any nurse willing and capable of taking up a leadership role in nursing should at least, be valued, mentored and supported to achieve success. However, the findings of this study show, that once a vacancy is filled, the newcomer is consistently left to blindly negotiate the pathway through transition. Appointing someone to a senior role is not the end of a process, it is the beginning (Laborde, 2000).

The participants in this study felt there was a lack of information about the CNE role prior to and following application. Most had applied without any concrete information about the role. One of the participants, an external candidate, had never received a job description. Giving an applicant a job preview and discussing the job description prior to final selection are effective ways to clarify expectations and reduce turnover, misunderstandings, stress and difficult transitions (Hsiung & Hsieh, 2003; Laborde, 2000).

There is also the accountability of the applicant; every effort should be made to investigate a role prior to application. Prior to application candidates may find it helpful to contact the previous incumbent in the role, to discover what the key responsibilities are and the size of the role (Louis, 1982). However any role, particularly a senior role, should have as a minimum, an updated job description and person specification readily available (McConnell, 2006).

The appropriate hiring of nursing leaders should involve a rigorous recruitment process. Recruiting managers must be prepared to recruit into the specifics of the role and not rely on "gut reaction" or sub-optimal recruitment processes (Corning, 2002, p. 375). Being prepared includes the development of consistent job descriptions (Hsiung & Hsieh, 2003) and creating a more structured interview process with clear expectations of the applicant's role and what the organization will expect of them. This should include embracing a culture of succession planning and expecting current leaders to actively mentor potential leaders.

Once a position is filled, the next stage is orientation. Orientation is a short, defined period of time which begins once a person is employed (Wanous & Reichers, 2000). This short, defined time however, proved a problem for all the participants in this study as they were either given no orientation or had limited input which they didn't find particularly useful. The use of a preceptor was attempted, however this proved sub-optimal for all those interviewed as the allocated preceptor wasn't always available or appropriate for the newcomer. The participants in this study stated that use of network groups proved useful in the early stages to enable them to meet with others in similar circumstances, useful as they could share their experiences, learn the ropes, players, pecking orders, norms, values and systems (Louis, 1982). Ongoing socialization is recommended as an ongoing way of supporting staff in new roles (Hsiung & Hsieh, 2003; Wanous & Reichers, 2000).

Linking transition, orientation and organizational socialization
The current study primarily utilizes a transition framework (Bridges, 2003, 2004). This can be linked with organizational socialization theories, which offer some instructive frameworks for orientation. Organizational socialization deals well with the environmental component of a job shift and the organizational acceptance of new staff. Transition looks at the individual's feelings during a job shift (Wanous, 1992; Wanous & Reichers, 2000). In this study organizational socialization is used in support of the theoretical framework of transition. Combined, the two theories provide a more rounded view of a work-role transition.

Transition theory can be linked with socialization theory (Woods, 1999), suggesting that transition is bound up in past personal experiences and the environment into which a

person is transitioning Socialization theories and frameworks have been evident for many years (Louis, 1982; Louis, Posner & Powell, 1983), dealing with the issues of orientation, socialization and organizational acceptance of new staff. Wanous (1992, p. 180) presents four stages of organizational integration.

- Stage 1: confronting and accepting organizational reality; conflicts between personal values and needs, discovering what you do that is acceptable to the organization and what is not.

- Stage 2: Achieving role clarity; being initiated into tasks, congruence between ones own evaluation of performance and the organization's expectations; learning how to deal with structure and ambiguity.

- Stage 3: Locating oneself in the organizational context; resolution of conflicts, starting to commit to the job, establishing relationships.

- Stage 4: Detecting signposts of successful socialization; high satisfaction and feelings of mutual acceptance.

There is a difference between orientation and socialization. Orientation is a short coordinated period of time, involving a small number of people new to an organization. Socialization can involve many people within an organization, including newcomers and anyone moving across boundaries, such as staff moving into an organization (organizational entry), from bottom to top (hierarchical), horizontally into different jobs (functional) and moving closer to the organizational power base (inclusional) (Wanous & Reichers, 2000). This indicates that combined with transition, the CNEs have been experiencing the impact of ongoing organizational socialization.

Preparation for leadership and ongoing development

Preparation for senior nursing roles requires increased focus on developing leadership. However, the CNE role also requires clinical credibility. A number of CNEs in this study were identified by senior nurses in the specialty as having potential to fulfill this role, due to their clinical proficiency. Unfortunately, some felt they were pressured and moved into the role before they were ready. Potential candidates for the CNE role should be functioning at an expert clinical level. However, clinical expertise does not necessarily translate to success in a leadership role as identified by Sherrod (2006) and Wilson (2005).

There are currently a variety of options to develop leadership skills. For those who have access to Professional Development and Recognition Programmes (PDRPs) and levels of practice, this is one way of developing beginning leadership skills, as level four of the PDRP focuses on developing leadership abilities to prepare for senior roles. Options for development of leadership within organizations could include seconded senior positions using more experienced staff nurses and rewarding high performers with increased career opportunities. Manning et al. (2003) presented an initiative where staff nurses worked as clinical coaches to provide education and clinical practice support, working alongside nurses in practice and in close collaboration with charge nurses and CNEs. This role was seen to increase understanding for the coaches on how senior roles function, and was utilized as a stepping stone to a senior role, a strong succession planning initiative.

Leadership and management training within organizations and post graduate courses in leadership are vital tools (Grossman & Valiga, 2005; Redman, 2006; Tourangeau, 2003). The formal post graduate education of nurses in leadership is now available at a number of tertiary education providers around the country. The challenge is to ensure that education opportunities are accessible to nurses working as CNEs.

Interruption or disruption

"Interruption or disruption" to a service can occur when someone leaves a role, resulting in the loss of organizational knowledge (Redman, 2006, p. 93). Methods to minimize disruption caused by loss of organizational knowledge are succession planning and organizing time for the newcomer to spend with a previous role holder. The message from all the participants in this study was that more time with their predecessors would have helped their transition. However, this option is often not available and in some instances may not be suitable. One CNE who did spend time with her predecessor spent the week clearing out the office. If this was to be an option, it should be managed carefully to optimize the time available.

In this study it became clear that the previous incumbents in the CNE role held a lot of organizational knowledge in their heads, which is supported by Redman's (2006) work. Very little appeared to be available on databases or files and the newly appointed CNEs felt they were disadvantaged as they were unsure what had occurred previously. CNEs

felt this most keenly when issues with staff arose. Incidents may have occurred in the past but a lack of documentation meant for example, information on previous performance management or medication administration error management was lost.

Expert to novice

Finding themselves back in the position of novice was hard for the participants. Those who had spent the least time in the role were the least sure that they were achieving as they should be. Barb in particular was unsure she was the right person for the job and felt there were others who could achieve more. Imposter phenomenon or, more commonly, transient role confusion, are common feelings during the endings phase and neutral zone. Increased knowledge about transition, accessing a mentor and having the opportunity to reflect, can all improve the anxieties inherent in moving from expert back to novice (Huffstutler & Varnell, 2006).

Instilling a sense of personal value in the role and the work being achieved is important at this point to develop a positive self esteem (Cutts, 1999). Work-role transition involves personal development as well as role development (Nicholson, 1984). Comparing themselves with the success of a predecessor was a source of worry for a number of the CNEs. The perception that they had 'big shoes to fill' was an added pressure on their self assessment of their performance or abilities. However, they were comparing themselves to a person who had made a successful transition and had mastery of the role. These feelings could have been alleviated or at least normalized by an understanding of transition (Bridges, 2004).

During work-role transition, wider key relationships should be formed to support the process as well as communicating with a more experienced colleague, such as a mentor (Wells et al., 1998). Mentorship offers more than career development; it can be a tool for learning, a safe place to try out new ideas and to develop a broader perspective (Cranwell-Ward et al., 2004). For the CNE participants in this study, mentorship and support relationships tended to evolve from networking situations rather than an allocated person or preceptor. Goleman (2002) talks of high performing leaders who found that accessing a mentor early in their careers helped them to develop and grow their leadership abilities. Encouraging senior nurses to network and share experiences for example in the CNE meetings was a successful way, for some of the participants, to

match mentor and newcomer. Though some found it made them realize how much they still had to learn.

Emotional intelligence

Emotional intelligence is viewed as increasingly important in leadership roles of today (Cranwell-Ward, et. al., 2004; Goleman, 2002; Wasylyshyn & Gronsky, 2006). The CNE role, like many senior nursing roles, requires significant interpersonal skills, soft skills and emotional intelligence (Mateo & Fahje, 1998; Upenieks, 2002). The role requires neutrality (McCormack & Garbett, 2003) as it is in place to support the charge nurses and other senior colleagues as well as the staff nurses, enrolled nurses and health care assistants. The CNE must be able to listen and communicate, to accommodate the counseling or pastoral side of the role. They may need to assist with negotiation or conflict management. The participants felt that staff and colleagues often turned to this role as a safe person or use the role in a formal clinical supervision capacity. The need to be neutral can cause a feeling of isolation, which suggests CNE themselves should be accessing clinical supervision (Morton-Cooper & Palmer, 2000).

Role clarity

The findings of this study show that CNEs quickly realized that the clinical support and preceptorship components to the CNE role, which attracted them in the first place, are limited. The office based component, meeting schedules and generic organizational work, impact on the clinical time to such an extent, they impinge on a CNE's ability to perform the core duties of the role (Mallet et al., 1997) and they feel the job is not what was expected. However, in reality administrative responsibilities and meetings are an expectation of a CNE role and should be seen as an opportunity to advocate for improved services and provision for patients and staff (Mateo & Fahje, 1998). Subsequently, there is a gap between what the person believes their role is and what in reality it is allowed to be (Ewens, 2003). This situation can become frustrating, disappointing and ultimately untenable resulting in the person leaving the role prematurely, a potential problem with the neutral zone phase of transition or as Bridges (2003, p. 50) described it, the "... gap between the old and the new".

Leadership roles are often bigger than someone viewing them from the outside can understand. This is supported by Porter-O'Grady (2003a, p. 109), who stated "... during

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this significant transition, all work ultimately appears overwhelming. Every leader can testify today to the fact that he/ she holds a job that, considered in its entirety, simply cannot be done". The involvement in meetings and representing the employing service at an organizational level also came as a surprise. Often the CNEs noted they felt this was a waste of their time, as Emily stated "... there's working parties for Africa on every single thing you can imagine" (p. 3).

Self motivated, self directed roles have the potential for role overload. They require role clarity and time management skills to ensure productivity, to maintain intrinsic motivation and to avoid role ambiguity (Glen & Waddington, 1998; Mallett et al., 1997; Mateo & Fahje, 1998). In the early stages of socialization the newcomer to a role will often feel they are faced with choices whereas in reality, at this stage of socialization, they have no alternative but to chose the organizationally favourable option, such as helping out in the clinical area rather than finishing office based tasks (Wanous, 1992). The participants in this study reported they were often asked to do work they did not consider to be part of their role, like relieving for meal breaks. This was identified as problematic, particularly as they were still working out the boundaries their roles. They wanted to fit in, to support and help, however as stated by Cutts (1999, p. 1504) "... trying to be all things to all people could diminish the role". Nurses appreciate the CNE being visible, to ask questions and for support (Mateo & Fahje, 1998). However, managing different facets of a role can be problematic as any decision made can set a precedent for the future (Clifford, 1999; Mallett et al., 1997).

CNE roles need to become more politically aware within their organizations, to predict the need for changes in education provision, to make progress on projects, and to network and communicate effectively (Mateo & Fahje, 1998). Some of the participants felt inadequately prepared for leadership, as they had little understanding of the size of the role, its organizational reach, the influence they could hold and the impact they would have on policy development. However, a number of participants who had been in the role for some time realized they had to become more politically astute in the role, a skills seen as important by Mateo and Fahje (1998). They took time to find out what other people's roles were and learned to negotiate and rationalize the need for study days or training. They were beginning to feel more confident and accepted in the organization, described by Wanous (1992) as an indicator of successful socialization.

Credibility

The participants in this study felt credibility was vital to being accepted in the role. They described credibility as being seen to 'fit in' and to be accepted as clinically expert. This was not something that participants who had moved from within the clinical area into the CNE role felt was a big problem, though at times they did feel tested. It was more evident for those who had moved in from other organizations, as they adjusted to new ways of practising, new equipment and people, finding their place in the organization, feeling a need to prove themselves (Brennan & Hutt, 2001). This has been described as being in limbo and could be seen as portraying a type of identity confusion or of straddling new identities (Brown & Olshansky, 1997). Having performed as an expert, moving into an organization or role where they are no longer the expert is a challenge, and requires new understandings and development of a new skill set to adapt to the shift. This is another way of describing transition, of moving from the old to the new, which inevitably brings some degree of stress and upheaval.

Self care in leadership

Stress and self care as a leader were problematic initially for some of the participants. Working long hours, over the weekends and taking work home were not unusual patterns suggesting limits need to be set on this behaviour (Mateo & Fahje, 1998). Participants described physical and emotional signs of stress and though most had started to manage this, there were still indicators that it could still be a problem for some. Sick time and productivity can be affected significantly during transition, particularly in the neutral zone phase (Bridges, 2003). Managers need to be alert for these behaviours and offer positive interventions to support employees through this time.

Herriot, Hirsh and Reilly (1998) identified that working long hours and taking work home are considerable issues for management level workers in the United Kingdom, and are due to the recession in the early nineties, resulting in diminished numbers in the workforce combined with a need to increase productivity. This is not dissimilar to the effect of the health reforms on staffing levels in New Zealand's hospitals (McCloskey & Diers, 2005). Herriot et al. (1998) went on to state that this form of stress is a concern, as although productivity has increased, it has been at the cost of family and the worker's physical and mental health. A couple of the participants in the current study would have welcomed the opportunity to work in a more time flexible way, and had attempted to

negotiate and discuss this with their managers. Flexible hours are one way forward to accommodate the needs of the next generation of nursing leaders (Sherman, 2005)

Workers today have differing needs. The next generation of nurses who are moving up into leadership roles not only require different pay and conditions to accept that level of responsibility, but will potentially need roles redesigned to fit their requirements, their values, lifestyles and beliefs (Sherman, 2005). The health industry internationally needs to start thinking urgently in innovative ways about recruitment and retention of different generations of nurse leaders (Kupperschmidt, 1998).

The profession

Has the nursing profession in New Zealand experienced transition? Bridges (2004) talked about whole organizations experiencing transitions, so why not professions? Nursing has grieved the loss of old structures as a result of health reforms (endings), fought to establish its place as a recognized profession, to justify continuing involvement in governance and articulate its contribution (neutral zone). Through the development of academic legitimacy and new roles such as Nurse Practitioner combined with a new generation of emerging leadership, nursing is beginning to see a way into the future (beginnings). The phases of transition have been fluid; nursing has flexed, stretched and bent with pressures, challenges, hardships and opportunities over the last twenty years. Nursing has had to change its shape, merging old nursing identities with the new. The transition continues.

7.4. Recommendations

The recommendations are presented under the sub headings of education, research and practice.

Education

Organizations need to start considering transition and organizational socialization as priority areas for corporate learning. Not only does an understanding of the phases of transition give a sense of normality to those experiencing it, an understanding of organizational socialization processes can positively effect change in organizations with cultures of impatience, high expectations of immediate performance and intolerance for staff in new roles.

Nurses identified as having the potential to succeed in roles such as CNE, should be positively supported to access post graduate education in leadership. However, to do this the funding of post graduate papers on leadership and practice education will need to be seen as a strategic priority by the Nurse Executives of New Zealand and the individual Directors of Nursing. As the CTA funding model moves under the control of the DHBs (Cassie, 2006a), there is the opportunity and impetus to develop sound leadership capabilities within the future nursing leaders of New Zealand.

Orientation for leadership positions needs to be considered in a different way with the process perceived more as ongoing socialization after the first few weeks in the role (Wanous & Reichers, 2000). The use of split orientation, initially starting with organizational introduction, induction and mandatory training, then ongoing personal, individual meetings and learning opportunities would be a more tailored approach, suiting diverse roles. Learning fundamental job activities and developing role identity are an ongoing need, not just required for the first couple of weeks (Hsiung & Hsieh, 2003).

The pastoral or counseling component to the CNE role is something not unique to CNEs. However, the neutrality and positioning of this particular role, makes this a time consuming part of the workload. The absorption of issues and worries of other staff can take its toll on even the most experienced leader, and safety measures should be put in place to ensure CNEs are equipped to deal with this facet of their work. Formal training for the giving and receiving of clinical supervision is an area which can benefit those who have a high level of counseling in their roles (Morton-Cooper & Palmer, 2000).

Mentorship is seen as important by numerous authors on leadership (Bolton & Roy, 2004; Corning, 2002; Goleman, 2002; Kouzes & Posner, 1995; Peach, 1997). Mentorship is an opportunity to 'learn the ropes' from a more experienced colleague. The use of role mentorship and networking among senior clinicians must be recognized for its role in leadership development (Goleman, 2002). This needs to be organizationally promoted as a positive activity, encouraging relationship building across organizations. An organizational culture committed to learning and leadership development will enhance this process (Cranwell-Ward et al., 2004).

Research

Research has shown that succession planning and orientation for the CNE role is minimal. This study has highlighted the impact a lack of role clarity, blurred role boundaries and an under preparedness for leadership roles, has on new senior nurses. The CNE role in particular requires considerable skills in clinical policy development, quality assurance activities, leadership, communication, counseling and education. The role of the CNE is present, both nationally and internationally, though may be given different titles; however there is very little recognition for the role and even less research. As the CNE role has a vital role to play in managing clinical risk and ensuring clinical competence and confidence in nursing practice there is a need for the impact of these roles to be researched both within New Zealand and internationally.

The dearth of literature on clinical practice roles supporting post-registration nurses in New Zealand may reflect that the majority of research and articles presented on clinical education has been carried out by academic faculty. The researchers have been primarily concerned with students, hence the available research and literature in New Zealand on clinical education, has tended to focus on clinical tutors and/or students (Dyson, 2000; Holloway, 2000; Orchard, 1999; Vallance & Scott, 2003; Vallant, 2004). Whatever the rationale, CNE roles are under researched. To ensure literature is available, there is an imperative for nurses, including CNEs themselves, to take responsibility for researching the impact of their roles in relations to patient outcomes or staff performance. To justify and advocate for access to ongoing educational support for post registration nurses, their colleagues in clinical practice.

As the new generation of nurses becomes more senior in the profession, the issue of work-life balance for nursing leaders is predicted to increase, as the next generations are expected to demand more flexible ways of working. The effects of transition on general health and wellbeing of newly appointed senior nurses could be a focus for future research. Not only the stress of adjusting to a new role, but the move from shift-work to regular hours, the impact of a change in work-life balance, the sense of overwhelming responsibility and the physical manifestations of stress are all mentioned by the participants in this study and deserve greater investigation. Nurses can strengthen any proposal for flexible ways of working and increased pay and conditions through the use of the results of such research.

Access to funding from the Clinical Training Agency (CTA) has been problematic for nurses wishing to pursue academic or research based post graduate education as there is a requirement for all post-entry clinical training to be clinically based (Clinical Training Agency, n.d). As the CTA funding is to be administered by the DHBs in the future it is hoped future allocation of funding will more effectively capture the needs of nursing today, including those studying at post-graduate diploma and master's level (Cassie, 2006a). Any increase in access to funding has the potential to increase the number of clinically based senior nurses engaging in research at masters level. This would enable research into role development and professional issues affecting nurses in New Zealand, making a significant contribution to the knowledge required to successfully engage in workforce development strategies, related to ongoing recruitment and retention of senior nurses.

Practice

A drive to support senior roles, offering consistent job descriptions, leadership and transition education for high achievers, tailoring orientations, making orientation periods non-negotiable, offering mentorship programmes and encouraging active succession planning for roles (before they become vacant), will all assist with recruiting and retaining quality senior nurses. Succession planning initiatives such as employment of clinical coaches and other staff nurse roles who work in close collaboration with senior nurses is a way of nurse leaders role modeling, giving staff nurses a deeper understanding of the complexities, challenges and opportunities a senior role can offer.

A national review of the skills required of CNEs, or practice development roles, generally is needed to ensure appropriate preparation and understanding of the contribution this role can make. A review of the title, clinical nurse educator, is indicated as the role has shown itself to be far more complex than employers and staff realize. The CNE group nationally is a small contingent of the senior nursing workforce in New Zealand, which is also small compared to the numbers of nurses nationally. Such a small but valuable group may benefit from specific representation by a professional body, such as the College of Nurses Aotearoa, or the Nurse Executives of New Zealand, to raise its profile, awareness of the group nationally and a drive to review the job title, job descriptions and pay. The development of nationally agreed job descriptions for CNE roles would enable greater transparency, for employers and CNE alike, however along with standardized job

descriptions, more robust interview and selection processes are required to include assessment of emotional intelligence.

Increased profiling of professional nursing organisations, within the environment of clinical practice, would enhance wider networking and senior nurse involvement in the profession at a national level. Availability of resources such as the College of Nurses Aotearoa and other professional bodies, who are able to provide external mentorship, education and professional development, can offer alternatives to in house learning while increasing knowledge of the national political environment for nursing. The increased awareness of nurses to political activity and professional issues is now required, particularly at the level of designated senior roles within DHBs.

The need for role clarity is apparent and can be achieved in consultation with managers, and professional leaders through the development of formalized, consistent job descriptions and agreed key performance indicators. Regular appraisal and peer review will enable agreed goal setting for the role and targeted education opportunities for the CNEs to progress towards role mastery. Current CNEs should be required to maintain progress reports of role activity, and to maintain databases, to enable smoother handover to the next person to move into the role. The concept of succession planning for leadership, starting when a leader first takes up the role, should be supported and role modeled.

7.5. Limitations of the study

This study was a qualitative descriptive study into the transition of staff nurse to CNE. To establish a deeper understanding of work-role transition readiness, a mixed method study using both semi structured interviewing and questionnaire could be used, to identify CNE achievement of post graduate study, impact of leadership and education training on CNE performance and the clinical impact of having a CNE available within the service.

The study was carried out in one district health board and as indicated by the method, the sample of CNEs was small at only eight participants. The opportunity to research CNEs on a wider scale would further enhance understanding of how this role is applied

within DHBs nationally. This would contribute to any review of the role, development of standardized job descriptions and future job sizing criteria.

The study was limited to the participants' view of their experience with no ability to involve the people they professionally interact with, who may have viewed their contribution differently. Ascertaining the views of people who work with the CNEs would offer a different lens with which to view the contribution of the role, clarify misconceptions of the role and also offer support and value to those currently working as CNEs. Research along these lines could benefit CNEs in gaining further access to targeted education in leadership and professional development.

The study has provided the opportunity for participants to speak about their experiences, which were consistent enough among the participant group and in comparison to their colleagues at my own DHB. This consistency suggested that their issues and experiences were not isolated, but were rather a true representation of how this group felt at the time of their orientation and transition. Further research on senior nurse's transition and the impact of transition on succession planning, recruitment and retention is now needed.

7.6. Concluding statement

This qualitative descriptive study has presented the experiences staff nurses as they moved into their first designated senior role as a CNE. The study was presented using a transition framework (Bridges, 2003, 2004). Information was gathered using semi structured interviewing of eight CNEs, within their first two years in the role and working in a New Zealand DHB. Data gathered from the interviews was transcribed by the researcher, then analysed using a general inductive approach (Thomas, 2003). Five main themes were identified and were presented using the transition framework, endings, neutral zone and beginnings.

The key findings related to, lack of knowledge of the role, job size, minimal orientation periods, feeling overwhelmed, stressed, needing to find support systems, developing leadership skills, managing expectations and competing facets of the role. Much of these feelings and perceptions are normal components of transition, however they can be alleviated to some extent by an increased organizational wide knowledge of transition

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and socialization, resulting in an organizational culture of tolerance, benefiting any organizational retention strategy.

The concept of transition can and should be introduced into organizations (Bridges, 2004). With improved understanding of the phases of transition, the expectations of the newcomer and the team they are joining may be somewhat moderated. Management training on transition theory could maximize the positive aspects of this process. People situated in the neutral zone can be extremely creative if managed well (Bridges, 2004). A clearer understanding of the phases of transition and placing feelings associated with endings and neutral zone into normal human responses can have significant effect on morale. In presenting the initial themes of this study to the key stakeholder group, significant emotional response and engagement with the framework was noted. Transition is normal and can be identified in work-role transition to assist newcomers or the newly promoted in normalizing feelings. It can also be used in organizational and possibly profession wide transitions.

Clear information on the role and job descriptions to match expectations of the organization is required. Once an employee is appointed to a senior role, orientation and socialization are needed and must accommodate the needs of the employee. The CNE role in this study was found to be significantly larger than expected for the participants. Role clarity is a key component to role success, employer understanding of role boundaries and key objectives for the role should be consistently reinforced to ensure optimal performance.

The CNE role is diverse, encompassing clinical policy development, education facilitation and presentation, clinically based support, leadership, counseling and clinical risk management. There is an imperative for this role to be researched, its contribution to practice, education levels of nurses and subsequent value to the retention rates of the district health boards in New Zealand needs to be identified. The role of CNE is undervalued and poorly understood, the time is right for this role to be profiled nationally.

The CNE role is pivotal in all DHBs, not just in education provision, but as a valued support service for nursing staff of all levels. Though this role is increasingly seen in the DHB sector, it is not yet seen widely in primary care or non-governmental organizations.

A wider understanding of the contribution this role will enable deeper understanding of its contextual application. It is a role that can function in any setting where nurses are working and need education, professional development and support.

The findings in this study have been significant, they have shown that the phases of transition are a normal part of work-role changes, but preparation for change, increased knowledge of roles, along with mentorship and support can significantly ease the process. Though the participants in this study have relayed their natural discomfort and stresses on moving to a new role, no-one expressed any regrets, infact they all stated categorically that they enjoyed their role as a CNE.

Appendix 1

The transition from staff nurse to clinical nurse educator

Participant information sheet

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Invitation to CNEs.

I would like to invite you to become a research participant in this study as you are currently employed as a clinical nurse educator and have identified an interest in sharing your experiences. My name is Liz Manning, I am the Nurse Advisor: Professional Development at Waitemata District Health Board and a student at Massey University where I am currently completing my Master of Philosophy Degree. My supervisors are Stephen Neville and Dr Denise Wilson.

The purpose of this research is to study the role transition from staff nurse to clinical nurse educator. The study will focus on the personal and professional developments required to adjust to a new role, at a new level, within a New Zealand District Health Board. This is a qualitative study as I am interested in how CNEs perceive their role transition and the skills and knowledge CNEs have to develop in their first year at a senior level. This information could impact on succession planning, recruitment and orientation programmes for future CNEs.

Selection criteria
Inclusion criteria
Participants must be:
- *A registered nurse working as a clinical nurse educator*
- *In their first senior role in an organization and have been a clinical nurse educator for between 6 months to 2 years*
- *Employed 0.8 fte to full time as the sole clinical nurse educator for an identified clinical area*

Exclusion criteria
Participants must not:
- *Be jointly employed by a tertiary education provider*
- *Be a Waitemata DHB employee*
- *Be less than 0.8 fte or in a job share role.*
- *Have had previous experience in a senior designated position, e.g. charge nurse, clinical nurse specialist or educator.*
- *Be employed solely to train either mandatory skills such as CPR, or leadership development courses.*

If you meet the inclusion criteria and would like to participate in the study, you can contact me by phone, email or in writing, my details are listed above. If you require information please continue to read the attached sheet and please contact me or my supervisors for any further questions.

Further information
Your involvement
- The interviews will take place between October and December 2005.
- Participation in this study will require you to undertake one interview approximately an hour in length. The interview will consist of a number of questions, structured to allow you to describe your opinions and perceptions and to create the opportunity for you to relate your experiences of transition to the clinical nurse educator role. The interview will take place at a venue of your choice. The interview will be audio-taped, and you have the right to request the tape to be stopped and to leave the interview at any time.
- If you choose not to participate it will in no way affect your employment.

Use of Data
- I will be personally transcribing the interview. Audio-tapes and transcribing will be stored in a locked filing cabinet, to which I will hold the key. With your permission the audiotapes will be destroyed once the study is completed. The transcripts will be stored for a period of 10 years, at which point they will also be destroyed.
- The only people with access to the information you provide, will be my supervisors, as listed above and me.
- Findings from the data will be used to complete my thesis and may include quotes and statements you have made.
- The thesis will be made available through Massey University library, Waitemata DHB library, article publication and presentation to appropriate nursing groups.

Confidentiality
- To ensure confidentiality, I will ask you to choose a pseudonym for the purposes of presenting the data. Only I will know your actual identity. Your consent form will remain secure in a locked filing cabinet, to which I will hold the key. Computer files will be password protected, and I will be the only person to know the password.
- If you name specific institutions, people or places in the course of the interview, the names will not be used in the presentation of data.

Statement of rights
You are under no obligation to accept this invitation. If you decide to participate, you have the right to:
- Decline to answer any particular question
- Withdraw from the study up to two weeks post interview
- Ask any questions about the study at any time during participation
- Provide information on the understanding that your name will not be used unless you give permission to the researcher
- Be given access to a summary of the project findings when it is concluded
- Have the right to ask for the audiotape to be turned off at any time during the interview

Thank you for taking time to read this information.
If you have any queries or concerns regarding your rights as a participant in this study, you may wish to contact your professional organization.
Please feel free to contact me or one of the research supervisors if you would like more information.

This study has received ethical approval from the Northern X Ethics Committee.

Liz Manning

Appendix 2

Consent Form

The transition from staff nurse to clinical nurse educator

This consent form will be held for a period of five (5) years

Request for interpreter

English	I wish to have an interpreter	Yes	no
Maori	E hiahia ana ahau ki tetahi kaiwhakamaori/kaiwhaka pakeha korero	Ae	Kao
Cook Island	Ka inangaro au I tetai tangata uri reo	Ae	Kare
Fijian	Au gadreva me dua e vakadewa vosa vei au	Io	Sega
Niuean	Fia manako au ke fakaaoga e taha fakahokohoko kupu	E	Nakai
Samoan	Out e mana'o ia I ai se fa'amatala upu	Ioe	Leai
Tokelaun	Ko au e fofou ki he tino ke fakaliliu te gagana Peletania kin a gagana o na motu o te Pahefika	Ioe	Leai
Tongan	Oku ou fiema'u ha fakatonulea	Io	Ikai
	Other languages to be added following consultation with relevant communities		

I have read the Information Sheet and have had the details of the study explained to me. My questions have been answered to my satisfaction, and I understand that I may ask further questions at any time.

I agree to the interview being audio-taped, and understand I have the right to decline to answer any particular questions, and that I have the right to ask for the tape to be switched off at any time during the interview.

I understand that my participation in this study is confidential and that no material which could identify me will be used in any reports on this study.

I understand that my participation in this study is voluntary (my choice) and that I may withdraw from the study at anytime up to two weeks post interview.

I agree to participate in this study under the conditions set out in the information sheet.

I _____ (full name) hereby consent to take part in this study.

Signature: _____ Date: _____

Glossary

Annual update day; a rostered day to attend mandatory training such as CPR, manual handling and fire training.

DHB; District health board. There are 21 DHBs in New Zealand. They are responsible for providing, or funding the provision of, health and disability services in their designated districts. They were established in January 2001 when the New Zealand Public Health and Disability Act 2000 came into effect.

In service; short education session provided within the clinical area, usually between thirty minutes and one hour duration.

IV test; a formal written test for nurses understanding of intravenous medication administration, policy and calculations.

Modular programme; an in-house programme set up to provide education on a particular specialty, usually between one and four days duration.

New grads; short term for the new graduate nurse, within the first year of practice, post registration.

Orientation; the first 10 weeks of employment are usually identified as an orientation time, though more specific and intense orientation will occur in the first two weeks.

Overseas nurses; nurses who have qualified in another country who require a competence assessment programme approved by Nursing Council of New Zealand prior to receiving a registration to practice in New Zealand.

Portfolios; portfolios are a vehicle for providing evidence of competence, used in professional development and recognition programmes around New Zealand.

Practice education; Education delivered for specific clinical learning and clinical risk management, delivered in the clinical area or in a classroom setting within the employing organization.

Preceptor; A title given to a registered nurse who over a short, defined period of time will work alongside new staff to orientate them to the clinical setting, work practices, clinical culture and accepted social norms of their new work area.

Return to practice; A return to practice course is required for nurses returning to the workforce who have been away from direct clinical practice for a period of five years or more.

Senior nurse; a registered nurse working in a designated role with clinical, professional, educational or managerial responsibilities.

Staff nurse; a registered nurse working in a clinical setting in a non-designated role.

Students; any nursing student in the three year undergraduate programme

Study days; in house education, set up to provide education on a particular speciality or area of practice development, can include professional development areas of preceptorship and leadership training, usually one or two days in duration.

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