Novice Nurses' Perspectives on Nursing Education

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A Thesis

in

The Department

of

Education

Presented in Partial Fulfillment of the Requirements
For the Degree of Master of Arts (Educational Studies) at
Concordia University
Montreal, Quebec, Canada

March, 2007

Your file Votre référence
ISBN: 978-0-494-28834-4
Our file Notre référence
ISBN: 978-0-494-28834-4

ABSTRACT

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The purpose of this study was to learn whether recent graduates of a nursing program thought their nursing education had prepared them to integrate smoothly into the workplace and to practice autonomously. The study reports on data obtained through interviews with five novice nurses, four months after they started professional practice.

All five nurses indicated that they were satisfied with their nursing education and they stated that they were encouraged to practice autonomously in the last year of the program. They reported that their education helped them to feel comfortable in their first job setting. Stories about their education did describe an environment that was authoritarian at times. They indicated their preference for teachers who were able to assess their knowledge without making them nervous and encouraged them to show initiative while practicing safely. All agreed that a humanistic approach to nursing education is most likely to foster autonomy.

The orientation period on the first job is a very important phase for transition to workplace practice. From the interviews some common themes emerged: 1) the importance of a well planned orientation period in adapting to the workplace; 2) feelings of being overwhelmed at times; 3) difficult working conditions beyond their expectations; 4) and an appreciation for autonomous practice. Overall, the novice nurses indicated a clear preference for a comfortable environment in which to integrate theoretical knowledge with practice especially during the on the job orientation period.

Acknowledgements

I would like to acknowledge a number of people without whom this thesis would not have been possible. I am extremely grateful to the participants who took the time to be interviewed, and who freely shared their experiences and perceptions with me.

Two former colleagues, Donna Moffat and Jocelyne Faille, proofread the final version. They not only looked for typographical errors, but also gave me feedback as to whether they agreed the conclusions were justified by the data. I appreciate the time they spent and the enthusiasm with which they did this.

I would like to thank the members of the faculty of the Department of Education at Concordia University. My teaching career has been, and will continue to be shaped by what I learned during the past three years.

And lastly, I would like to mention my faculty advisor, Professor Arpi Hamalian. She guided me from the beginning, and her constant reminder to "do what is good for you" made the process enjoyable. Her experience and her wisdom were invaluable, and I thank her.

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Introduction

The health care system in Canada is changing rapidly. Increased use of technology, spiraling costs, globalization and longer life expectancies are some of the factors that have increased the complexity of delivering health care. This in turn has changed the scope of nursing practice. Upon entry to practice, the nurse is required to function autonomously, as well as to work with members of an interdisciplinary team. Unfortunately, autonomy continues to be elusive both to individual nurses and to the profession as a whole (Akoma,1993; Brophy, 2000; Wade, 1999).

Nursing education in Canada changed radically in the 1970s, when it was removed from hospitals and transferred to colleges and universities. Today's nursing programs include material from many disciplines: biology, psychology, and sociology, as well as nursing theory. Nursing courses include theoretical material, knowledge about diseases and their treatments, communication skills and practical skills. There is also a process of socialization into the profession (which may not be explicit), in which nursing educators attempt to acquaint students with the attitudes of the profession.

The links between theory and practice are made in what is commonly called the clinical setting. These settings include hospitals, long-term care institutions and community agencies. Students go to appropriate clinical settings in a group of eight or less, with a clinical instructor. During their nursing education, students will spend about 40% of their time in clinical settings, practicing what they have learned in class and in the nursing laboratory setting.

The amount of practical training the students receive has decreased considerably since the days of hospital based nursing education. The knowledge base in nursing has

expanded with research and advances in medicine. During a three or four-year nursing program, it is impossible to cover every disease, syndrome, and skill the nurse may need to know upon graduation. Nursing education turns out generalists. To bridge the gap, the employing institution provides an orientation period to the novice practitioner. This includes information about policies of the institution as well as the specific unit the nurse is hired for. Novice nurses spend a period of two to six weeks as supernumerary, before being expected to function as team members. It takes anywhere from six months to one year before the novice nurse is comfortable in the new position.

The first few months of a new nurse's working life are extremely stressful. The third year student is often comfortable in the student role, but upon graduating, realizes how much more there is to learn. Studies have described the stressors novice nurses experience during this transition (Horsburgh, 1989; Kramer, 1974; Pereira, 1992). Novice nurses reported internal conflict because their education encouraged patient-centered nursing care, while their new practice environment stressed the management of tasks to be performed within a certain time frame, or nursing shift.

Purpose of the Study

Pereira (1992) suggests that while education is dissociated from reality, it is vital to educate nursing professionals prepared to face the problems they will encounter in their practice. This is the challenge for nursing educators today. Knowledge about the outcome of nursing education and how former students are integrating into the workplace will help educators improve nursing curricula.

As a fairly novice nursing teacher with less than three years of experience teaching, I myself have been preoccupied by learning to teach. I am concerned with

knowing what teachers are doing that facilitates learning, and also what we may be doing that could be improved. In 1977, Miller looked at nursing education in the College d'enseignement général et professionnel (CEGEP) system in Quebec. The students described an environment that was rigid and authoritarian. Anecdotal evidence from my own students has told me some teachers still follow this approach to teaching. Studies have shown that students in clinical placements do best in environments in which they feel supported and appreciated (Andrews & Roberts, 2003; Brown, Herd, Humphries & Paton, 2005; Chesser-Smythe, 2005.). I believe this kind of environment should be promoted, not one that is authoritarian. Students are not able to learn autonomy when they are afraid of their teachers. The participation of students in their learning and evaluation encourages their development as competent, self-directed professionals, capable of functioning autonomously in our complex health care system.

My reason for undertaking this research is twofold. The first is to gain insight into how to facilitate students' learning. The second is to know how to help students develop into autonomous professionals able to function as respected members of an increasingly well-educated interdisciplinary health care team.

The purpose of this qualitative, exploratory study is to examine how former students perceive their education, once they have graduated and begun to work. The research questions are:

1. Do graduates of an English-language CEGEP in Montreal perceive that their education adequately prepared them for practice as nurses?
2. Do they feel they were encouraged by their teachers to be autonomous in their nursing practice?

Significance

This research is important for the following two reasons. The first reason is that much of the current workforce will be retiring in the next 10 or 15 years. It has been predicted that by the year 2011, Canada will face a nursing shortage of over 110,000 nurses (Canadian National Advisory Committee, 2002). The nurses that are trained need to feel comfortable as they begin to work or the potential for job dissatisfaction and burnout will be high. The highest turnover rate is with low-tenure nurses (Maiocco, 2003). When nurses are dissatisfied, they look for work elsewhere. Hospitals in the United States are only too happy to recruit nurses from Canada.

The second reason is the nurses who do graduate and work in Quebec need to be able to function autonomously in our health care system. The English hospitals in Montreal, particularly those in the McGill University Health Centre, are secondary and tertiary centres. The most specialized care in Quebec is in Montreal, where educated professionals from around the world gravitate to work. To be respected and attain their full potential, nurses must be well educated. Should nursing schools turn out technicians who are unable to make decisions and show poor judgement, the population is not well served. Nurse educators have a responsibility to serve the needs of their graduates, the professional workplace, and the citizens of Quebec.

Chapter One

Literature Review

Overview

The issues affecting nurses, as well as the context in which nurses practice, are increasingly complex. Spitzer (1998), in a discussion of nursing in the postmodern world, captures the issue of complexity:

> Complexity is a phenomenon that needs to be captured as a whole. Any attempt to analyze, understand, and/or intervene in complex systems by decomposing them to their parts is futile. Thus, in complex systems, a change in any of the independent parts is bound to reverberate in many other parts via the rich connection system. It is, however, impossible to predict which elements will be affected and in which way....Nothing in our experience, perceptions and previous knowledge promotes our understanding of this phenomenon. (p. 166)

While it is impossible to convey this complexity, the circumstances of the novice nurse can only be understood in the context of the practice of nursing, nursing education and health care in Quebec. This literature review provides this background and context.

The first section looks at the roots of nursing in Canada, with a focus on Quebec. These roots help us to understand the origins of some of the problems faced by nurses now. The second section examines some current issues in nursing, and how these issues will affect nurses in the near future. What trends do we see, and how will that change the nature of nursing?

The concept of autonomy is discussed in the third section. The importance of autonomy as a personal and professional characteristic is explored. To this end, the literature regarding autonomy and nursing education will be examined.

The fourth section explores relevant aspects of nursing education: entry to practice, attitudes and skills, nursing education in the CEGEP system, and the internship.

The last section of the literature review will discuss the stressors and shock experienced by the novice nurse at entry to practice.

Roots of Nursing in Canada and Quebec

The historical background of the nursing profession sets the context to understand some contemporary issues. The origin of nursing in Quebec dates back to the early days of colonization. Religious nursing orders in France sent nuns to staff Montreal's first rudimentary hospital in the 17th century, very soon after the colony of New France was settled (Dick & Cragg, 2006; Storch, 2006). Jeanne Mance founded the Hotel Dieu Hospital in Montreal in 1642, staffing it with nuns. From then to the end of the 19th century, religious orders were mainly responsible for the provision of health care in the colony that became Quebec.

Modern nursing is considered to have begun with the work of Florence Nightingale during the Crimean war between 1852 and 1856. Nightingale initiated revolutionary changes, guiding nursing practice by scientific principles rather than compassion (Desjardins, Flanagan & Giroux, 1971). She demonstrated that nurses needed specific skills and knowledge. While Nightingale's students and nurses were not nuns, they followed a similar lifestyle. She insisted they be chaste, devout, and obedient (Gunderson, 2002: Villeneuve & MacDonald, 2006). Nightingale, a member of the aristocracy, saw nurses as part of the servant class (Akoma, 1993). Although Nightingale is viewed as one of the founders of the nursing profession, in some ways her legacy has held the profession back from achieving true professional status.

Canada's first hospital-affiliated nursing school opened in 1874. It espoused the motto: "I See and am Silent". This is a very contradictory attitude to the professional obligations, responsibilities and accountability of today's nurses (Dirk & Cragg, 2006; Villeneuve & MacDonald, 2006). During the early days of hospital-based instruction

nursing education was an apprenticeship, and the environment was very restrictive. Freire (1970) describes this as the "banking system" of education. Teachers imparted information, and students received it. Physicians taught what little theory the students received, and this was sandwiched in between shifts in the hospital. Senior nursing students gave most of the practical instruction (Dick & Cragg, 2006). Hospitals eventually hired nursing instructors but the emphasis remained on practical training. Nursing students were seen as a cheap source of labour. Both the medical profession and the hospital administrators made decisions on behalf of nursing, and this contributed to the perception that nurses existed to help physicians and hospitals care for the sick (Ashley, cited in Akoma, 1993). Duchscher and Cowin (2005) compare attitudes towards nurses as that of wives to physician "husbands", taking care of the patient "child".

In 1929, the Canadian Nurses' Association and the Canadian Medical Association jointly formed a committee to study problems in nursing, particularly related to education. The 1932 Weir report recommended that training schools for nursing students be primarily educational institutions rather than economic assets to hospitals (Desjardins, Flanagan & Giroux, 1971). It took almost 40 years for Weir's report to be taken seriously.

Eventually the provincial governments realized that more education was required for nurses than could be provided in hospital-controlled nursing schools. The growing feminist movement may have provided momentum for this push by making nurses aware of women's rights (Galligan, cited in Akoma, 1993). In Quebec, education of nurses was taken out of the hospitals and transferred to the newly created CEGEP system in the late 1960s. In 1970, diploma nursing education was transferred from the jurisdiction of the

Department of Health to the Department of Education. This change put an emphasis on nursing "education", rather than nursing "service" (Miller, 1977).

Most licensing bodies in North America, recognizing the complexities of the entry-level competencies in nursing, now require an undergraduate degree to enter the profession (Dirk & Cragg, 2006). Provincial regulatory bodies that do not yet oblige a baccalaureate for entry to practice have set up integrated programs between universities and community colleges (CEGEPs in Quebec) to ensure that students can go immediately into shorter undergraduate programs after receiving nursing education diplomas.

The origin of the nursing profession can be traced back to pious compassion for the sick. Religious roots were perhaps stronger in Quebec than in other areas of Canada, but views about nurses are similar throughout the country. Despite the present educational base of science, clinical and professional skills, knowledge and judgment, nursing is still sometimes perceived as a vocation or as "women's work" (Dick & Cragg, 2006). Cultural assumptions about the nature of work carried out by females still affect the nursing profession. Kondas-Hagg (1994) posits that the nurse's role is seen as an extension of the female role of caregiver and nurturer.

There is a growing acknowledgement that female-dominated professions are disadvantaged (McDonald & McIntyre, 2006). The public admiration of nurses has not been accompanied by economic support or power (Kirby, cited in Villeneuve & MacDonald, 2006). Stuart remarks employers still think they can "...recruit women interested in self-denial, servitude and the expression of their natural qualities as women...." (p.22, 1993). However, nurses today are more likely to view themselves as professionals, and their work as a career (McDonald & McIntyre, 2006).

A review of sociological literature testifies to the medical dominance of all health care labour (Adamson, Kenny & Wilson-Barnett, 1995). For nursing, this is evidenced in many ways: a) the continued authority of physicians in most workplaces; b) nurses' lack of control over their work; c) nursing shortages; d) lack of resources; and e) incongruities in the way nurses are taught and the way they must practice. Lack of power leads to a lack of autonomy. The next sections will examine some of the trends in nursing, and why nurses need to be able to practice autonomously.

Nursing Today

Current Issues Affecting Nursing

Health care, like the rest of society, is undergoing rapid change. Canadians are living longer, the population is aging, and the number of people with chronic illness is increasing (Villeneuve & McDonald, 2006). While the cost of managing these chronic illnesses is escalating, governments are attempting to contain spending on health and social services (Storch, 2006). There are lengthy waiting lists for surgical services in most communities, a lack of general practitioners, and overcrowding in emergency rooms (Villeneuve & McDonald, 2006).

Technology has had an impact on health care, as the system increasingly uses technology-based diagnostic methods and treatments for many conditions. Though beneficial, the cost of acquiring, maintaining and upgrading the technology is high. The cost of drugs is escalating, applying pressure to the health care system (Villeneuve & McDonald, 2006). Use of the Internet has resulted in a population that is more aware of medical conditions and treatments.

The increased use of technology and in the number of patients with chronic disease has led to an increase in the complexity of care of hospitalized patients. Lach provides us with a portrait of a patient with multiple problems. One client may have: "... physical (e.g., a primary diagnosis with secondary complications), emotional (e.g., coping deficits in regard to chronic illness), and financial (e.g., drained resources) problems, as well as knowledge deficits (e.g., operating high-technology equipment)" (1992, p.12). These multifaceted issues oblige nurses to be technically competent, both

in their knowledge and skills. The nurse must be able to provide care as well as coordinate and maintain continuity of care in a complex health care system.

Fiscal constraint has resulted in additional pressure on the profession. In the mid-1990s, the government of Quebec closed hospitals and provided incentives to encourage early retirement. Large numbers of nurses took advantage of the retirement opportunity. Admissions to nursing schools were cut at the same time. Unfortunately, the number of people needing nursing care did not decrease. The past ten years have been difficult in the health care system, as those who remained attempt to cope with staff shortages. Younger nurses have had to develop in the absence of mentoring by senior nurses who had retired (McDonald, McIntyre, Thomlinson, 2006).

The nursing workforce is aging and the average age of nurses in Canada is now 44. Once again, large-scale retirement is looming, as baby boomers achieve retirement age. The CNA (2002) estimated that Canada should be graduating 18,000 nurses yearly to maintain the workforce. Nursing schools are currently struggling to graduate 8000 new nurses per year.

One reason the nursing workforce is aging is that fewer people are entering the profession. The large-scale entry of women into the workforce over the past 50 years initially increased absolute numbers of nurses (Aiken, 2004). However, nursing has become less attractive as other opportunities have opened up for women, and enrollment in nursing programs is declining. By the year 2020, it is forecast there will be 20% fewer nurses in the workforce than are needed (Buerhaus, Staiger & Auerbach, 2000). In the past, when numbers of nurses were insufficient to meet needs, the door was opened for the entry of workers with less education (Aiken, 2004). This is somewhat troubling, as

predictions are that nurses will assume greater responsibilities and will have a more autonomous role to play in decision making in health care in the future.

Trends in Nursing

One of the goals of nursing education is to educate nurses who are able to function as autonomously as possible in this complex environment, and to cope with changes in the future. In 2005, the Order of Nurses of Quebec (ONQ) stated:

> In the practice of her profession, the nurse assumes her responsibilities relating to all aspects of her field of practice...The nurse shows that she has the knowledge for her professional practice, in particular by making the appropriate clinical decisions. In the practice of her profession, the nurse:
> - takes the necessary means to ensure continuity of care;
> - identifies and analyses risks to the safety of clients...
> - takes the means to prevent harm to the client;
> - evaluates the results following nursing interventions; (pg. 22).

There are predictions of a shifting focus of nursing practice and movement of employment settings (Hyndman, 1999). Nurses will need to augment their responsibilities in the face of increased levels of patient care, and to be adaptable to fill a variety of roles dependant on the work setting (Canadian National Advisory Committee, Health Canada, 2002; Villeneuve & MacDonald, 2006). Abate (1998) cites both the American Nurses Association and the American Academy of Ambulatory Care in reporting professional autonomy as an essential component for nurses to function in changing roles.

The shape of nursing practice will be impacted as technological and medical advances allow us to predict who will develop diseases, as well as providing cures. The nurse's role will expand to include helping people understand their diagnoses and available treatments, and assisting them to navigate the health care system. Nurses will provide much of the primary care that is currently carried out by general practitioner

physicians (Villeneuve & MacDonald, 2006). For example, it is possible that advanced practice nurses will have the responsibility of running diabetic and coronary artery disease clinics, and of prescribing medication. Nurses will also be expected to play a more active role in health maintenance, case management, health education and health promotion.

To meet these challenges, Health Canada has been attempting to reform models of practice. There has been a focus on establishing interdisciplinary health care teams capable of working together to improve primary health care. Nurses no longer work in small homogenous teams. They must be knowledgeable and articulate to take their place on the team, collaborating with other members (Villeneuve & McDonald, 2006).

In summary, the complex system in which nurses practice today has created a demand for a new practice paradigm. Nurses will need to function autonomously. The next section looks at autonomy in nursing, and in nursing education.

Autonomy

The Concept of Autonomy in Nursing Practice

A rudimentary definition of autonomy is "the quality or state of being self-governing, especially: the right of self-government" (Merriam-Webster Online Dictionary, n.d.). Schutzenhofer's definition of professional autonomy is:"...the practice of one's profession in accordance with one's education, with members of that profession governing, defining and controlling their own activities in the absence of external controls" (Schutzenhofer, cited by Abate, 1998, p. 14). Self-direction and self-determination are other terms used in the nursing literature to describe autonomy.

Today's nurses place more emphasis on autonomy than previous generations of nurses (Wynd, 2003). Yet it often seems to be lacking in our practice. The American Nurses Association (2002) reported that the primary reason individuals are admitted to the hospital today is to receive professional nursing care (Villeneuve & MacDonald, 2006). Yet the role of nurses in decision-making around health care remains limited.

The nursing profession is hampered both by being a female-dominated profession and by its origins linked to organized religion. Nurses are still struggling to achieve full professional status (Akoma, 1993; Brophy, 2000; Gunderson, 2002). An essential element in establishing professional status is autonomy on both individual and group levels. The defining value for professionals is autonomy in their practice, coming from a core characteristic of mastery of a knowledge field and commitment to a unique service (Stuart, cited in Akoma, 1993).

Lach (1992) concurs, stating that professional autonomy exists if members of the nursing profession govern and control their own activities, taking the freedom to make

prudent and accurate decisions and perform actions within one's scope of practice. The nurse must be committed to being accountable for both her decisions and her actions.

Akoma (1993) defines nursing autonomy as the independence within nursing, functioning at the professional, organizational and educational levels. There has been an emerging concern about the development of autonomous practice for nurses, as attainment of professional autonomy is thought to be crucial to the professionalization of nursing (Gunderson, 2002; Keely, 1990; Kondas-Haag, 1994). Not only has autonomy been linked to job satisfaction, limited autonomy has led many nurses to leave the profession (Gunderson, 2002; Kramer, 1974).

In a concept analysis of professional nurse autonomy, Wade defined autonomy as the belief in the centrality of the client when making responsible discretionary decisions reflecting advocacy for the client. She emphasizes that the nurse most clearly demonstrates autonomy while acting as the patient's advocate. Wade found the antecedents of professional autonomy to be personal and educational qualities. Qualities related to education are: a) competence grounded in a strong knowledge base; b) a clear understanding of the scope of nursing practice; and c) a baccalaureate or higher degree in nursing. Abate (1998) concurs that nurses with higher education reported more professional autonomy.

The lack of autonomy reported by nurses has been attributed to several factors, the predominance of women in the profession being the main one. Role socialization to occupations is learned through experienced members of the group serving as models or referents of behavior (Keely, 1990). Behavior is usually dictated by the profession, as individuals who wish to become part of the group adopt the values and attitudes of that

group (McLaughlin, 1998). In hospital settings, issues of power, gender and the medicalization of health care have affected the socialization of nurses (Abate, 1998; Wade, 1999). Socialization of nurses to encourage autonomy must begin during their education.

Nurses' search for professional autonomy is reflected through their role in patient advocacy. The Canadian Health Research Foundation studied the workplaces of Canadian nurses (Baumann et al., 2001). Nurses expressed a need to have input into the patient-care decisions related to their practice. Control over their own practice was consistently linked to job satisfaction. A study conducted in Australia and Britain found that nurses in both countries experienced a lack of professional autonomy, particularly in regard to the medical profession (Adamson, Kenny & Wilson-Barnett, 1995). In fact, having an undergraduate degree led to increased frustration at the difference between the two professions.

Autonomy in Nursing Education

Although autonomy is a highly desirable quality for nurses, it is often found to be absent in education and in practice (Brophy, 2000). As the primary socializers of nursing students, nursing educators have a responsibility to foster and model autonomy (Brophy, 2000; Wade, 1999). Yet this is not always the case.

Brophy (2000) found that nurses who had been practicing for two years were not able to recall discussing the concept of autonomy during their education. These nurses, who may be described as advanced beginners, described their clinical rotations as being intimidating and oppressive. Examining their experiences from a critical feminist viewpoint, Brophy suggests nursing schools are upholding the dominant male model.

This perpetuates the power status of the dominant group, the medical establishment, still overwhelmingly male.

Brophy suggest that traditional educational philosophy has been held over from the time when nursing education was carried out in hospitals, supervised by physicians. Students perceived the clinical instructor as the main power figure in their educational experience, as well as the key factor in determining whether or not their clinical experience was good. Students perceived the learning environment to be instructor-directed, inflexible, and intimidating, with unrealistic expectations of students. Staff nurses were power figures and the students needed to "fit in" to have a good experience. In contrast, the elements that contributed to autonomous experiences were collegial relationships, trust and independence, clinical competence and constructive feedback. Self-esteem and self-confidence were affected by the support and caring of the instructor.

Powerlessness is a common theme in the literature on socialization of nursing students. Nursing students who wanted to be independent and autonomous became passive because they felt powerless (Brophy, 2000). Kelly (2000) reported that recent graduates of nursing schools described feeling powerless during their education. McLaughlin (1998), in a study conducted in a Montreal area CEGEP, interviewed nursing educators who felt they promoted independence, assertiveness and autonomy in their students. Yet, nursing students in McLaughlin's study reported feeling both discriminated against and disempowered. Powerlessness limits the ability to learn professional nurse autonomy.

Wade (1999), who calls for changes in both nursing education and practice, suggests a learner-centered curriculum based on a theoretical model. Models are

believed to be instrumental in helping nursing students relate knowledge to practice. Nursing models that stress choice and advocacy are said to help in the development of autonomous nursing practice. Courses addressing professional issues, leadership, and change theory are said to facilitate autonomy. Other suggestions are incorporation of a strong liberal education that promotes acting in the public interest both locally and globally, furthering the profession of nursing.

Wade (1999) also supports the encouragement of values, attitudes and behaviours that reflect professional practice. Because being a primarily female profession has hampered the professionalization of nursing, she calls for the promotion of androgynous values. Societal gender roles affect the development of autonomy. Traditional masculine views of autonomy emphasize control and separation, while females construct their concept of autonomy within the context of relationships and the ethics of caring. Androgynous values lie between the two, emphasizing the dependence and independence between nurse and patient. Wade suggests Gonzalez's vision of autonomy that includes the freedom to act responsibly while caring for others (Gonzalez, cited in Wade, 1999).

Pereira (1992) describes a patriarchal relationship between nursing students and their teachers in Brazil. She refers to this relationship as "dominance-submission". Pereira suggests nurse educators should change to a more caring approach wherein students are free to question, and to try new ways of thinking and asking. She believes the teacher's role is to encourage and help learners pursue their capacities for self-direction, self-determination and fulfillment by the establishment of a new relationship between teachers and learners. By doing this, students will develop into professionals who can examine the assumptions underlying their everyday activities and work toward

changes in their professional practice. The students in Pereira's study preferred teachers who were facilitators of learning. After graduation, their preferences were positions in which they would have more autonomy.

In summary, nurses both need and want to practice autonomously and their educational process should facilitate learning the knowledge base and skills for autonomy. The next section will look at the educational preparation of nurses.

Nursing Education

Nursing Education and Entry to Practice

The function of nursing education is getting bodies through an educational system as cheaply as possible, yet the government wants a workforce that can take on the work of junior doctors. This requires highly educated nursing staff with a strong academic background (Villeneuve & MacDonald, 2006). Educational preparation for entry to practice in the nursing profession has been an issue in Canada since there has been organized nursing (Dick & Cragg, 2006). There is a belief that university degrees have added to the legitimization of an occupation as a profession (Keely, 1990). The CNA and other regulatory bodies have been working since the 1980s to make a baccalaureate degree the entry to practice.

While in most of Canada entry level to nursing practice is a university undergraduate program, Quebec students have two options. They may, upon completion of a Health Science diploma at the CEGEP level, pursue the degree program at university. Alternatively they may choose a three-year CEGEP program. After successful completion of this program, graduates write licensure exams given by the ONQ and enter the profession. While the latter group is strongly encouraged to enroll in a baccalaureate program after qualifying, no regulation exists for a degree as entry to practice in Quebec.

Nursing Models and the Nursing Process

Conceptual models of nursing were first elaborated in the United States in the 1950s (Timmins, 2006). In the ensuing years, nursing theorists have developed a number of models. Each model attempts to define the nature of nursing as well as the

nursing process (Heath, 1998). Both nursing models and the nursing process attempt to view clients holistically, as individual bio-psycho-social beings rather than following a disease-based medical model. Since in the mid-1970s, each nursing department in schools and healthcare institutions chooses a nursing model to adopt (Wimpenny, 2002).

The use of nursing models places an emphasis on the science of nursing and the development of nursing as a profession (Henderson, cited by Heath, 1998). There is a lively debate about the value of such models. It has been suggested nursing models provide a structured guide which is useful for those beginning to practice (Fawcett, 2003; Heath, 1998). Wade (1999) suggests the use of models stressing choice and advocacy will help in the development of autonomous nursing practice. Criticism directed towards the use of models asserts these models are too idealized and abstract, impossible to follow (Timmins, 2006).

Nursing faculty follow frameworks to give structure to their teaching. The first year of nursing education places an emphasis on the nursing model. Models are quite complicated, involving the learning of concepts and model-specific terms. The students will use this framework during their education to learn the process of nursing. Timmins (2006) concludes conceptual model use often results in a paper exercise bearing little relationship with actual practice. Nonetheless, nursing education still involves the use of such a model.

Nursing Skills

The terms *skill* and *critical thinking* are extensively used in the nursing education literature, yet their meaning remains ambiguous. Definition of terms appears to be in order. The term *skill* defined in the dictionary refers to: a) the ability to use one's

knowledge effectively and readily in execution or performance; b) dexterity or coordination especially in the execution of learned physical tasks; c) a learned power of doing something competently; and d) a developed aptitude or ability (Merriam-Webster Incorporated, 2006-2007). The Cambridge online dictionary describes a skill as: "an ability to do an activity or job well, especially because you have practised it" (Cambridge University Press, 2007). The first definition does not confine the definition of skill to a physical domain. The second is somewhat less vague, but is not completely clear.

Barrow (1987) argues persuasively that the concept of a skill is inherently physical, something that can be perfected through practice. He decries the current tendency to refer to critical thinking skills as though these skills can be practiced and developed. While there is a trend to discuss critical thinking as if it was one of a group of skills, Barrow contends that it is erroneous to suggest it is possible to acquire or improve "intellectual, emotional and interpersonal ability in much the same way as one develops muscles" (Barrow, 1987, p.195). One cannot be critical if one does not have an understanding of the domain or an understanding of the knowledge base of the domain.

There is much in nursing literature about the need to develop critical thinking skills in students. It is thought this will help students develop into nurses that do not practice by formula. The goal is to educate nurses who do not practice by rote, but adapt care to the individual. The nursing process always consists of the same steps: assessment, analysis of data, formulation of diagnosis or problem statement, planning, implementation and evaluation. Nursing skill consists of knowing what and how much data to collect, how to analyse the data, possible nursing diagnoses and formulating a nursing diagnosis. Nevertheless, the concept of critical thinking has been much debated.

Hyslop-Margison (2003) also contends that the word skill should be relegated to the psychomotor, and that the construct of critical thinking is flawed. He argues that instead of attempting to teach a group of skills which together lead to critical thinking, teachers should be attempting to foster desirable intellectual qualities and academic dispositions. A strong knowledge base that includes policies, protocols and consequences will lead to lifelong education.

The concept of critical thinking is a universal component of nursing education, and is integral to the field of nursing (Profetto-McGrath, 2003). The Watson and Glaser definition of critical thinking is the most widely used in nursing literature. It defines critical thinking as a synthesis of attitudes, knowledge and skills (Abegglen & O'Neill Conger, 1997; Profetto-McGrath, 2003). Critical thinking has also been defined as an active, ongoing cognitive process of logical reasoning in which the individual methodically explores and analyzes issues, interprets complex ideas, considers all aspects of a situation and/or argument and where appropriate follows with prudent judgment" (Profetto-McGrath, 2003).

For the purpose of this paper, the terms *skill* and *critical thinking* are used when others have done so. When discussing psychomotor skills specific to nursing, the term *technical skill* is used.

Nursing Education: Attitudes and Skills

The National League for Nursing is a regulatory body whose role is to accredit nursing education programs in the United States. In 2003 this body called for a movement away from content coverage toward more innovative teaching methods. It advocated pedagogical methods to educate nurses to function effectively in ambiguous,

unpredictable, and complex environments, demonstrate critical thinking and flexibility, and execute a variety of roles throughout a lifetime career (National League for Nursing, 2003). Educators are challenged to educate nurses, balancing theory and content, with education focused toward attitudes and ways of thinking.

CEGEP nursing education imparts theory and skill. Some skills are psychomotor, while others cross over into the cognitive and affective domain. Programs include courses in liberal arts and humanities with a view to helping students better understand the world in which they will practice. Nursing education also aims to teach or encourage specific attitudes. Attitudes are a state of mind, awareness, and/or an impression regarding a concept, event, or environment (Akoma, 1993).

Benner discusses an attitude fundamental to nursing when she writes there is "... a central role of caring, of a committed involved stance in nursing practice" (2001, p.170). Villeneuve and McDonald describe caring and knowledge as the "two paths of nursing" (p.80, 2006). Since the time of Nightingale there has been this dichotomy in nursing. What does this mean in terms of skills?

Hyndman (1999), in a review of nursing literature examining the types of skills nurses need to practice, identified 30 different skills that are essential to nurses practicing in institutions. These include intellectual skills such as problem solving and a good knowledge base, as well as interpersonal skills such as effective communication and caring. One of the 30 skills identified was *technical/psychomotor skills*, which in itself contains a huge number of different skills.

What Hyndman describes as skills are called dispositions, competencies or abilities by other authors. The CEGEPs use the term competencies, as does Marshall

(1999), who examined what graduating nurses need to know upon beginning to practice. The categories of competencies she described were: a) critical thinking/problem solving; b) interpersonal/communication skills; c) direct care/technical skills; d) psychosocial skills; e) self-management skills; and f) management/care coordination skills. In Marshall's study, nursing faculty rated *psychosocial* and *critical thinking/problem solving* skills higher than nurse managers or staff nurses. Staff nurses rated *direct care/technical skills* higher than the other two groups.

What both authors describe is a profession whose practice requires a number of different abilities to function at an acceptable level. The technical skills are only one type of competency that nurses need, and which technical skills are needed will depend on the setting in which each nurse is practicing.

Nursing Education in the CEGEP

The CEGEP program for nurse education integrates the biological and social sciences with nursing theory, and teaches a process of nursing. The nursing process is carried out within a nursing model which describes a view of the client, the environment, health, nursing and the practice of nursing. Students study health promotion as well as disease and how it is managed by nurses and other health care professionals. Psychomotor skills are taught in the college in laboratories which simulate hospital settings.

The links between theory and practice are made in the clinical practicum. During their nursing education, students will spend about 40% of their time in clinical settings, practicing and synthesizing learning derived from the classroom and in the laboratory setting. During their education they will probably be exposed to up to ten different

nursing environments. Nursing teachers provide classroom and laboratory teaching, as well as clinical supervision.

Clinical experiences are a critical and intense part of nursing education. The unpredictability of the situation, demands placed on students for accountability, the necessity to assure safety of the patients and the close association between teachers and students contribute to stress experienced during the day (Emberley-Burke, 2000). The ability of the clinical instructor to work with students is crucial to the students' development as nurses. This setting is where the students can learn to be autonomous, when so encouraged. The experiences gained in the clinical practicum are essential to the development of decision-making skills (Wade, 1999). Wade advocates that for the final semester, students should be given the opportunity to work with a preceptor nurse who demonstrates professional autonomy.

Preceptorship

Having an experienced staff nurse work with a nurse who is new to a unit is an accepted method of professional socialization. Nurses who act as such may be referred to as either mentors or preceptors. The two terms are not the same, and they should not be used interchangeably. A mentor is defined as a wise and trusted advisor or counsellor (Merriam-Webster OnLine, n.d.). Greene and Puetzer (2002) looked at mentorship in nursing. The mentor was an experienced nurse who agreed to act as a role model and resource person over the first year of practice of the newly hired nurse. Mentors have been described as persons taking a personal interest in helping a nurse pursue career development (Deane & Campbell, cited in McCarty & Higgins; 2003). The mentor keeps

in close contact with the novice, but does not necessarily work directly with her. The mentor maintains a close, more personal type of relationship with the junior nurse.

Preceptorship is more formal than mentorship. A preceptor role may be defined as an experienced nurse who facilitates and evaluates learning in the clinical arena over a predetermined amount of time, while carrying out regularly assigned functions (Pearson Floyd, 2003). Specific outcomes are sought, and the preceptor must formally evaluate and report about the progress of the novice. The preceptor exposes the new nurse to the routines, as well as to the reality of nursing practice on the unit, but is available to discuss professional conflicts as they occur. In some nursing schools, nurse preceptors will be assigned to students in clinical settings.

Consolidation of Skills: The Internship

Another acceptable method of professional socialization is the internship. During the final semester, the student works with an experienced nurse who teaches, guides, supervises and serves as a role model for a student (Gerrish, 2000; Usher, Nolan, Reser, Owens & Tollefson, 1999). It is desirable that the students work with the same nurse for several weeks, with the experienced nurse acting as a preceptor and role model.

The literature suggests the quality of the experience for students depends on many things: a) the willingness of the preceptor to take on this role; b) the education, knowledge and clinical competence of the preceptor; c) adequate preparation of the preceptor for the role; d) nurse-patient ratios; and e) the relationship between the student and her preceptor (Allrich, 2001; Barn, 1996; Lillibridge, 2006; Spouse, 2001; Usher et al, 1999). It is sometimes difficult to find preceptors who have knowledge of adult

learning principles and who are able to practice collegiality to encourage a novice's positive transition to professional practice (Maiocco, 2003).

The benefits of an internship to the student and to the profession of nursing are many. Students have reported an increase in: a) learning opportunities; b) application of learning; c) awareness of the setting/context they were working in; d) assessment and communication skills; e) comfort with procedures. They have also reported better awareness of the nurse's role in the interdisciplinary team, and development of problem-solving and critical thinking skills (Allrich, 2001).

Spouse (2001) found the most significant factor influencing professional development was effective mentorship. She believes one function of the mentor is to communicate her craft knowledge, which can be done by teaching while engaged in expert practice activities. Benner (2001) suggests that the preceptorship is not only valuable in helping the novice gain proficiency, but that it may also increase perceptual understanding of the knowledge embedded in nursing expertise. Communication of this type of knowledge and expertise may be one of the most meaningful aspects of the internship.

While the preceptor role is crucial to the internship, it is also necessary for the orientation of a new graduate. When a new nurse is hired, she will work with a preceptor during the orientation period. The next section will look at the novice nurse and her world.

The Novice Nurse

Beginning to Practice: The Novice

Benner uses the Dreyfus model of skill acquisition to describe the developmental progression of nurses (Dreyfus & Dreyfus, cited in Benner, 2001). Five developmental levels of expertise are described: novice, advanced beginner, competent, proficient and expert. Movement from one level to the next is based on experience, education and ability. The novice level will be discussed for purposes of this study.

The novice level of change is a movement from reliance on abstract principles or theory to the use of past experience as paradigm. The new nurse has virtually no experience of situations in which she is expected to function. Novice nurses have been taught objective attributes and concrete, context-free rules. The novice nurse takes in little of a situation, is overwhelmed by the setting and often can only remember the rules taught.

The Theory-Practice Gap: Reality Shock

Most new graduates are hired by hospitals. Hospital nursing is a very stressful occupation due partly to constantly changing technology and the acuity of the patients' illnesses. Various studies have shown the world of the new nursing graduate is extremely traumatic (Brown & Edelmann, 2000; Gerrish, 2000; Horsburgh, 1989; Kelly, 1998; McKenna, Smith, Poole & Coverdale, 2003). The stressors placed on novice nurses can be overwhelming. The process of socialization of students into healthcare professions involves internalizing the norms, beliefs and values of the professional culture into which novices wish to be admitted (Philpin, 1999). The disparity between values espoused by

the educational establishment and those practiced in clinical areas is anxiety provoking for new graduates (Gerrish, 2000; Kelly 1991; Kelly, 1998).

This phenomenon has been labelled "reality shock" (Kramer, 1974), and is attributable to the theory-practice gap, or the difference between what is taught and what is practiced. Although this seminal work is more than 30 years old, it is supported by current research (Duchscher & Cowan, 2004). Novice nurses often have difficulty in recognizing the connections and relevance between the theories they were taught and situations occurring in the setting in which they work (Spouse, 2001). While acknowledging there are many reasons for this discrepancy, it is suggested that nursing curricula and educational practices integrate clinical practice (Ferguson & Jinks, 1994; Landers, 2000). A key role has also been ascribed to nursing management in hospitals to minimize this gap (Duchscher & Cowan, 2004).

Kramer coined the term reality shock in an eight-year, multi-site study of graduate nurses in California. The term refers to a total social, physical and emotional response to a situation that is unexpected, unwanted, and potentially intolerable. Reality shock is likened to culture shock, which she describes as the shocked surprise and reactions when discovering that one's own culture is not necessarily the only or best way of organizing societal life and interacting with one's fellow man.

From this perspective, it appears the problem is a failure of the socialization of the nursing student. Kramer suggests the student nurse needs to recognize new values and behaviours appropriate to the role of nurse, and to adopt them as one's own. Kramer developed a program to better prepare nurses. She proposed to integrate into the curriculum a more realistic professional socialization of the student and named it

Anticipatory Socialization Program. Students who went through the program had fewer days of absence from work, were perceived as happier, more stimulated, and were more highly rated on professional job functions by their employer than students who had not followed the program (Kramer, 1974).

Kelly (1998) posits that there is no universal culture in nursing, or in any hospital institution. Each nursing unit (formerly called the nursing ward) is a separate entity, with its own practices, traditions, power structure and rules. Kelly (1991) found new graduates assumed they were entering a culture they knew and understood, but this was a misconception. The culture of the unit was the single most important factor in the success of the new graduate's integration into the workforce.

Unsuccessful socialization of new nurses has been identified as the main reason nurses leave the profession (Kelly, 1991; Kramer, 1974). Kelly (1991, 1992, 1996) studied one cohort of students as they progressed through their nursing education and began work as novice nurses. She examined the transition from student to novice nurse. Overwhelming stress during the first year after graduation was related to the influence of educational socialization, self-expectations, and perceptions of the expectations of nursing management. This study was conducted on baccalaureate nurse graduates, who experienced resentment from other staff who were not baccalaureate-prepared. Universal factors identified as adding to the stress are: pressure to conform to routines on the unit, inadequate staffing, and delegation to unlicensed health care workers such as orderlies and auxiliary nurses. Eight of the ten nurses Kelly studied left nursing in the hospital, and moved on to different employment.

Summary

The complexity of the health care system is increasing and the role of the nurse is changing. The roots of the nursing profession in Canada help to explain some of today's issues. Nursing, an overwhelmingly female profession, is struggling to achieve professional autonomy. At the same time, individual nurses are attempting to establish autonomy in their own practices. Responsibility rests with nurse educators to facilitate autonomy. However, nursing education, at times authoritarian and rigid, does not promote autonomy. The socialization of nursing students into the profession of nursing may be incomplete, as entry into the practice environment often overwhelms novice nurses.

How to prepare nursing students to function in our health care system is a concern for nurse educators. This study proposes to explore how novice nurses experience their first few months of practice. Their perceptions may contribute to educators understanding how to ameliorate their integration into the profession. The next section will discuss the theoretical framework chosen for the research. It examines how a move from behaviourism to humanism in nursing education may help educators encourage students to mature into autonomous professionals.

Chapter Two

Theoretical Framework

Traditional Nursing Education Philosophy

Nursing education in Quebec was carried out in hospitals until 1970. One nursing instructor who had been educated in the hospital described her education thus: "There were many strict rules and regulations – length of uniform, little or no private life. All nursing care techniques were standardized, heaven help the innovator!" (Miller, 1977, pg. 57). Some nurses had internalized this approach to education: "Yes, there were rules and regulations which dictated a strict code of behaviour, but we were young and the rules helped us to mature into well-disciplined persons" (Miller, 1977, pg. 57). These quotes describe an educational style that was authoritarian, a good example of the "banking method" of education. In 1974 Freire described a style of teaching in which the teacher makes deposits of information into the students' minds. The teacher talks and the students memorize - an exercise in domination. There is no room in this style of education for discussion or dialogue as the teacher's word is absolute.

Nursing education in the 21st century remains, at times, oppressive and authoritarian. It is still possible to find learning environments in which students feel vulnerable and anxious (Brophy, 2000; McGregor, 2005; Pierson, 2003). Some studies have reported nursing students' complaints of being abused by their teachers (McGregor, 2005).

Behaviorism in Nursing Education

In Quebec, the Ministry of Education and the Order of Nurses have imposed a competency-based style of pedagogy on nursing schools. This is not an uncommon

philosophy for nursing education (Ironside, 2005). Competency-based education is one practice that can be traced to behaviourism, particularly in vocational training (Elias & Merriam, 2005). It can be found in the curricula of schools, colleges and universities. It can also be found in professional associations, government training programs and industry. Peruniak (1998) describes competency-based education as infused with an aura of accountability, very reassuring in these neo-liberal times.

This approach to education involves identifying behaviourally stated competencies - knowledge, skills or behaviours - by analyzing the role of the worker. Criteria for assessing the competencies are then determined. The student's behaviour is observed as the primary source of evidence that indicates the criteria are met, and proof is sought that the student has the appropriate knowledge. Peruniak (1998) describes the advantages to this type of evaluation of learning: a) it allows for individual differences in skill or knowledge at the beginning of the instruction; b) flexibility in the length of time for mastery of skills; c) different learning strategies can be used to master the competencies; and d) being evaluated in this way may seem non-threatening. The process bears some similarity to the time-and-motion studies carried out during the Industrial Revolution.

While it may appear attractive to use this kind of evaluation to evaluate nursing competencies, there are drawbacks. The requisite skills for nurses are not so easily defined. Nurses practice in a great variety of settings, requiring different skills in each specialty. The nurse who works in the operating room needs different technical skills from the nurse practicing in the palliative care unit. At first glance, the perioperative nurse appears to need only to be able to count the number of instruments and sponges on

the sterile field, but she also needs to be able to comfort the extremely anxious patient awaiting surgery. The palliative care nurse needs psychomotor skills to program the electronic pump delivering pain relief, knowledge about the signs of respiratory depression related to narcotic use, and psychosocial skill to comfort a grieving family. The core of nursing education is to help students develop the ability to apply knowledge from nursing and other disciplines in making independent decisions in nursing practice (Valiga, cited in Evans & Bendel, 2004). Not all skills and knowledge can be reduced to competencies.

Humanistic Education

Humanistic education is concerned with autonomy, freedom and the participation of the student in the construction of knowledge. Humanism shares certain themes with existentialism. In particular are the tenets that humans are responsible for their own choices, and that human relations are the most important part of life (Elias & Merriam, 2005). These themes have been a major influence on the humanistic philosophical approach to education. Patterson (cited in Elias & Merriam, 2005) states the purpose of education is to develop the whole potential of humans. In Patterson's view, the way in which to do this is the development of a good relationship between teacher and student.

Humanist psychologists have had an important influence on humanist education. In particular, Carl Rogers and Abraham Mazlow articulated similar ideas about the ultimate goal of education, seeing this as the development of humans to their full potential. Mazlow coined the term self-actualization while Rogers described the fully functioning individual (Elias & Merriam, 2005). The notion that education must be student-centered was critical to Rogers. This means not merely allowing for learning

styles and needs, but actually considering the student as the starting point of education. The teacher is viewed as a facilitator and partner in the learning process. The subject matter is not the end, but rather the means by which to cultivate the self, and grow towards self-actualization (Scott, 1998).

Rogers (1969) refuted the behaviorist view that behaviour is caused outside the individual and that change takes place in response to an external stimulus. He believed a person chooses to change their behaviour. It is this freedom to choose and the commitment to change that will lead to change. Rogers suggested a pedagogical approach built on the premise that students have the potential and desire to learn, if a facilitating environment is provided (Rogers, 1969). Learning, or constructive personality change, is fostered by a second person who is empathetic, congruent and values the learner (Aspey & Roebuck, 1975). Research in the United States and in Germany suggests that students will learn more and behave better when taught with understanding, caring and genuineness (Aspey & Roebuck, cited in Rogers, 1983).

Humanism in Nursing Education

Nurses are an integral part of the interdisciplinary health care team, and as such, need to function autonomously. Rather than relying on formulated care plans and techniques, they must have the requisite knowledge base to be able to adapt care to individual patient needs. It is difficult to see how one would develop such skills and confidence in a traditional, hierarchical system.

The fourth Educational Conference of the National League for Nursing in 1987 unanimously proposed to transform curricula from a training model to one that would educate caring health professionals (Goldenberg & Deitrich, 2002). Since then, there has

been a call for a more humanistic approach to nursing education (Diekelmann, 1990; Diekelmann, 2002; Severtsen & Evans, 2000; Tiller, 1999). Playle (1995) noted a shift towards humanism in both nursing practice and nurse education since 1975. Student-centered education is deemed appropriate in the current trends of holistic practice and professional autonomy. Playle contends that autonomous practitioners will develop from autonomous students. Such students are those who are allowed to play a major role in what and how they will learn.

Summary

Until the 1970s, the pedagogy for nursing education was mainly authoritarian. Over the last few decades, the pedagogical style has been behaviorist, focusing on learning outcomes and objectives. Neither of these styles has been shown to encourage higher order thinking. The pedagogical style of Carl Rogers, who used a humanistic approach to teaching and education, has been shown to encourage learning. Within nursing education humanism is emerging as a guiding philosophy.

Chapter One set the context of nursing in a historical and contemporary perspective and the need for autonomy in nursing. Chapter Two examined current nursing education philosophy, and advocated humanism as an approach to fostering autonomy. Chapter Three will describe the methodology of this study.

Chapter Three

Research Methodology

Methodology

Qualitative research has been described as an umbrella term that refers to several research strategies sharing similar characteristics (Bogdan & Biklen, 1998). When planning a qualitative research study, research questions are formulated to investigate topics or issues in all their complexity, and the researcher is concerned with understanding behaviour from the participants' frame of reference. Research methodology is chosen based on the match to the particular problem the study addresses (Pierson, 2003). This particular study is an exploratory one. The goal was to understand the experiences and the perceptions of the novice nurses from their own perspective, in a specified setting.

Setting

Although there are three English-language CEGEPS in the Montreal region, interviews were conducted on graduates of a single college. This was partly due to the small sample size (seven participants). The other reason for this decision was because the colleges have set up their programs very differently, with only one of the three colleges using an internship model for the final semester. Graduates of the college using the internship model were interviewed. This college will be named the Urban College. It is a large CEGEP, with students of many different cultures, race and mother tongues.

Ethics Approval

The research proposal was submitted to the Human Research Ethics Committee of Urban College. The committee chair concluded that because the study was to take place

after the students had graduated, it was not necessary to gain approval of the committee, and the request could be made directly to the Nursing Department (Appendix A). This was done, and permission was granted. Each participant was given a consent form to sign before the interview commenced, and also received a copy to keep (Appendix B).

Sampling

I met with the graduating class shortly before the end of the semester, in May 2006. I explained the purpose of the study, along with the method to be used for data collection. At this time, 41 of the 57 graduating students were present. Twenty-three of them agreed to be contacted in the fall of 2006, and supplied me with their names and contact information.

Because the sample size was to be small, purposeful sampling was used to select the participants. There were 10 teachers of the graduating class, including myself. Each teacher had taught about 15 members of the class in the clinical setting. In a team meeting, I circulated a list of the entire graduating class, not indicating who had agreed to be contacted. I explained that I was looking for participants who had shown good reflection about their practice and learning when they were students, and who might be able to articulate well their feelings about their experiences. I asked the other teachers to note which students they thought would be able to do this if interviewed. Thirteen of the 23 who had given permission to be contacted were singled out as being potentially appropriate candidates.

Potential participants were contacted beginning in late September of 2006. Interestingly enough, all participants contacted agreed to be interviewed, although there were two participants who did not come to the interview after agreeing to do so. Most

had been working since the beginning of June, with one having started in July. Seven participants were interviewed between October and November of 2006. Even with the small sample size, there was a wide range of settings of employment and experiences.

The last participant I interviewed had not been singled out by the third year teachers as having demonstrated good reflection, or as having the ability to articulate well. She was included because she was working in a French hospital off the island, and I thought her perspective might be interesting.

Method

The method used to gather data was interviewing. Semi-structured interviews were conducted with participants. The interviews were very loosely structured in order to encourage the informant to reflect, expand upon and verbalize her/his perceptions. Participants were encouraged to discuss how well they were prepared to practice nursing upon graduation. Did they feel they were lacking skill in procedures? If so, was that problematic? Did they know what autonomy meant, and did they feel their teachers had encouraged their autonomy? The interview questions were tested on a participant who had graduated from a different CEGEP in Montreal. The data from this interview is not included in the research findings.

Interviews with participants were semi-structured. I had the list of questions before me during each interview. Some of the questions were modified as the research was conducted, based on data collected in early interviews. Five participants were interviewed in my office at Urban College, and two chose to be interviewed in their homes. The interviews were tape recorded, and lasted between 45 and 90 minutes. I transcribed each interview personally, as soon as possible after the interview took place.

Role of the Researcher

I graduated from a CEGEP nursing program in 1976, but not from Urban College. In the ensuing years, I worked in many different places. I accumulated 23 years experience as a nurse and nurse manager in four Montreal hospitals, never working for more than five years in one unit. For the past three years I have taught at Urban College.

I therefore bring a unique perspective to this research. Because I have worked in many different units, I personally know, or know about, the hospitals and units the participants are working in. I know the managers, the physicians, and something of the different cultures the students described. I know the working conditions and the problems in the system. Before beginning this research, I did not expect to be so personally involved. Upon transcription of the interviews, I found that as the novice nurses described their experiences and perceptions, I had not restricted myself to just posing the questions and listening to the participants. I understood what they were saying and was able to sum it up. Very often the participant would say something and when I responded, the participant would say "Exactly!"

As well, I had been the clinical teacher of one of the participants. I found that this interview unfolded more like a conversation. This was a student I had come to know fairly well, and we were comfortable talking to each other. In this interview it seemed the participant and I were constructing knowledge together.

In a discussion of the participant/observer continuum, Bogdan and Biklan (1998) state there is a spectrum of how involved the researcher can be. This role ranges from that of a complete observer, to having total involvement at the site. Bodgan and Biklan suggest the amount of participation depends on the researcher, on one's values and

personality. During the data gathering process, my role was a more active one because of my background. An outsider who had no experience working as a nurse in these hospitals would not have had the same type of understanding of the settings in which the participants worked. Hatch (2002) writes that some researchers think of their participants as co-constructors of the knowledge generated, and may encourage the participants in collaborative relationships.

Data Analysis

After each interview was transcribed, it was re-read for accuracy. This was also a means of becoming very familiar with the data. Once all the interviews were complete, the data was analyzed for common themes. Five different themes were identified from the data: a) orientation; b) on my own: beginning to practice; c) the real world: working conditions; d) autonomy; and e) being prepared: education. Most of the themes were constant across the seven interviews, although other themes were evident in only two or three of the interviews.

Limitations of the Study

There is much debate about how to ensure rigour when conducting qualitative research in nursing or nursing education (Chiovitti & Piran, 2003; Horsburgh, 2003; Rolf, 2006; Tobin & Begley, 2004).

For example, Rolfe argues "there is no unified body of theory, methodology or method that can collectively be described as qualitative research" (2006, p. 305). He suggests judgements about the quality of the research, and the responsibility for research appraisal lie with the reader, rather than the writer of the report. Judgements can only be made about the way in which research is presented rather than on the research itself.

Horsburgh (2003) takes the opposite view. She agrees qualitative research cannot be evaluated by the same criteria used on quantitative research. She posits a formalized framework for the appraisal of qualitative research.

In this context of uncertainty, I will explain the attempts I have made to address issues of rigour in this study. I conducted a thorough literature review looking at pertinent issues in nursing education before beginning the interviews. I drew up the questions and tested them by interviewing a graduate from another CEGEP to see if the questions elicited information about the issue being researched. The sample was purposeful, and I solicited the opinion of my fellow faculty members before selecting novice nurses to interview. The faculty members did not know which participants had agreed to be contacted.

I transcribed the interviews myself and became very familiar with the participants' stories before examining them for common themes. The voices of the participants are used to illustrate the various themes coming from the data. After describing the findings, I checked back with the participants to see if they agreed with my conclusions about their own contributions. The data and conclusions were read by two colleagues, a former nurse manager and a retired nursing teacher. And lastly, I have described my own role and positionality before telling the stories.

Summary

This chapter has described the methodology of the study. The goal was to understand the experiences and the perceptions of the novice nurses from their own perspectives. An exploratory, qualitative study was designed to do so. Participants were recruited from a single English-language CEGEP in Montreal, from the graduating class

of 2006. I interviewed seven participants, most of who had been designated as articulate and as demonstrating good reflection when they were students. The data was then examined for common themes. The issue of rigor in qualitative research was discussed. Chapter Four looks at the research data – the stories of the novice nurses.

Chapter Four

The Stories

Introduction

The research data is found in the stories of the participants. It is by listening to their stories that one can understand their experiences and perceptions, and how the research questions are addressed. The stories of five of the seven participants will be presented. Four were chosen because they are representative of the experiences of the others. The last was included because this novice was hired onto an Intensive Care Unit, and her perspectives on autonomy, in particular, are noteworthy.

Two stories have been excluded from the data. This was partly because I thought I would rather give five full stories than seven shorter ones. One novice's story was left out because of difficulties with the taping during the interview. The other was the student who had not been singled out as being reflective and articulate. The interview with her added very little in the way of rich data.

Common themes will be addressed in Chapter Five. The names of the participants have been altered.

Data Presentation

The purpose of this thesis is to understand if novice nurses feel their nursing education at Urban College prepared them to begin working upon graduation, and whether autonomy had been encouraged by their teachers. This data was collected through interviewing. The stories of the participants are told here in Chapter Four. The purpose in keeping a detailed presentation of the stories in the body of the thesis is to give the reader a taste of the data. The stories presented are not the raw data, but rather

excerpts with comments by the author, who attempted to make some meaning from the stories.

The findings, or themes that came out of these stories, are discussed in Chapter Five. Not all interviews yielded rich data on all the themes. If the reader should choose not to read each story in its entirety, the table below indicates which novice's perspectives on each theme are elaborated upon in Chapter Four. Alternately, the reader can look at Chapter Five for the discussion of common themes.

	Sandra	Nadia	Annie	Kate	Julia
Orientation	√		√	√	√
On My Own: Beginning to Practice Overwhelmed	√	√	√	√	√
The Real World: Working Conditions	√		√	√	√
Integrating					√
Knowledge base					√
Autonomy		√	√		√
Being Prepared: Education	√	√	√	√	√

Sandra

Sandra was one of the younger novice nurses interviewed. She was 21 when she graduated. She had studied commerce for a while before realizing she was not really interested in this field. She met with an academic advisor and decided to try nursing. Although her mother tongue is French, she came to Urban College to perfect her English, with an eye towards traveling after graduation.

Orientation

Sandra was hired onto the unit she had done her externship on, a medical unit. She received a four-week orientation. She felt it went well because she knew the unit, and because she had the same two nurses for the entire orientation period:

> They saw my growing, so it helped a lot. And also I was followed by the nurse educator from my unit. I was meeting her every week, to talk about patient cases or any questions, concerns, watch videos, do procedures I had difficulty with. So it was a good [orientation]. Yeah. Definitely. Compared to some of my friends. I've heard stories, like four days, five days. Oh yeah!

Sandra's orientation was supposed to be six weeks, but it was shortened because she was doing well, and because of staff shortages as the summer vacations approached.

On My Own

Beginning to practice

When she was scheduled to work on her own after four weeks, Sandra felt she was ready, though still a little nervous:

> The night before, I didn't sleep. I mean, I slept, because at some point, I just got tired. But...I was anxious. I was like "Tomorrow, it's me, and only me". Even if I could get help, it's me. So I was anxious....I was there at 7 o'clock to make sure I got organized. I like to be well organized and it helps me with my work. But I was anxious...but I felt as ready as I could.

For Sandra, being on her own was the most difficult aspect of her new career. She said the most problematic thing for her was "transition from being a student, to being alone...being just me, with my patients. Not having the teacher."

Sandra felt she had a good relationship with members of the nursing team. This translated into good support from the other nurses during the first few months, which helped her to feel confident.

> Since I was there a year before, there was a relationship that built, you know. Some of them I still go ask until this day "This, I'm not sure about. This order, does it make sense to you?" And they say no, and so I say "OK, let me go and see the doctor now". But yeah, definitely. I still feel I can go and talk to them.

Feeling that the more experienced team members were open to helping them helped keep the anxiety from being overpowering.

Overwhelmed

Sandra initially told me that she did not feel overwhelmed when she first began to work. Later in the interview she did describe being overwhelmed at times with the expectations placed upon her:

> And sometimes because we're fresh, they think we can take more...do extra shifts or take extra patients. If we all have five patients, and there's an admission, they'll give it to us. So far, I've been able to deal with it. I'm like "No, I can't take an admission. I'm sorry. I'm already overwhelmed with what's happening with my patients right now. I can't." But they expect because I'm a fresh, new graduate four months ago: "Come on, you can do it!" They overestimate.

She felt the nurses expected that because the novices were new to the difficult working conditions, they would be able to accept a heavier workload. This led to her experiencing feelings of being overwhelmed.

The Real World

Sandra also talked about what she called "the real life", the working conditions on the unit. Although she had an idea what it would be like before beginning to work, she was not prepared for it:

> You have seven patients sometimes. This is what I found the hardest. Sometimes having a patient load that is unacceptable....But that's the real life, and in school we're not taught this, because it's not what's supposed to happen, so they don't tell us about those kinds of things. You have one, two, three or four in the internship. Four is the max. And that was perfect....And also having to deal with people calling in sick....Somebody calls in sick, can you stay an extra 4 hours? Oh, and tomorrow we're short....So this is something that all graduates learn as they are working: Oh, it's not just about me. It's a team....[The teachers should] tell us: "Sometimes you'll be short". We do have a class in that, but it's briefly touched on. And telling us, you have to stay over. Like, yeah, yeah, don't talk to me. I'm not going to stay over. But when you're actually in that situation, you're like: Oh, now I see why...It's the real, real life.

The working conditions could be difficult, something she knew ahead of time, but didn't really think about before finding herself in the situation. Even though there had been a class about working conditions and preventing burnout, she was not prepared for the reality. When asked if the teachers at Urban College should have stressed this more in the program, she replied "I think maybe it would help, but how to prepare us for that?"

Education

When asked, she said she felt that her education at Urban College had prepared her to begin working as a nurse.

> Definitely. I mean, the knowledge base that we did get was very good, but now that I look back...we had no clue what it was about, because we didn't understand it like we do now....I wish I could go back and do it again....It's a three year program, so we try to learn as much as we can, but there's so much to learn and to understand. So I feel that often, we did get a good education, with the main diseases and everything. But sometimes I feel I wish I could go back to get more in-depth into it...like hypertension: What's that? There's so many things you didn't know, it built itself, as I got to know more. And now, I know a lot, but not everything. [laughs]

In the above passage she describes how students at the beginning of the program are often so unfamiliar with the material being taught, that they "had no clue what it was about".

Sandra did not really understand the use of the nursing model. "It wasn't needed in terms of learning by heart, all those terms... All that memorization, but the process itself was...It's just having to learn data, all those words...but I guess we have to use a model."

The clinical teachers who helped her most were those who questioned students about their knowledge, about their patients and how they had planned to care for that patient:

> She would come and ask me: "Tell me what will you do for the patient today. What are the main important things you're going to look at, what are you going to ask him?" So this made me look at my patient as a whole. Because it's difficult, when we've been looking at parts of [different systems] separately, to incorporate them all together. This took me a while...[but then] I was like "Yes!" You know all of this comes together, because they all affect each other. *Oh my gosh*, you know! [laughs]

It seems likely the combination of the teacher's questions and the fact that she was advancing through the program that led to the moment of realization when things clicked into place. Third year students frequently say their first year was a big blur.

Sandra described one kind of teaching style of clinical teachers, one that seemed to be what most students preferred:

> Give us some space. You know, you go do, and come back and report off to me. Or if it's your first time doing a procedure, "I'll come with you and assess how you're doing it. I'm giving you feedback, and next time, depending on how it went, I'll let you go alone." Because this is how we feel more independent. And that's what the real world is like. You know, there's no teacher to say: "So, let's go and do it together"... While others were just: "Well, you go and do it." There were no questions, no feedback. I guess there was a lot of trust, which was good.

> She trusted her students, but I know personally that some of my colleagues didn't do all the work.

In the above passage, Sandra relates how most students feel. They want the teacher to be available, but not constantly looking over their shoulders. They do realize that the teacher's questions and feedback are invaluable in their progress, and most of them prefer teachers who are more involved in guiding the student during the clinical day.

Technical skills

When discussing technical skills, Sandra talked about how she had evolved during the three years of the nursing program:

> I felt like...most of us, nurses, we always want to do stuff. Doing, doing, doing for, doing for. And that's why we're in nursing, part of it. But I guess that when you're a student, you want to learn skills, because that's what you think nursing is all about. You want to, like "Oh, a dressing today, yea! A packing, yea!" But then, when I went into third year and we incorporated critical thinking, that's when I saw that patients' families do dressings for them, and that's not a big deal. To assess the dressing, what needs to be in it, the condition, *that's* what's important.

Sandra realized that while nurses need to be able to perform technical skills, they must also have a good knowledge base. It's interesting that Sandra had picked up the teachers' language, and mentioned critical thinking as a concept that was introduced to the students and something they could learn to do.

Summary

Sandra's first months as a nurse were satisfying to her. She was helped during this period by the fact that she had worked the previous summer as an extern, and so she knew the unit and the nursing team. She also received what she felt was a good orientation, with the same two preceptors. Even though the orientation was shortened by two weeks, she still felt fairly comfortable working on her own in "the real life". Support

from the team was present, and though the working conditions were difficult at times, she was enjoying her work. She felt proud that she was able to meet the expectations of the staff.

When discussing her education, she felt the teachers at Urban Collage had done a good job preparing her. There were several areas which she felt were not stressed enough, or she didn't really understand the significance of the subject matter. She did not seem to attribute this to oversight on the part of the teachers. Examples of this are the working conditions and much of the subject matter in the first year.

Nadia

Before changing career tracks, Nadia had completed a CEGEP diploma in Science and had started an undergraduate degree planning to become a research scientist. Realizing she wanted to "work with the public", she applied to nursing. She chose not to go directly into a baccalaureate nursing program, though she could have with her diploma in science. She wanted to go into the clinical setting early, so she would be sure of her choice. She was 25 years old when she graduated.

Orientation

Nadia was hired on a surgical unit, specializing in cardiovascular and thoracic surgery. She had worked on the unit as an extern and she chose it partly because of the working conditions. There were permanent night nurses, so she had no shift work. The floor was very well organized, with a lot of experienced nurses, and no staff shortages. She loved the busy pace on the floor. Her orientation was shortened to four weeks from six because she had been an extern on the unit. Nadia felt her orientation had gone very smoothly. "Oh, it was great. The nurse I had worked with last summer did my orientation, and she's great."

On My Own

Even though she had been an extern on the unit, and the orientation went very well, Nadia was still a little nervous when she started working without a preceptor:

> Well, I don't want to say it was overwhelming, but it was a bit scary. I mean, throughout school, you always have your teacher with you, maybe not right there with you, but you know she's there if you need her. I mean, she's watching you, or at least checking up on you [laughing], but you're not alone. And then in the externship you work with a nurse. And in the orientation, she's [the nurse] there as well. She lets you do everything, as much as possible, but she's there. But when you're on your own, you know, it just seems like a lot more...responsibility.

In describing how she coped with the responsibility, she said "I was still checking to see if other people thought the same thing as me, you know: 'This is what I'm thinking, what do you think?' That kind of thing."

She felt she was ready to work on her own after her four-week orientation. In the following passage she again talks about checking in with her preceptor or another nurse to validate her perception:

> It was time to stop having someone look over my shoulder. It was nice to have her there, everything was a little simpler, you know.... But after a while, it wasn't advancing my learning so much as keeping it where it was. Because I always had her to fall back on. Even for the first couple of weeks after orientation, when I was on my own, I still felt that I was looking back at her, or somebody else....I still sometimes look for that validation that what I'm doing is OK....I'm trying to get away from it.... It's four months of it, and I think I need to do it alone.

After four months of working, Nadia was ready to try to make decisions on her own, without validating or checking in with someone.

Autonomy

Nadia felt the teachers at Urban College had encouraged her to practice autonomy. She described a situation which made it clear she was already beginning to function autonomously. The unit she worked on specialized in cardiac and thoracic surgery. The resident doctors would spend most of the day in the operating room, only coming up to the unit between cases. This usually meant they made rounds very early in the morning, about 6:30 a.m., and then disappeared until noon. Nadia talked about one incident:

> I had my patient who was not doing so hot. And like, there was not something you could put your finger on it, but...you could just tell he wasn't doing well....And I got the [resident] doctor involved....I told him "Go see him. Listen to his lungs. He's not doing well". So he did like a quick little listen...and he says "No, no. It's wheezing. Just give him Ventolin." And I'm like "Listen!" And he's like "No, no." And I'm like "Can you at least order a chest X-ray?" So he

> did...but then he walked off the floor, and my patient wasn't doing well, and he's like "No, don't worry about it" when I called him. So I went over his head, and I went to my assistant head nurse...and said "Listen, there's something wrong with him. I want someone involved"....She went in and looked at him, and she goes "Yeah, I think you're right". So she called in the Thoracic guy to look at the chest X-ray for the cardiac surgeons. And he had a pneumothorax....He had a pleural effusion; he had all kinds of stuff going on.... They had to put a chest tube at the bedside. They had to rush him down to ICU. That's how bad he was.

Here Nadia demonstrated a level of competency far beyond what would be expected from a novice nurse. The patient was very ill, with serious complications, and the resident doctor did not see it. Instead of letting it go, she insisted he order a chest X-ray. When the doctor refused to do anything, she spoke to the assistant head nurse, who agreed with Nadia and called in another doctor. This is an example of the craft knowledge embedded in nursing expertise described by Benner (2001).

When I pointed out to Nadia that it seemed that she was already performing autonomously, she said:

> Mind you, he didn't get mad that I went over his head....He has more experience than I do, and I'm still only a few months in. But there was something wrong. I've had enough thoracic and cardiac patients to know there was something wrong.

I asked if she felt vindicated when the second doctor diagnosed a very serious complication. She said "Yeah, I was happy, because it made me feel like 'You know what? I can do this!' His case actually made me feel like I can do this. Like I don't have to ask everyone if I'm doing OK."

Yet when I asked Nadia what the biggest difficulty for had been during her first few months, she responded:

> It was just making decisions without having someone there to...just not having someone to bounce the idea off of. To validate...that was really my *big* issue. Like and to this point, I still have to catch myself not constantly being "Well, OK. I'm doing this."

While Nadia's first few months went so well, she still felt a need to check with others, to make sure she was right before making a decision.

Education

Nadia felt, even though she was on a specialized unit, that her education had more or less prepared her for working. "Well...it's a specialty floor, so there were a lot of things I didn't know. I kept having to go back to the books to look things up. But that's understandable. There's no way they can teach you everything." She felt the clinical rotations, in particular prepared her for work:

> It started right at the beginning. I had a great teacher....She's very nice, but you've got to know your stuff....You have to come to the hospital prepared, know your medications, have researched the disease your patients have, you know. She was nice, but tough. And then in Geriatrics, I had [a teacher who was] tough. But I do well in that sort of environment. If I'm challenged, I strive to do better.

Nadia knew what kind of learning environment was best for her. She took pride in doing well in the hospital setting. She appreciated having third year teachers who encouraged her growing independence.

> A hands-off approach was great in third year....She was there in the morning, and she'd quiz you in the morning before you went onto the floor about all your patients, but then when you were on floor...she was never behind me, staring at what I was doing....If I needed help she was there. A lot of the time she would be there with the weaker students....I didn't feel her presence staring at me, kind of concept. Which was nice, and prepared me for the internship. Because there was nobody there in internship really.

Nadia was another participant who did not really understand why it was necessary to learn a nursing model:

> Oh, I hated nursing process! I forgot about that. I erased it from my memory, actually. I didn't, I wasn't good with nursing process... I just...it was like random words that we were shoving into a little diagram. And I know like, there's a reason behind it, and blah, blah, blah. But it just didn't kind of...I don't know how to... a lot of it just seemed like common sense. So I couldn't quite grasp why

> they were making such a big to-do about it. And you had to memorize their words, the words associated with that model.

Summary

Of all the participants in the study, Nadia had the smoothest transition from student to novice. She was fortunate in that the working conditions were good, and her orientation went well. She had done well as a student, and took great pride in her work.

Nadia described a situation in which she had shown a great deal of autonomy. Although she said her greatest problem had been coping with the responsibility of working on her own, she demonstrated that she was capable of making accurate assessments, and could trust her own judgment. Nadia felt that her education had prepared her well to enter her practice, and gave much credit to clinical teachers who challenged her.

Annie

Annie had originally studied Exercise Science, but working with handicapped children had made her realize she wanted to become a nurse instead. She was 24 when she graduated, and had been hired on a postpartum unit, caring for mothers and babies after delivery.

Orientation

Annie had her full six-week orientation, but felt she missed out because she had several different preceptors over the six weeks:

> No, I was very unlucky. I was supposed to be assigned one particular individual....The entire time I was in my rotation, they were short....So I had maybe five different people throughout the six weeks. So that made it very difficult.

In Annie's case, short staffing led to a less than ideal orientation. She tried to talk to the head nurse about the situation, but things did not improve. She was fairly philosophical about it:

> Yeah, it was a very frustrating experience...And they didn't know me, so they have to start fresh, so that they can see OK, do this....Yeah, they had to see for themselves. "Can I trust this person?" Which makes sense. But at the same time, I was missing out. Whereas other people, the majority of the time they had the same person. It's hard in the summertime when everybody's on vacation....So, it happens. In the end, it's OK. I'm doing fine now, but the beginning was rocky.

Although she wasn't happy about her orientation, she was able to accept it, and to get on with her practice.

On My Own

When she started to work on her own, Annie felt nervous, like most of the other novices.

> I was nervous. Very nervous. It was like: It's for real; I don't have a teacher hovering around me, coming behind me saying "You didn't do that". [laughs] So

> I had to learn to trust myself and to have confidence in myself. Which at first, was like: Oh! You question: Can I do it? Especially with the inconsistency in the orientation. I think the transition would have been easier if I had a full six weeks with one person...It took me another couple of weeks on my own and I wasn't afraid to ask questions.

She quickly developed the confidence she needed to work with nobody directly supervising her:

> I was chasing anyone that I knew was more senior, hounding them with questions, as much as I could. Now I feel comfortable. But it took a couple of weeks before I felt really sure of myself. Even now, you still run into things you don't know. But that's expected. There's always the situation where I say to myself "Well, I haven't seen this before."

Annie received support from the other nurses on the unit, which helped her through the first few weeks after orientation:

> But after a couple of shifts on my own, I was OK. And all the other nurses were saying "How's it going? Do you need any help?" They were very supportive in reaching out ...they were very good at following up with us. "Do you guys need anything?"....There was a little umbrella there for us.

She seems to have made the transition from student to novice nurse quite smoothly in the end, despite the poor orientation she had.

The Real World

Annie found that being a nurse was more difficult than she had anticipated. She described it as being in the real world:

> I'm finding out how hard it is to be a nurse....I was very naïve, and "I love nursing". I *love* nursing and I know it's the job that I want to do. But you see how the system is poorly set up and it makes it difficult for you to do your job properly....*So* many people call in sick. It's a vicious cycle.

The unit was often short-staffed, and Annie found the working conditions difficult. She said that this was the most difficult part of starting her new career:

> Getting used to schedules. [laughs] Honestly, the hours. I didn't realize what working full-time meant, as a nurse....Everybody's forced to do extra hours,

> everyone's called...for instance, I get called often at 5:45 in the morning....Who wants to be called then? You know, you're sleeping, or you weren't planning to work so you stayed out late, or they call you on your weekends off....It's hard to cope, I've noticed. It's a very demanding job, and I guess I was sort of in La La land, because even in the internship, by the end we've only had two patients. And when I go to work I have five or six or seven. If I'm working nights I have seven patients....I was not prepared for that....In the real world you realize how heavy it is, and how busy it is.

Annie had started a baccalaureate program in September, and so was working fewer shifts, which helped her cope.

Autonomy

Annie described her concept of autonomy: "Being able to independently think, critically assess things and on your own without having to go back and say 'I'm not sure about this'." She brought up a very interesting point here. She remembered what her biology teacher said: "The most important thing in your profession is knowing what you don't know." Annie said that was part of being autonomous, being comfortable enough to admit to yourself and to others that you don't know something.

She felt the teachers encouraged autonomy in the students, especially in the third year:

> Yeah, they really emphasized thinking for yourself. And *stop doing things* because the nurses are telling you to do it. Why are you doing it? Question everything! And this was really emphasized in the last year....It was something that they stressed – you *have* to think for yourselves. Don't be a robot.

Education

When asked about her education, Annie talked about things that teachers did that provoked anxiety in her when she was a student. Students do not like teachers criticizing them in front of patients, and it does happen from time to time:

> You need some happy medium, where you know they're checking up on you, and you know they're following up, yet they're not creating anxiety or saying things in

> front of your patient that will make you feel insecure about yourself. I only had one incident where that happened, but the teachers should be very careful not to say anything negative about the student, because the patients are very impressionable....You know, it just makes you feel very unsure of yourself.

There were teachers who were intimidating. Annie dreaded some days in the clinical setting: "I didn't sleep for one rotation. Every Wednesday night I did not sleep. By the Thursday night I was a little better, but the first night before, it was anxiety provoking."

Annie described one teacher who was frustrated with the students and did not act in a professional manner at times:

> But she would get up in arms with us, in front of the nurses, in front of everyone, *yelling* at the top of her lungs. And we'd be so like little puppies, retracting. But one-on-one she was fine; it was in the group she couldn't handle seven people constantly bombarding her with questions. And she admitted to another student this was too much for her.

When I asked if this teacher had just started teaching, Annie said that she was an experienced teacher. The students were even uncomfortable asking questions: "Things like that make it hard for the student to ask questions, to seek help when they need it. Because then they're like: 'She's going to yell at me, or ridicule me, or put me down'."

Annie said that she had several teachers who were able to strike a balance between being too "laid back" and being too tough:

> At the time I was probably like – Oh, I don't like this, it's too stressful. But looking back, it was those teachers that I learned the most with. The ones that were more on the fence, I didn't learn as much. I appreciate independence, but I also understand that for the first couple of weeks of your rotation, your teacher has to be there, they have to be on your back. They have to know what you're doing....They have to assess, like you said, that whether or not what you're doing is right....But also at one point you have to say "OK, fly! Go on your own. I will be here, checking, but you're doing it for yourself."

When asked if she thought her education had prepared her for practice, Annie credited the internship for helping her develop the confidence she needed:

> I think that the internship makes a big difference in the way you practice, because you have independence. Your teachers are not there, you do have your nurses obviously. You're working in tandem with them. I was in Oncology, and after the first month, the nurses there knew us, they trusted us. They knew that we would go to them if we were unsure of something. They had that confidence. They let us breathe, they let us learn....I think that really helps boost your confidence....You always know that you have that safety net. So when you're on your own you have to...you're doing all the critical thinking. You're thinking for yourself. You don't have somebody else saying "Hey, did you do this, this, this and this?"

In the above passage, Annie describes the teaching style she prefers.

Technical skills were not a problem for Annie during her training: "I worked on a surgical floor and we had plenty of dressings...and plenty of yucky dressings like vacs, and quite extensive wounds. So for that aspect, I've had a lot of practice with dressings, so I feel comfortable."

Summary

Annie talked quite a bit about teachers, and what teachers did that helped her learn. She also described situations in which her teachers acted in ways that made her feel anxious and stressed. She described the internship and the attitude of the teachers she had in her last year as helping her to become independent. These teachers fostered autonomy in the students.

She hadn't had a very good orientation, but overcame that obstacle. The working conditions were the aspect of her new career that caused her the most stress. The constant shortage of nurses and the pressure put on the staff to do extra shifts was difficult. However, it seems that Annie knows what she is and isn't capable of, and is able refuse to work when she has had enough.

Kate

Kate was slightly older than the other participants. She was 31 at the time of graduation. She had a degree in commerce, and had worked in marketing for several years. At some point she realized she didn't enjoy her job, and wanted to do something that "had some value to it". She chose nursing because she thought it suited her temperament.

Kate was hired on the unit she had done her internship on, a busy unit specializing in complex diseases and transplant surgery. She was a student in the first clinical group I had when I began to teach. I knew her as an excellent student who placed high demands on herself.

Orientation

When first contacted, she said she had "lots of stories to tell". Her first months had proved to be very difficult, and she was eager to talk about them. The orientation had not gone well. She said:

> I think I got shafted on that. Because I did my internship on that unit, and so I got hired from the internship. The training should have been six weeks with an option to extend it if I felt I wasn't prepared. I got two weeks....not because they were short staffed, but because the head nurse felt that [because] I had done my internship [on the unit] I was a lot more equipped and already oriented to the floor, more than a new [graduate]. And at the time, the thing is, I was so new, I didn't realize all the stuff I *didn't* know. I kind of trusted the fact that she knew what she was doing. So, I accepted that... It sounded reasonable to me. [laughs]

Nor did she work with the same nurse for the two-week orientation:

> I specifically asked that I be with *one nurse.* I requested a specific nurse...and she said "OK, no problem."...[I had] four nurses...in two weeks! Oh, it was terrible! It was terrible, terrible....Because it's ridiculous. You're starting over; you're not growing. You don't have that sense of continuity that you're supposed to have. And you're just not building on anything....I kept being reassured that "You'll get there; you'll get the right training. It'll be fine, it'll be fine."

On My Own

After finishing her orientation, she did not feel too apprehensive, trusting the head nurse's judgement:

> I felt "I'm going to have to start sometime." Also, that I'm never going to feel confident, like I'm never going to feel like Yes! I'm ready. And I figured you know what, you just have to jump in and just *do it* sometimes. And so I felt like, OK, you know what? Bring it on! We'll see what happens.

I asked how she felt the night before she was to work by herself. "Were you nervous, anxious, excited, overwhelmed?" Her response was:

> All of it! [laughing] Because I wanted...the thing is that, the way that I was taught in Urban College is really, really safe teaching.... I really appreciated having that foundation. I found it was *impossible* to do it in the day. It was *impossible* to do it. And I tried to, and that's where everything fell apart...Inside the first hour, I realized this is impossible....My *very first* day alone, I was mortified, mortified! It was the worst experience I've ever had!...Because I made all kinds of mistakes. I didn't sign off medications; I was late on *everything* I was doing.... And I felt like such a failure! Like "Oh, I'm such a screw-up!"

Kate really had a difficult time, probably due mostly to the short orientation period, and the lack of continuity as several nurses acted as preceptors during that period. I asked how she felt during this time, if she felt she was inadequate, or did she attribute her problems as being partly due to the poor orientation she had received:

> I felt that it probably had something to do with my training. But more than anything I felt that I was inadequate. That it was a real statement on how I could do the job. But I felt *really* bad, and I decided that, and this is the only way that I could keep going into work for the first few weeks, is that it was *going* to get better....But, I mean - really, it was humbling [laughs]. And it was really overwhelming.

I commiserated with Kate, and said that knowing she had been such a capable student, she must have felt terrible during this time. She responded:

> And that was another thing too....Going back to all of my teachers saying these things to me, and also going back to....When I worked in business, *I was good*! I know I'm a good worker....[But] this is the advantage that this floor has, talking

> to the other nurses. I got put on an amazing team. The nurses there were really, really supportive and really helpful. And it made all the difference.

She said she hadn't received support from the head nurse or the assistant head nurse, but that "The other nurses there, they would constantly tell me how good I was doing. I'm like 'Are you seeing what I'm seeing?'" [laughing].

Eventually she realized the unit itself is very disorganized. "This floor is special, and it's what all the nurses kept telling me, including the head nurse, and the assistant head nurse. This floor is *really, really* difficult, and it's a very disorganized floor. The floor is just chaos!"

The Real World

After five months on the job, Kate was only just beginning to feel comfortable. However, she found the working conditions to be very difficult. Because of staff shortages, the nurses often have a higher patient load than they should. The maximum on the day shift should be four patients per nurse. But often, the nurses each have six or seven patients. It takes a toll on the staff:

> I'm so tired. I feel as though I should be looking in my books and reviewing so much more. But at the end of the day, I'm so tired. I'm so tired, I can't. I can't. And then the days off, I mean, I want *my life*!

Even though she was only just beginning to feel comfortable in her role as a novice nurse when she was interviewed, Kate described a situation in which one can see she is already demonstrating autonomy. Kate described how she dealt with a difficult situation after she saw a nurse handle a patient roughly. She immediately said something to the nurse:

> I was like "*Nooo*." And I told her it was inappropriate. And I said she shouldn't be handling any patient, under any circumstances. And she tried to justify herself, kind of thing. She'd been nursing for 22 years. She said she knew how to handle

> this type of patients and not to worry, to me. And I said "No. Handling a patient is inappropriate." And I just left it at that. And I didn't pursue it on a higher level.

Education

In discussing education, and whether or not it had prepared her to work, Kate expressed a couple of different sentiments:

> Yes, in that I was told the right way to do things, and I think that should absolutely be the way that we're taught. Because when we start breaking the rules, we know where to go about breaking them, and also to really, what to pay attention to....However, I think in the last semester, there should have been no theory ....Yeah, just give me my practical, I mean really show me. Because that's what I felt clouded my internship. I had to study for things....And so, I think I would have benefited more from the last six months of my education being...getting used to being a nurse. Not a student nurse.... I mean, show me what I need to know, but don't have me competing for a grade and don't have me studying for that. Really help me *be a nurse*. Not be a student.

Kate was the only participant to suggest that she could have benefited more from the internship if she had not been responsible for learning on an academic level as well as consolidating her clinical practice. Because she struggled so much after her orientation was over, it is possible she attributed her difficulties to her education, and not to problems with the orientation.

When asked specifically what teachers did that helped or hindered her, she responded:

> I like that I was asked questions. Why are you doing this? What is this for? What's your priority? That kind of thing, because it's something that you need to really focus on and it's something that you do when you're nursing too....A lot of the clinical teachers did that. What wasn't helpful was really nitpicking....Your dressing has to be done at this point, and it can't be done later. You know, you have to sign your meds off like *this,* you know? I mean, *really*! That's not really the biggest priority. The biggest priority is making sure that your patients are taken care of, you're monitoring them, but I mean, in terms of signing off a medication this way? Not a huge deal.

It seems Kate is able to cope with ambiguity, looking at the larger picture. As a student, Kate showed very good initiative, and in my view, needed only minimal guidance. She did not appreciate teachers she felt were inflexible:

> One was just combative. She argued with how you drew up heparin, and said: "This isn't the way to do it." And I was asked by this one particular teacher what were the side effects of this medication, and I knew the primary side effects, but I didn't know some others. And I was made to feel that I should have known, and that I was unprepared to give this medication, because I didn't know some secondary effects....Actually, in that group, I was probably treated as one of the best students. So there were other students that were really, really picked on.

Kate thought the use of a nursing model had merit, but did not like the model followed by Urban College:

> The model is useless. I mean, it's just *useless*. To this day, I don't use [it].... I think that using a framework is absolutely necessary...I mean, if you're going to look at a patient, the way that I do it, and I haven't even learned it, I'm using systems."

Technical skills

Kate did not feel she would have benefited from more practice with technical skills during her education:

> At the time, I probably did. But when I started working, no. Because you have all that time. I mean what you taught us was maintain a sterile field, explain why that was important....Yeah, but that's why that last six months I was suggesting is so important, because that's when you really start to feel comfortable. But, no, no, the theory behind it is really important. And actually, we did learn a lot more skills than some of the other students coming out of [other schools].

One can see that Kate is contradicting herself somewhat. On one hand she thinks she would have benefited from a more intense clinical experience in her last semester. On the other, she feels she had enough time to practice technical skills. Most likely, what she was missing was the experience to organize her workload. It probably didn't help that the unit she works on is so chaotic that being organized is difficult.

Summary

Kate found her first few months of practice to be very difficult. A good student, she had not expected to feel so inadequate. Fortunately, she was able to recognize that her difficulties stemmed from an inadequate orientation, and a unit that was very disorganized. The nursing shortage on the unit left her feeling very tired, and at times, overwhelmed. She was another novice who described receiving much-needed support from her colleagues, which helped her get through this period.

She felt the academic background she received at Urban College prepared her for work, and that her technical skills were adequate. It was the business of becoming a nurse, the routines and what measures she had to take to get through the day, that she felt were lacking.

Julia

Julia was 25 years old, and had studied communication before entering nursing. She had worked for a telecommunications company in customer service and then as a caregiver. Julia had done her internship in the Intensive Care Unit (ICU), and was hired to work there when she graduated.

Orientation

Because nurses cannot work in an intensive care unit until they have passed their ONQ licensing exams, Julia worked in the step-down unit of the ICU. This is an area immediately adjacent to the ICU where patients who are not quite so acutely ill are cared for. The nurse patient ratio is not quite as high as in the ICU unit itself. She received six weeks of orientation:

> I have to say I was really disappointed with orientation. Because I was expecting more class time and theory than practical. I think they over emphasize the practical....I think maybe one time in the six weeks did I ever have time to crack open a book. To actually review a pathology, to have the book in front of me and to have the patient in front of me and to make linkages that way.

On My Own

At the end of her orientation, Julia felt relieved to be on her own, which is very different from the experiences of others.

> Oh, my God! I felt so much relief. I couldn't wait till it was over....By the fourth week, I thought it was so ridiculous....I felt there was not a clear-cut plan as to what my orientation should be, so different preceptors interpreted it differently. My preceptor thought: "Oh, she should be OK there, she should be comfortable, she should be fine. She shouldn't have any questions and we can leave her alone because she seems to be managing OK", which is *not* how I felt. And it was very difficult for me to communicate that. And so by week 4, I was pretty much relying on myself, and asking key people on the unit questions, not my preceptor. And so by the end of week 4, when my preceptor would criticize me or critique me, I wouldn't respond very well to it. And by the time I was finished, I was kind of doing stuff on my own anyways, and it was pointless to have a preceptor anymore.

Julia and her preceptor seemed to have different ideas about what the orientation should be like. The lack of clear objectives was part of the problem. It is interesting that Julia, who seemed to be fairly assertive in other areas of her practice, was not able to discuss this with the preceptor. She felt relieved when the orientation period was over, although later she described situations in which she felt overwhelmed.

Nurses in the ICU usually have both strong technical skills and a very good grasp of pathophysiology. Julia did not think the practical skills should have been stressed as much as they were during orientation. The nurse who was her preceptor was most likely concerned with Julia being able to function on her own as soon as possible. Julia felt she needed a stronger knowledge base. She did feel that the rest of the nurses expected a great deal from her, but not in regards to skill and technique.

> No, like knowledge, more knowledge. Nobody will every say "Oh Julia! She drew up that insulin and she fumbled". But they will say "Julia can't really explain diabetes. We have a problem"....So, I'd rather know my stuff, and I do, in certain respects, basic things that we learned in school. And I don't fumble when I draw up insulin. But to go into all the cardiology and respirology issues....But to go into that, really in detail, no I don't have that. And I was disappointed.

I commented that it usually took a year for a novice nurse to feel comfortable on a regular unit, and ICU is a difficult place to begin. Julia said she might have been placing high expectations on herself. "Nobody ever expressed it, that they were disappointed in my knowledge base, but I kind of felt it within myself. Because I do place very high expectations on myself, very high goals for myself."

Overwhelmed

At times Julia felt weighed down with responsibility. She doesn't say if she thinks it's because she's working in a critical care area:

> It's the amount of responsibility that's placed on the nurse's shoulders. I feel sometimes, if the patient does badly, it's your fault. If the patient does good, "Oh, we did such a good job! Oh, yeah!" Or you don't even hear that. You just hear: "OK where's the next patient?" But if you didn't do well, it's "Oh, Julia!" If there's a time that I feel overwhelmed, it's during the night. Because I feel like the staff on nights are not as forthcoming with information.

She goes on to describe an incident in which she was very upset about patient she was assigned, and thought she did not have the experience to take care of this patient.

> The other day I got a kidney transplant. And I was like "No way! Who's running the show here?" Because I was really mad, because I had never done a kidney transplant before. And I don't want to mess up this woman's new kidney, you know? I kept asking the assistant head nurse: "I don't think I'm doing this right." It's like "What's wrong, what's wrong?" And I couldn't explain what was wrong. I just needed her to come and validate me. For her to tell me...."Yes, you have to monitor her output, and replace whatever she's peeing out for the next hour." And I knew I was doing that right, but it was my *charting!* Like, where am I supposed to write this? And I got caught up in everything that was happening, and that was my *third patient*! So, I was kind of like "You guys, this is *really* not fun."

Julia rightly felt she had been given an assignment that was unrealistic for her at that point in her career. She was terrified of making a mistake that could result in the failure of the transplanted kidney. She thought she may have been given this assignment because she doesn't complain very often.

Integrating

Another area in which Julia was experiencing some difficulty was integrating into the team. The culture in the ICU was proving to be intimidating, even though she had done her internship in the unit.

> I work with a very particular set of nurses. I don't know if they're all like that in all ICUs, but they can be quite hostile...And me integrating means that I have also become a little hostile. And so we get along now. I'm developing that same hostility. [laughs]... Yes, they're very territorial people, and I'm becoming territorial too, and not afraid to disagree outwardly with a medical opinion....You have to be assertive. People will step all over you. We deal with many different services, they do many things at the bedside, and that's our territory. I mean, *we* have to be at the bedside.

During her nursing education, Julia never felt that she wasn't getting enough practice in technical skills. "One teacher didn't think I was very interested in doing skills at all, so she would kind of push me. 'Julia, just try to go do a dressing or something!' I have the rest of my life to do dressings." In the ICU, she would be performing technical skills very often, and this was a source of friction between Julia and her preceptor. Julia felt it was more important for her to understand what she was doing, and her preceptor wanted her to be good at what she was doing. However, the preceptor did not provide enough support when Julia was attempting to do something for the first time.

Knowledge base

Julia felt that she had to expand her knowledge base as much as she could, although this kind of understanding of pathophysiology and nursing science takes years to develop. She explained: "And I'm not really comforted by I won't be comfortable for a year, but I need to start learning something more concrete now. But they don't want to overwhelm you; I think they want you to take it slowly." Part of the reason for this is that all team members participate in rounds. She felt she had to keep up with the medical residents during rounds:

> Half the time, I'm like "Whatever the resident said, sure, yeah." "Sure, yeah, he got it right. I don't have to repeat it". Or they ask for report, and I'm missing some crucial element. I wouldn't even have thought of that. So, I almost feel like I'm just cheating.

None of the other participants seemed to think their knowledge base was a problem. Working in the ICU with people who were very experienced is most likely the reason Julia felt this way. In the Intensive Care Unit, there is an increased emphasis placed on

understanding exactly what is happening to the patient. Nurses follow this carefully so that decisions can be made about appropriate treatment methods.

Working conditions

Julia also did not feel the teachers could have done anything to help the students deal with the difficult working conditions and staff shortages.

> You know, you know it's going to happen, because you hear the nurses talking about it. But until it really happens....As a student you can't wait to work for overtime, because you need the money. But now, it's like: "Oh, I don't need the money as much anymore". But they're still asking you, and you feel bad....I do feel bad. Because it's always the same people that stay. And, I'm sure these are not poor, starving people that really need the extra money. They just feel obligated to help out. And I totally see myself becoming one of those people. I don't think there's ever been a time when they've called me on a weekend when I'm not supposed to work, and I say "No, I'm not going to come in". I'll say, OK, I'll come in for four hours, or something"....We're supposed to function with 17 nurses on a day shift, a healthy quota. I guess they can get away with 13. But the other day when we started, we had 11 people, and we did not close beds. And they had to close beds. I've never seen it that bad.

Julia had started a baccalaureate program in September, and was only working every second weekend. The staff shortages did not affect her very much because she could control how much extra time she worked. She did feel that she could easily become a nurse who was doing overtime whether she really wanted to or not.

Julia became frustrated because she felt the nurses were overworked. She stated: "When I leave work at the end of the day, I don't feel that I've been able to do all that I should have done." She said that nursing education had taught her the ideal circumstances, but that didn't happen very often. She experienced some anxiety due to this theory practice-gap. But she did say that she was proud to "know what I do know about my patients" and had no plans to leave the ICU for a while. This is another

example of Julia's emphasis on her knowledge base, part of being considered competent in the ICU.

Autonomy

Even though Julia was experiencing difficulty integrating, she had internalized some of the aspects of the ICU culture. Autonomy is a very strong part of this culture. Julia does not seem to realize she is struggling for autonomy. When asked if she can see herself functioning autonomously, she replied "No, not in my unit, no, no, no." Later on, she says:

> If they [the residents] don't respond appropriately, the staff [physician] will look to the nurse. If they see something happened, they don't turn to the resident; they'll be like "What? Julia, is that true?" [laughing]...I remember, it was funny because this is a staff who was married to one of my friends...and I had a patient with a GI [gastrointestinal] bleed, and I came on at 3:30 [p.m.]. And they had not taken a CBC [blood test] from him since early that morning. And so, I heard him telling the resident "You should never let the GI bleeds go 12 hours without taking any tests, and you have to do it every 4 [hours], or every 6, or whatever. We don't know, maybe he's completely exsanguinated!" Which he hadn't, but you never know. So I heard him talking, and I'm walking over, and he's like "So, Julia, why wasn't any blood taken?" I'm like "You know why! She didn't order it. And I just came on at 3:30 – it's 4 o'clock!"...And you have to get all defensive, and it's just awful sometimes. I don't know, I guess that's the real world.

Even at this early stage in her career Julia knows she will need to have a strong knowledge base to cope with responsibilities that working in the ICU entails. Not only are the nurses responsible for what is in their own scope of practice, but they are also pulled into keeping an eye on what the resident physicians are doing

Education

Students spend a good part of their first year learning about the nursing model the department has chosen. Julia felt much of what was studied during her first year was a

waste of time. When asked if she felt her education could have prepared her better for work, Julia replied:

> I don't think they needed a whole semester to teach us what they taught us in first semester. Yeah, Orem, I did not understand it in first semester. I think I only understood it in third year. Or in [second year], or something like that. Now, I have a greater understanding, but it was very foreign. That whole first year, I really wasn't understanding what they wanted us to know... because in first year, you're all so excited. Head in the clouds. I can't believe I got into nursing! Second year, you're a little bit more grounded.

This is something that third year students express frequently: the whole first year was a bit of a blur. Later on, Julia talks about the internship in the last semester:

> It could have been better. We could have reviewed more. I feel that they should have incorporated a lot more cardiology, respirology type of things, not because I work in that field [laughs], but because a lot of us are on floors that you need that knowledge....[It was taught] in the second semester. Because that was too early for me to really like "Oh, OK." Because when you hear about it ...you're like well, coronary artery disease. But now, you're like: Of course! Coronary artery disease! Duh! But I don't really remember all of that stuff...

Julia would have liked more material on cardiology and respirology, but says that is not because that is her field of nursing. The problem to her is that in the second semester of the program, the student cannot understand what coronary artery disease really means, hence the need for the review at the end of the program. Although other participants said that they appreciated the review in the final semester, Julia actually felt she could have used less time in the clinical setting, and more time reviewing.

Summary

Julia's orientation was not really what she thought she needed. This discrepancy in her learning needs and the actual on-the-job training may have been due to a lack of clear objectives. It may have been partly her personality. It seems she was never focused on technical skills, which are essential in an ICU. She wanted a stronger knowledge

base, possibly setting expectations for herself that were too high. Julia is in a very difficult situation, trying to advance from novice to expert nurse in a period of a few months. The kind of expertise she sought is the product of both knowledge and experience, and will take years to develop. It may have been partly a quest for autonomy, without her being able to name it as such.

When discussing her education, Julia focused on material she felt was not stressed enough in the program. She did not seem to realize that her needs were different than other graduates because she was working in a critical care area. She never really answered the question about whether she felt her education had prepared her to work as a nurse.

Chapter Five

Findings: The Themes

The interviews are replete with information in the form of stories. These stories were examined for common themes. Some themes are about process: the orientation period and education. Others deal with feelings, such as being overwhelmed. By looking at the commonalities in themes, one can begin to understand the process of becoming a nurse for these novices as they begin to practice. By understanding what they go through, it may be possible to improve the process.

Orientation

The academic process only lays the groundwork for nursing practice (Greene & Puetzer, 2002). It is through the orientation that the novice learns how to practice on a specific unit. Every nurse being hired on a unit will receive an orientation. However, the orientation of a new graduate is more comprehensive than that of an experienced nurse. Novice nurses often complain of having received an inadequate orientation (Boswell, Lowry & Wilhoit, 2004; Reese, 2005). A nurse manager, Reese has heard new nurses complaining they have been left to "sink or swim", or of having been "thrown to the wolves".

An orientation is usually four to six weeks long. The novice should not be counted in the staffing quota during this period. She should work together with an experienced nurse who has been trained in the role of a preceptor, and who has agreed to take on this role.

Preceptorship

The preceptor is an important variable in the orientation process. Of the five participants, only two felt their orientation went well. The other three had complaints about the process as well as the preceptors. Two had several preceptors during the orientation period. The last one had the same preceptor, but didn't like her teaching methods. Kate, in particular, felt that the nurses precepting her had no other goal than to show the novice what to do. "They hadn't been trained to teach. You know, they hadn't been trained to precept. And it's not as easy as 'OK, go show them what you do'".

Another participant who felt her orientation did not go well was Julia, who was hired to work in an Intensive Care Unit (ICU). She did not like her preceptor's methods of showing her specialized skills she needed to learn. The skills in the ICU are very technical, and Julia would not have practiced them during her education. It sounds as though this preceptor had little interest in the preceptor role, and very little preparation for this role. There seemed to be poor communication between the novice and the preceptor.

It is well documented in the literature that good preceptors will improve the process of orientation, and increase retention of new nurses (Greene & Puetzer, 2002; Pearson Floyd, 2003; Ulrich 2003). Unfortunately, availability is often the only criteria for selection of preceptors. Nurses should be adequately prepared and compensated for acting as preceptors. One cannot assume that the practitioner's clinical competence will equip the nurse with the necessary skills to fill the preceptor role (McCarty & Higgins, 2003).

Mee (2004) writes that an orientation should go more smoothly if a novice nurse has been an extern on a unit. That was the case in this study with the graduates of Urban College. Sandra and Nadia had somewhat shortened orientations (four weeks instead of six), but they had both been externs on the units they were working. These two novices were very comfortable after orientation and were integrating well into their respective units. Sandra's statement explains why she thinks this is the case: "Since I was there a year before, there was a relationship that built, you know". As well, she had the same two preceptors for the entire orientation. This continuity is very important. Ulrich (2003) found that graduates who have consistent preceptors gain confidence more quickly. Kate only had two weeks of orientation, and had several different preceptors. Annie had the full six weeks, but had four different preceptors. These last two participants had the most difficult orientations. Annie was able to overcome this, but it took Kate five months before beginning to feel comfortable.

Julia had worked as an intern in the ICU, and had the same preceptor for both the internship and the orientation. She therefore worked with that nurse for a period of 14 weeks between February and July. Greene and Puetzer (2002) suggest three phases to the orientation process: planning, implementation and evaluation. As Julia's story shows, it is important during the planning phase to clarify objectives, so both novice and preceptor have a common goal. Julia thought more time should have been spent on developing her knowledge base. Her preceptor felt technical skills were more of a priority. In reality, both are important. A formal orientation plan should have been discussed with the two of them, with objectives and performance criteria elaborated. As it was, at the end of her

orientation, Julia still felt that her knowledge base was not adequate, but was really looking forward to working on her own.

On My Own

Beginning to practice

The world of the new graduate is not easy. Novice nurses experience a sudden increase in responsibility when beginning to practice, and worry about making errors (Gerrish, 2000; Ulrich, 2003). Priority setting and clinical decision-making are also concerns in the novice's practice. The novice finds it difficult to cope with unexpected and unplanned events, which necessitate sorting out priorities (Horsburgh, 1989). In particular, nurses who are unable to tolerate ambiguity will become overwhelmed by situations in the acute care setting (Taylor, 2000).

The participants in this study discussed the anxiety related to increased responsibility. Sandra and Nadia, both of whom had orientations they perceived as going well, experienced some anxiety when their orientation was over. For Sandra, this was the most difficult part of being on her own: "Being alone...being just me and my patients." Nadia said: "When you're on your own, you know, it just seems like a lot more responsibility."

Although they were anxious, both of these novices described how they would validate, or "check in" with more senior nurses when they were unsure. Nadia described it thus: "Even for the first couple of weeks after orientation, when I was on my own, I still felt that I was looking back at her, or somebody else.... I still sometimes look for that validation that what I'm doing is OK."

A New Zealand study (McKenna, Smith, Poole, & Coverdale, 2003) found that 24% of novice nurses reported being given too much responsibility without adequate support. New nurses who do not receive adequate social support are less able to cope with job-related stress (Boswell et al, 2004). The support that Sandra and Nadia describe is practical, being able to validate their perceptions and plans with more senior nurses. However, there is a strong social element to it as the novices must feel comfortable with the nurse they are approaching to give them advice.

Annie, even though she had a difficult orientation due to having many different preceptors, also had good support from the rest of the nursing team. She was nervous at the beginning, but "After a couple of shifts on my own, I was OK. And all the other nurses were saying 'How's it going? Do you need any help?'" She said she felt a "little umbrella" there for her.

Kate, although she describes the rest of the team as "amazing", struggled at the beginning. "My *very first* day alone, I was mortified, mortified!...I felt like such a failure!" She had done very well clinically during her education, and she trusted the head nurse's assessment that she would be able to function alone. When that didn't prove to be the case, she was devastated. She was not prepared to work alone, nor for the feeling of failure. Kate felt the reason for this was the poor orientation she had received. Fortunately, she was able to look beyond the first few months, and convince herself she would get better. And she did, although it was only after five months working on the unit that she was beginning to feel comfortable.

Julia, working in ICU, had a different experience. After spending 14 weeks with the same nurse preceptor, she was really ready to be on her own. "Oh, my God! I felt so

much relief. I couldn't wait till [the orientation] was over." When she did begin to work alone, she was nagged by what she perceived to be her inadequate knowledge base. Maiocco (2003) recommends that there be periodic advanced education classes to support new graduates in ICU settings. This was not the case during Julia's orientation. Her perception that she needed more knowledge was correct. Students are not trained for specialized units, especially critical care. Her orientation should have included classes to help her gain the knowledge base she needed. Julia was another participant who described the weight of the responsibility she felt, at times overwhelming her.

Copnell (2006) looked at what critical care nurses thought "practicing knowledgeably" meant. She found there was an unofficial hierarchy in the ICU: nurses were ranked according to their perceived knowledge. Knowledgeable meant knowing the reasons for nursing actions, and also how to perform activities. Nurses needed to be able to back up their arguments when they spoke to the physicians, as well as know how to carry out procedures. The nurses not only needed to be knowledgeable, they needed to be perceived as such by the other nurses. If other ICU nurses felt a nurse was not competent, they would not allow that nurse to carry out certain procedures. To achieve this, the nurse in charge would not assign the most acutely ill patients to a nurse who was perceived as incompetent. Julia, as a new nurse, would have been at the bottom of the pecking order because her knowledge would not have been perceived to be great. This culture was probably not spelled out to her, though she came to understand it during her first few months on the unit.

But clinical competence in an ICU is not only about technical competence, nor is it just about scientific knowledge. It is really the knowledge that is gained from

experience that is needed, the craft knowledge described by Benner (2001). Lindberg (2006) found that nurses in the ICU regarded competence as an ability to understand the situation, including an ability to collaborate and an awareness of personal body of knowledge and limitation.

Julia was placing very high demands on herself. She said: "I'm really not comforted by 'I won't be comfortable for a year'". In her discussion of the novice nurse, Benner says it will take between six months to a year before the novice is comfortable (2001). Julia, more than the other participants, experienced some difficulty integrating into the team. This may be partly due to her working in a smaller unit that was part of the ICU, but a little apart – the step-down unit. Kelly's 1991 study found that new graduates assumed they were entering a culture they knew and understood, but this was a misconception. The culture in critical care areas is particular. The nurses are highly specialized, often with more knowledge than the resident doctors rotating through the ICU. There is an emphasis placed on expertise, not just technical skills, but also on combining these skills with "book knowledge". The knowledge that is gained from experience is equally important, but is less tangible to gain. Julia was not getting a lot of support from the rest of the nursing staff. This may have been because she had not yet integrated into the culture of the unit.

Most of the novices described some kind of tension between the way they had been taught to practice and the way they were forced to practice. Kate said " The way that I was taught in Urban College is really, really safe teaching.... I really appreciated having that foundation. I found it was *impossible* to do it in the day". Sandra found that conditions did not permit her to practice the way she wanted to all of the time: "So you

have always have to be alert...while people are running, talking to you. You have seven patients sometimes. This is what I found the hardest. Sometimes having a patient load that is unacceptable....But that's the real life".

The participants seemed to be settling in and integrating better by their fifth month of practice. Even Julia was beginning to pick up the culture on the unit: "And so we get along now. I'm developing that same hostility. [laughs]...Yes, they're very territorial people, and I'm becoming territorial too ".

Overwhelmed.

Three of the participants stated they had, at times, felt overwhelmed in their new jobs. Benner describes the novice nurse's reaction to situations in which she has virtually no experience is that of being overwhelmed by the setting. Often the novice can only remember the rules she was taught (2001). Listen again to Julia as she describes the anxiety she felt while caring for a patient immediately after her surgery for a kidney transplant: "And I was like 'No way! Who's running the show here?' Because I was really mad, because I had never done a kidney transplant before. And I don't want to mess up this woman's new kidney, you know?" To make matters worse, Julia was looking after two other patients! Nurses become extremely anxious when they are placed in a situation in which a patient is acutely ill and they are unsure of their ability to ensure a positive outcome for the patient.

Other participants did not have experiences as dramatic as Julia's, but at times they still felt overwhelmed. Sandra stated that sometimes the other staff expected too much from her: "I'm like 'No, I can't take an admission. I'm sorry. I'm already overwhelmed with what's happening with my patients right now. I can't.'" When Kate

was asked if she had felt overwhelmed on her first day she answered: "Like I said, I was trying to do my 5 rights, and 3 times and no! [laughing] Inside the first hour, I realized this is impossible!... But, I mean, really, it was humbling [laughs]. And it was really overwhelming."

Duchscher and Cowin (2005) describe the reaction of novice nurses when they feel unable to protect or advocate for their patients and the accompanying pervasive belief that ethical compromise is unavoidable in hospital nursing. In order to survive in this environment, these authors suggest novices are coping by compartmentalizing the two versions of nursing, task-oriented versus patient-centered. The novices accept the reality of task-oriented nursing by rationalizing that it is only temporary. If novices continue to experience situations in which they feel overwhelmed or torn between two philosophies, chances are that they will leave their initial employment.

Cook (1991) asserts that it is impossible to eliminate this theory-practice gap, because the needs of the patient, which the students learn about in their educational institution, will always be somewhat at odds with the limitations of the institution, which the graduates encounter on the job. The curriculum is predicated on the self-actualization of the client, but the hospital promotes social order and conformity. It is noteworthy that Kate, who had extremely high standards as a student, learned so quickly that she would have to change her practice. In her own words: "I was told the right way to do things....That should absolutely be the way that we're taught. Because when we start breaking the rules, we know where to go about breaking them, and...what to pay attention to."

According to Benner (2001) the first level of change is a movement from reliance on abstract principles or theory to the use of past experience as paradigm. Kate changed the way she did things, realizing that she needed to do so to survive in her new career. Kate was internalizing the culture of the unit in order to carry out all the tasks she had to complete to do her job satisfactorily. She felt very anxious and experienced guilt over taking short cuts when completing her tasks, but she realized she would have to do so to survive. After several months, Kate found she was more organized and able to practice the way she had been taught. She was experiencing less guilt when this happened.

The Real World: Working conditions

The participants had known about the nursing shortages before they began to work. The only participant working on a fully staffed unit was Nadia. It was rare that nurses on her unit were assigned more than four patients, occasionally five. That particular unit also had permanent night staff, decreasing the shift work for the rest of the staff.

However, the others only realized how bad the situation was when they experienced the working conditions for themselves. Sandra described working on a unit often short of nurses, with frequent sick calls and nurses suffering from burnout. Because of this, pressure was put on her to work overtime. Kate was assigned more patients than she was supposed to have, taking care of six or seven patients, when ideally the nurse patient ratio was 1:4. Julia described one day when there were only 11 nurses working, on a critical care unit that should have been staffed with 17.

The working conditions made things difficult for Annie. She said this was the most difficult thing for her to get used to when she began to work. She described what

conditions were like on her unit: I get called often at 5:45 in the morning....Who wants to be called then? You know, you're sleeping, or you weren't planning to work so you stayed out late, or they call you on your weekends off". Because her unit was so short-staffed, she found she had many more patients than she had expected.

> And when I go to work I have five or six or seven [patients]. If I'm working nights I have seven patients....I was not prepared for that....In the real world you realize how heavy it is, and how busy it is.

Annie was able to tell her co-workers when she didn't want to work, but not everybody can do so. Julia said she always went to work when called in:

> Because it's always the same people that stay...They just feel obligated to help out. And I totally see myself becoming one of those people. I don't think there's ever been a time when they've called me on a weekend when I'm not supposed to work, and I say No, I'm not going to come in. I'll say, OK, I'll come in for four hours, or something.

Constantly being short-staffed leads to increased stress for nurses. When the nurse patient ratio is higher than it should be, nurses take short cuts and are more likely to make errors. A literature review looking at the relationship between quality of care, staffing levels and nurse autonomy (Currie, Harvey, West, McKenna & Keen, 2005) found a higher level of nurses to patients is generally correlated with better patient outcomes. Nurses working in hospitals with lower levels of nursing staff reported higher levels of burnout and job dissatisfaction. There was also higher 30-day mortality of patients and higher death rates following complications of surgery. A shared governance model, in which nursing has more involvement in the decision-making processes of management, is another factor correlated with improved quality of care, increased staff retention and higher morale. A UK study (Sheward, Hunt, Hagen, Macleod & Ball,

2005) found that increasing numbers of patients to nurses was linked to risk of emotional exhaustion and job dissatisfaction.

The participants in the current study, while decrying the working conditions, accepted this as part of what they termed "real life", or the "real world". Sandra said there barely enough time in school to learn enough about pathophysiology, and talking about working conditions was not a priority. However, when actually in the situation of being told that she had to stay and work overtime, she realized she didn't have a choice: "And telling us, you have to stay over. Like, yeah, yeah, don't talk to me. I'm not going to stay over. But when you're actually in that situation, you're like: Oh, now I see why....It's the real, real life." She had heard during her education that forced overtime was a possibility, but never thought it would happen to her. When it did, she realized that real life means sometimes *having* to work overtime.

When the staffing situation on the next shift is dangerous, the appropriate supervisor or manager will force overtime. Someone has to stay and work another shift to provide safe care for the patients. Annie had experienced this. She said: "In the real world you realize how heavy it is, and how busy it is."

Julia talked about the real world with respect to the responsibility placed on the nurses. She was not expecting to have so much responsibility for patient outcomes. "I feel sometimes if the patient does bad, it's your fault....And you have to get all defensive, and it's just awful sometimes. I don't know, I guess that's the real world." Julia was having difficulty with the ICU culture. She agreed that she was experiencing pressure integrating into the team, as well as pressure to perform. Her previous work experiences had been jobs in which colleagues were friendlier. In the ICU this was not the case:

"Yeah, all the cool people are pissed all the time [laughing]. And when they're happy, you're like: 'What's wrong? You're smiling'. It's very weird."

It is generally the role of the preceptor to help socialize the novice nurse into the new environment. Julia's perception of her preceptor's priority is one of *getting the work done by the end of the shift.* Julia's focus had been different during her student days. She liked talking to patients about their lives and how they were coping with their illnesses. She experienced stress when she was pressured to focus on the tasks at hand. Horsberg (1989) describes this conflict as "adjustment meant the acceptance of nursing as [the] management of tasks." The tension between Julia and her preceptor probably contributed to Julia's difficulty integrating into the workplace. Duchscher and Cowan (2004) suggest the socialization of the novice may be hampered by the novice being marked as an outsider within the larger group. The unspoken friction between Julia and her preceptor may have led to the preceptor considering that Julia was not "fitting in" with the culture, and therefore not providing her with an entry into the social sphere of the unit.

Kramer's concept of reality shock describes the tension felt by the novice. This is the failure of socialization of the nursing student to the reality of the hospital. The disparity between the values of the educational system and those of the actual practice of nursing can be huge, and this causes stress for the novice nurse (Gerrish, 2000; Kelly 1991; Kelly, 1998).

Although most of the participants agreed that the working conditions were difficult, it does not seem they were experiencing a great deal of reality shock four to five months after beginning to work. They all seemed to be fairly confident about their

capabilities. Some of them admitted to feeling overwhelmed on occasion during the first few months, but they all expressed the sentiment that things were going well.

Autonomy

Stuart (cited in Akoma, 1993) describes the principle characteristic of professional autonomy as mastery of a knowledge field and commitment to a unique service. In Copnell's 2006 study, ICU nurses studied felt they gained autonomy once they were recognized as knowledgeable. They were "allowed" to do more procedures, but also to have input into making decisions about the patients' care. The participants in the current study regarded autonomy as being able to provide nursing care alone, without having to ask others for their input.

Sandra says autonomy is: "Being able to do what I'm supposed to do, in my own time and way". Annie described it as: "Being able to independently think, critically assess things on your own without having to go back and say: I'm not sure about this". She felt there was an emphasis placed on learning to function autonomously during the program.

For Nadia, it was really important that she begin to work alone, without looking for validation: "It's been four months of [seeking validation], and I think I need to do it alone". Nadia's experience with the resident doctor not agreeing with her assessment made her feel as though she could practice autonomously: "I can do this. His case actually made me feel like I can do this. Like I don't have to ask everyone if I'm doing OK." She does not yet have enough experience to realize there will be times when she will be wrong in her assessment, and someone else will be right.

The meaning of autonomy to the participants in this study is very similar to both Stuart's (cited above) and to Lach's: "...the freedom to make prudent and accurate decisions and perform actions within one's scope of practice" (1992, p.17). Experiencing increased autonomy when competence develops is consistent with the literature (Brophy, 2000; Wade, 1999). Brophy described similar findings in her study of nurses who had been practicing for two years. Increased clinical competence increased the nurses' ability to be autonomous. Brophy also found that participants' descriptions of autonomous practice developed if there was an atmosphere of caring, collegial relationships. This was true for relationships with teachers while the participants were still students, and with their co-workers once they had begun to practice. With the exception of Julia, participants in the current study described the members of the nursing team as very supportive.

When asked if she felt she would be able to function alone when she graduated, Julia's reply was "No, not in my unit, no, no, no". Working in an ICU, this makes sense. But Julia's struggle to improve her knowledge base relates to the desire to be considered competent. As Copnell (2006) found, knowledgeable practice was central to ICU nurses' sense of identity as good or competent nurses. Julia felt the nurses expected a great deal of her in terms of knowledge: "Nobody will ever say 'Oh Julia! She drew up that insulin and she fumbled.' But they will say 'Julia can't really explain diabetes. We have a problem.'" And so, because she did not feel her knowledge base was adequate, or that it was not perceived as adequate, she did not feel competent or autonomous.

In summary, the participants described their concept of autonomy as being able to practice alone, without needing the input of other nurses. They did not discuss autonomy

as it relates to the profession as a whole. At the beginning of their careers, novice nurses are very task-oriented, and it is probably too early for them to be considering the autonomy or lack of autonomy of the profession. Most of the novices felt they were beginning to achieve some personal practice autonomy. This may have been a little premature, as they are still novices, and need more experience before they can really be considered as autonomous.

Education: Being Prepared

The purpose of this study was to examine how novice nurses felt about their education, once they had begun to practice. Each participant was asked the question specifically. All replied they felt their education did prepare them for practice, but the focus of their responses differed.

Knowledge

Four of the five participants felt the content of the program had provided them with the knowledge they needed when they began. They understood that the program turns out generalists. Sandra felt the knowledge base she received was good, but wished she'd paid more attention during classes. She also expressed the feeling that she'd had no clue about what was being discussed in some classes at the beginning of the program. Julia felt the same way: she hadn't understood some diseases taught in the first year because her head was in the clouds. Nadia said she had to go back to the books and look things up when she started: "But that's understandable. There's no way they can teach you everything." Three of the five novices said more emphasis should be put on understanding diagnostic tests, particularly blood tests.

Julia's struggle to further her knowledge base was unique among the participants. Working in a critical care unit as a new graduate led to her perception that she was ill prepared when it came to knowledge. She did not believe that it was due to something lacking in her education. She realized her need was different because she was working in ICU. Other participants did not describe this sentiment. Their issues were mostly time-management.

Sandra, Nadia and Kate talked about how their continued learning was now their own responsibility. In doing so, they demonstrated the adult learner principles of self-directedness and immediacy of application. Life-long learning is a concept that is encouraged in the nursing profession, as knowledge of the domain grows at a rapid rate.

Nursing model

The participants were unanimous in their dislike of the nursing model used by Urban College. Only Kate really believed a nursing model had merit, but she did not like the one used. Most of the first semester is taken up with learning this model, its terms and concepts, and it seems to be a weakness in the program. The former students felt it was a waste of time.

The literature is divided on the usefulness of nursing models (Fawcett, 2003; Heath, 1998; Wimpenny, 2002; Woodward, 2003). Wimpenny's (2002) exploration of the meaning of nursing models to practicing nurses found the use of the term nursing model is limited and confusing. He suggests a three-model typology that clarifies the positions of different models. The first type is the theoretical model, which is abstract and general. This type of model is a potential aid to problem solving within a paradigm. The second is the mental model, a personal pattern or schema of the individual nurse. It

is built through personal experience and knowledge, and recognizes the central position of the individual in use of knowledge. The final type of model is a functional version of the theoretical model: the surrogate model. This is the framework around which each individual nurse collects data and communicates it to her colleagues. The results of Wimpenney's research suggest that in many cases, the individual nurse uses a surrogate model to put the theoretical model into practice. Kate's use of a systems approach to nursing care is an example of this.

Clinical teaching

Both Annie and Kate agreed they had been well prepared, addressing specifically the clinical component of their education. Nursing theories and knowledge is applied and reinforced during the clinical rotations. These experiences can be very intense. As Emberley-Burke (2000) found, the clinical setting is unpredictable and stressful. There are demands for accountability, and ensuring patient safety. The students are aware of the teachers' need to collect information about both their thinking and their actions for the purpose of assessing competence (Pierson, 2003). This increases their stress.

Wade (1999) considers the experiences gained in the clinical practicum as essential to the development of decision-making skills. Sandra appreciated teachers who asked her to discuss her priorities for the day: "This made me look at my patient as a whole...it's difficult to incorporate them all together." Students understood that the teachers were helping them integrate the knowledge they had gained in the classroom with the reality of the patient they were caring for. By the end of the program, Annie had learned that "Knowing what you don't know is still one of the biggest things they

[teachers] will look for. And I still, now, am the same way. I know what I don't know, and when I need help, I'll ask."

Annie discussed several situations in which she found her clinical teachers acting in an oppressive manner. She described a teacher who yelled at students in the nursing station, another who was very aggressive with her in front of a patient, and one who she feared would ridicule her. Kate found one of her teachers to be very combative, and felt some of her fellow students had been picked on by the teacher. These situations describe teachers who still adhere to the old style of nursing education, teacher-centered instead of student-centered.

The three other participants reported mostly good clinical experiences during their education. Sandra and Nadia described situations in which their teachers encouraged the students to do things on their own, after having assessed the student as having enough knowledge to do so. All participants said they liked when their clinical teachers questioned them during their rotations. The participants found it was helpful to be questioned about their patient's condition and medications, because they learned the most from those teachers. Annie felt the experiences of each semester built appropriately on the previous rotation. She appreciated teachers who asked questions: "Some of those teachers were probably the best teachers, the ones that paid attention to you, the ones that followed up on everything. They said 'I'm going to ask you about this', and they did ask you about it."

The participants described how teachers would question them to assess the students' knowledge, as well as to encourage deeper reflection on the part of the students. Kate said she liked being asked questions: "Why are you doing this? What is this for?

What's your priority?....It's something you need to really focus on." Although the students felt stressed at first when teachers questioned them, they eventually realized that they learned the most with those teachers.

Kate also described teachers' behaviour that was very inflexible, and focused on "little details" like making sure the patients were bathed by a certain time. She was the only participant who related such an incident, but it is troubling if one is looking at a context of promoting autonomy.

Internship

The former students all agreed that the internship provided them with a good base for practice. Again, they understood that each unit and specialty has its own focus and it is not possible to educate everybody to work on every unit. Annie credited the internship with giving her independence. Nadia liked the internship because she felt she was prepared for it. During her fifth semester, her teacher had made sure Nadia knew what she was doing, and then mostly left her alone, while she watched unobtrusively. This prepared her for the internship, because "there was nobody there in internship really".

There were two differing opinions about how the sixth and final semester (the internship) could be improved. Julia would have liked more emphasis on content in the final semester, while Kate would have preferred only clinical. Both these participants were hired onto the unit they did their internship on. Julia's orientation focused mostly on the technical and practical skills needed in ICU, so it is understandable that she would have liked more content during her education. Kate, on the other hand, was really lost when she started working, and so it makes sense that she would have wanted more

practice. She felt that having to learn content and produce on an academic level hampered her "getting used to being a nurse".

Wade (1999) suggests students should work with a preceptor nurse who demonstrates professional autonomy for the final semester of the students' education. It is possible, even probable, that the internship at Urban College contributed to the feeling of autonomy of the participants.

Technical skills

Studies examining which skills novice nurses thought were most essential (Boxer & Kluge, 2000; Gerrish, 2000) report similar findings. In both studies, novice nurses rated similar rudimentary skills as most frequently performed and essential for a nurse: precautions related to infection control, assessment of vital signs, management of intravenous therapy, administration of medication and a range of patient hygiene-related skills. The novice is preoccupied with the most basic tasks of bedside nursing, and therefore rates the associated less complex skills as most important.

The participants agreed that they felt well prepared with respect to technical skills. They all understood that they were taught general skills during their education, and that they would become proficient in only some of these skills before graduation. The skills they needed to practice would be reinforced during their orientation, and the first few months of practice. Some, like Sandra and Kate, thought that during their clinical rotations they probably put more focus on the practical skills than they needed to. Two of the others, Nadia and Annie, felt they had enough practice during the program.

Julia's case is a little different, because she was performing very complex skills in the ICU. During the program, this had never really been her focus. During the

orientation, her preceptor had seen this as very important, more so than Julia. Yet Julia complained that the preceptor did not give her enough support when practicing skills, telling her it was really common sense. Julia did say that things were getting better, four months after she began working.

In Marshall's 1999 study, nursing faculty rated psychosocial and critical thinking/problem solving skills higher than nurse managers or staff nurses. Staff nurses rated direct care/technical skills higher than the other two groups. Boxer and Kluge (2000) found that novice nurses rated technical or practical skills as most important, over skills such as physical assessment and patient counseling. The current study did not find that new nurses were struggling with performance of technical skills. Indeed, Nadia's experience with the patient suffering from complications of surgery demonstrated her assessment skills were exemplary.

Rochester, Kilstoff and Scott (2005) investigated what capabilities successful nurse graduates thought were needed to function well when beginning to practice. Job specific technical skills were rated quite low when compared with items coming from the emotional intelligence scale. Such items as *the ability to empathize and work productively with people from a wide range of backgrounds* and *a willingness to listen to different points of view before coming to a decision* were rated highest. It was not that the technical skills were not considered important, but that these were not practiced in a vacuum. Technical knowledge was a critical foundation for competent practice, but required other capabilities to ensure it was used appropriately.

Encouraging autonomy

Two participants spoke about how their teachers encouraged them to develop autonomy during the program. Annie described how the third-year teachers really emphasized the need for students to think for themselves. They were encouraged to stop doing things just because the nurses told them to. "Why are you doing it? Question everything! And this was really emphasized in the last year....It was something that they stressed – you *have* to think for yourselves. Don't be a robot."

Sandra's experience was similar: "In the internship [it was reinforced]. Think on your own! Make links between the disease and the second disease... But in the real life...you *have* to deal with some issues on your own.

The other participants did not discuss in detail being encouraged to practice autonomously during their education, but all agreed that by third year this had been a focus. They expressed the need to practice autonomously in somewhat different terms. Nadia repeated several times that it was time for her to stop seeking validation from the other nurses on the floor; it was time for her to do it alone. Kate was able to tell more senior nurses that she didn't agree with their ideas or actions. Julia felt it would be quite a while before she could work autonomously in the ICU, yet she described how important it was for her to gain a strong knowledge base. She had internalized the ICU culture of equating knowledge and experience with competency. She aspired to the status of a competent critical care nurse.

It seems as though the novice nurses all realized they should work at developing autonomy in their practice. The internship was credited for helping them develop autonomy.

Brophy (2000) explored the experiences of nursing students' autonomy during their nursing education. The former students mostly described a lack of autonomy during their education. Brophy found them to be an oppressed group, whose learning environment was "controlling, inflexible, intimidating, and posed unrealistic expectations" (2000, p.ii). Some participants in the current study did describe some situations in which they found their teachers to be controlling and autocratic. Others described an environment that was supportive and encouraged them to function autonomously. As students, they appreciated their teachers asking questions both to assess knowledge and to encourage thought about what they were doing. Once a student demonstrated she was able to differentiate situations in which she needed help and those in which she didn't, the teachers allowed that student a degree of autonomy. Sandra put it best when she described how she liked to be supported. The teacher told her to "go do, and come back and report off to me" as Sandra described it. The student felt both supported and independent because of this approach.

Summary

Although each novice nurse had her own story, there are common themes that run through the stories. All said their education had prepared them for practice. Some participants struggled more than others with the transition from student to practicing nurse, but most realized their education prepared them as generalists. It was during the orientation that they were further equipped to work in the specialty they had chosen. Only Kate felt more could have been done to prepare her for the real world. She was, however, the novice who had the shortest orientation. She acknowledged the short orientation and absence of consistent preceptors contributed to her difficulties when

beginning, but felt the last semester should have focused more on the practical side of being a nurse.

All participants felt some anxiety when they first started working on their own. This was due to the sense of increased responsibility, and of being alone. Most knew they could count on support from the other nurses on the team. The exception here was Julia, working in an ICU. Her anxiety came from two sources. The first was her perception that she lacked a strong enough knowledge base, the second the high demands she placed on herself. To be considered competent in a critical care setting, a greater knowledge base and more experience are needed. Julia did not acknowledge this, even though her head nurse pointed it out to her. She still felt inadequate.

Being overwhelmed was a feeling expressed by all the new graduates. They described some stress due to reality shock: too many patients, not enough nurses, and not being able to practice the way they were taught. When interviewed four months after they began to work, the participants had mostly conquered that feeling, and were more comfortable in their new role. They did not think their education could have prepared them better for the working conditions in "the real world".

And finally, all of the participants were in some way demonstrating a desire to practice as autonomously as possible. This had been fostered during their education, particularly in the final year. The next chapter will examine the implications of the findings for nursing education.

Chapter Six

Implications for Nursing Education

Chapter Five examined the common themes found in the novice nurses' stories. These stories were examined to seek answers for the research questions. Before looking at how to use the insights gained from this research, it is important to review the research questions once more.

1. Do graduates of an English-language CEGEP in Montreal perceive that their education adequately prepared them for practice as nurses?
2. Do they feel they were encouraged by their teachers to be autonomous in their nursing practice?

The themes identified in the stories were: a) the orientation period; b) being on their own, beginning to practice and feeling overwhelmed at times; c) the real world: reality shock brought on by the working conditions; and d) their education: whether or not they were prepared to work and practice autonomously.

The former students stated they had been prepared by their education to practice as nurses upon graduation. However, they all experienced some anxiety when it came time to work "on their own". There is still a need to integrate a more realistic professional socialization of the student during the educational process. The transition was smoother for some, but by their fourth month of practice, they were all feeling reasonably comfortable. Technical skills were not considered problematic.

This section will look at the implications of the findings for nursing programs and teachers. The implications for both philosophy and teaching methods will be discussed in the context of adult education. A teaching strategy that is increasing in popularity will be

described as one example of a new way to encourage higher order thinking and autonomy. The implications for health care institutions are then discussed. Finally, some suggestions for further research are specified.

Implications for Nursing Programs and Teachers

Nursing models

The literature on the use of nursing models is divided. While models are the framework around which the curriculum is based, the former students did not view the nursing model used at Urban College as useful. This is somewhat troubling. Wimpenny's research gives another perspective through which to consider the actual use of the nursing model in each nurse's practice (2006). It will be necessary to continue to follow the research about the usefulness of nursing models if we are to continue to use them. It also may be necessary to follow up on this issue to ensure the curriculum is meaningful to students.

The learning environment

The participants described different kinds of learning environments. Two former students provided anecdotes of teachers who were very patriarchal, instilling anxiety into the students. Two others recounted positive experiences. One did not say much about her clinical experiences, even when asked the question specifically. It would appear the educational philosophy of faculty members is not uniform.

As Patterson (cited in Elias & Merriam, 2005) stated, the purpose of humanistic education is to develop the whole potential of humans. The means by which to do this is to foster a good relationship between student and teacher. Participants in the study realized the teachers had been checking up on them, but accepted this as a means of

ensuring patient safety. They preferred teachers who treated them respectfully. This is consistent with studies looking at students' perceptions of effective and ineffective nursing instructors (Brophy, 2000; Pierson, 2003). Berg and Lindseth (2004) found that students rated personality and competency as the most important characteristics of effective teachers. Studies have shown that students in clinical placements do best in environments in which they feel supported and appreciated (Andrews & Roberts, 2003; Brown, Herd, Humphries & Paton, 2005; Chesser-Smythe, 2005). Boychuk Duchscher (2000) suggests that without power-sharing between nursing educators and students, it will be difficult to build trusting relationships necessary for humanistic education. It is necessary to foster this environment in nursing departments if students are to reach their full potential.

Unfortunately, the application of the curriculum in the CEGEP system is competency based, stemming from a behaviorist model. A satisfactory evaluation in the third year means that the student can, among other things, analyze patient needs and "...situations in order to solve problems and make decisions based on a body of knowledge from nursing, behavioral and physical sciences" (Clinical Evaluation Tool; 2006). Yet the student must also be able to state the actions, uses, pharmacokinetics, contraindications, side effects and nursing implications of drugs prescribed. The student is being told it is necessary to memorize the relevant pharmacologic data for each drug given. We continue to insist that students memorize information, while stating that we are trying to foster higher-order thinking skills. It is true that a solid knowledge base is necessary to progress from novice to expert, but can we realistically expect students to focus on memorization?

At present, a Baccalaureate degree and relevant experience are the only criteria for hiring nursing teachers at the CEGEP level. In many colleges right now, the teacher has been a nurse one day and is suddenly working as an educator the next. It would seem logical that nursing teachers should have some kind of pedagogical training. It does not necessarily come naturally. Because clinical teachers work alone with their students when in the hospital, they have nobody to use as a role model. If we want to educate nurses to use higher order thinking skills and to function autonomously, it will be important to educate the educators. What can be done to facilitate the learning of the educators? And how can we encourage them to move away from a behaviorist paradigm towards a more humanist approach to teaching?

Adult Education Principles

It used to be that the majority of nursing students were young single women who started their training very soon after completing high school. This is no longer the case. In 2005, only 10% of the students who entered the nursing program at Urban College came directly from high school. Many students began other CEGEP programs, or even completed undergraduate programs before choosing to study nursing. The participants in this study are a good example of this phenomenon. All of them had studied elsewhere. One had even had a degree in commerce. It would follow then, that teachers should be using the principles of adult education with nursing students.

Many writers have discussed the purposes of adult education. Selman, Cooke, Selman & Dampier (1998) list four types of functions of adult education: vocational, social, recreational and self-development. Nursing education falls under the function of vocational education.

The father of adult education was Malcolm Knowles, who contended that teaching adults was not the same as teaching children. He developed the concept of androgogy, which he called "the science and art of helping adults learn" (Knowles, cited in Spencer; 1998). This term is less important than the principles Knowles advanced in facilitating the learning of adults. The principles include: a) self-directedness of students; b) using their life experiences; c) readiness to learn; d) immediacy of application; and e) problem-centered education. It is important to keep these characteristics of adult learners in mind when teaching adults.

Knowles adhered to a humanistic philosophy of adult education (Dugas, 1999; Spencer, 1998). Students who assume a "...greater role in the teaching-learning process create for themselves a sense of ownership, increased feelings of satisfaction and stimulated levels of interest and motivation" (Knowles, cited in Dugas, 1999, p. 459.)

As discussed previously, the competency-based curriculum in nursing departments in Quebec CEGEPs is mandated by the Ministry of Education. In the nursing world, there has been a trend towards humanism in education (Diekelmann, 1990; Diekelmann, 2002; McGregor, 2005; Severtsen & Evans, 2000; Tiller, 1999). Rolfe (1993) discussed how to marry the constraints of a curriculum based on a behaviorist philosophy with the kind of student centered learning proposed by Carl Rogers. He asserted that with the trend towards primary nursing, holistic practice and professional autonomy, there was a greater need for student-centered courses. It is interesting that Rolfe wrote this in 1993, and we are still experiencing the same problems 14 years later. Rolfe suggested that autonomous, thinking, problem-solving, decision-making nurses will not develop when the responsibility for autonomy, thinking, problem-

solving and decision-making are the responsibility of faculty and those who design the curriculum. The difficulty Rolfe faced when trying to facilitate a student-centered course was that of how to allow students to identify their own learning needs, while ensuring the course content was covered.

One of the key elements of student-centered teaching is the problem of assessment of learning. Because candidates to the profession of nursing in Quebec must take an exam to be licensed, it is necessary to use exams as the major part of the evaluation process in school. The exam is the same throughout the province, and follows the same formula each time. A clinical situation is described, and questions about application of nursing knowledge are asked, requiring short answers. There are also practical exams in which the candidate is presented with scenarios, and is asked to respond in a specified time period. The candidates need to learn nursing knowledge, but also be able to pass this type of exam. The evaluation of students during the program is therefore heavily weighted with these kinds of evaluation methods. These methods are behaviorist in philosophy, but realistically there is little that can be done in the short-term to change the situation.

If we are to improve the education of nursing students, it will be necessary for nursing faculties to work on developing a philosophical orientation that is student-centered. Although we are constrained to using traditional evaluation methods, it should still be possible to improve the learning environment. Nursing faculties will need to discuss different philosophies of education and agree on a philosophy that is more progressive and humanistic within each department.

It will also be necessary to examine our teaching strategies and attempt to move away from traditional approaches to more innovative methods of teaching. This should happen both within the clinical setting and the classroom. In searching for new teaching methods, it is important to develop an adequate knowledge base as well as encourage dispositions or attitudes towards a problem to be solved. The following section looks briefly at one method that seems to show promise.

Problem-based Learning: An Example of Student-Centered Education

The use of problem-based learning (PBL) has been described as one way to facilitate student-centered learning (Baker, 2000; Mok, Lee, & Wong, 2002; Pastirik, 2006; Rolfe,1993). PBL has been implemented in many medical schools around the world, and its use is catching on in nursing (Biley & Smith, 1998). The process used in this teaching strategy is not one of the teachers presenting knowledge and then discussing how to use this knowledge in practice. Rather, the process starts with a clinical situation (the problem) or a real patient. Learners analyze problems by initiating and investigating. They are encouraged to use their existing knowledge of resources and of how to solve problems. The teacher does not answer questions, but guides or advises if needed. Biley and Smith (1998) suggest that PBL, in an ideal world, might enable the new graduate to enter the practice of nursing with thought processes developed to a much higher level.

The literature is divided on whether or not PBL can be used successfully in nursing education. Some conclude there has not been any real evidence that PBL is effective in improving knowledge and clinical performance (Hwang & Kim, 2006). Others believe the use of this model is an effective teaching strategy (Mok, Lee & Wong, 2002; Pastirik, 2006). One quasi-experimental study with nursing students found that

students who had been taught using PBL had statistically significant higher results than those taught using traditional didactic methods.

PBL can be used both in the classroom and the clinical setting. Although the method works best in small groups, it has been attempted in larger classes (Pasterik, 2006) with success. Williams (2004) suggests it is one way to facilitate self-directed learning. Other non-traditional forms of education are being tried in nursing faculties in attempts to foster higher cognitive abilities and problem-solving (Diekleman, 2002; Ironside, 2005). It should be noted that students are not accustomed to non-traditional methods of teaching in the classroom, and they may not understand their usefulness until years later, if they ever do. They may, however, accept this method more readily in the clinical setting.

It is important for nurse educators to find appropriate teaching methods to enhance students' ability to solve problems, make decisions and exercise clinical judgment. (Hwang & Kim, 2006). The participation of students in their learning and evaluation will encourage their development as competent, self-directed professionals, capable of functioning autonomously in our complex health care environment.

Implications for Health Care Institutions

The results of this study suggest there are changes needed in the orientation of novice nurses to their new workplaces. Only two of the participants of the study had their full orientation. Three had consistent preceptors, but two had several. Hospital units are often short-staffed, and the new graduates start to work in June, at the beginning of the summer holiday period. In this context, it is difficult for managers in health care institutions to ensure the full orientation period with consistent preceptors. However, the

literature and the results of the current study demonstrate it is critical for the novice to have a thorough and consistent orientation, at least in the short-term.

There are several factors which will add to the success of the orientation. The orientation should be an organized instructional program that introduces the new graduate to the philosophies, policies and procedures, as well as the expectations of an institution (Greene & Puetzer, 2003). There should be clearly defined goals and outcome criteria for the orientation. The experience and education of any nurse will affect the length of time needed for orientation, but Reese (2005) says the orientation process should be long enough to ensure the nurse has obtained enough knowledge and skills to perform the required job responsibilities. If the nurse has insufficient knowledge or cannot perform required skills, he or she would be left feeling inadequate and afraid of making mistakes.

It is important that the preceptor have clinical expertise and strong leadership skills, as well as good communication skills and high professional standards (Pearson Floyd, 2003). Teaching and sharing knowledge will be improved if the preceptor has some knowledge of adult learning. Pearson Floyd suggests that preceptors determine what learning approach the novice prefers, and tailor the orientation to that approach or combination of approaches. As examples of approaches, Pearson Floyd offers lectures, demonstrations, active involvement and audiotapes. Of course, these suggestions are useless if the preceptor does not have the time to spend teaching the novice. Preceptors should also choose to take on this role. Because of the already stressful conditions on hospital units today, there are many nurses who refuse it. It is very fatiguing to act as a preceptor while caring for a full load of patients.

To prepare for this important role, preceptors need training themselves. Nurse educators in health care institutions should work closely with the nurse managers to ensure successful orientations. Preceptors should be carefully selected, receive some training in how to fulfill this role, and be available for the entire orientation period. They should also have some knowledge of adult learning principles. Nurse managers need to resist the temptation to cut the orientation period short when there are staffing issues.

The McGill University Health Center, where most of the graduates of Urban College begin their careers, has started a project to ameliorate the preceptorship of novices. There is a one-day workshop for preceptors, covering different issues that may come up. It might be advantageous to survey the preceptors after they have functioned in this role. This would be one way to improve the process even further.

Implications for Further Research

All of the participants answered in the affirmative when asked if they felt prepared by their education to start working. Yet most experienced some difficulty at the beginning. There was anxiety about being on their own, feelings of being overwhelmed and considerable consternation at the staff shortages on their units. Because of the poor working conditions, some participants did have to practice differently than they had been taught. This was a source of anxiety and guilt for them. By the time they were interviewed, the novice nurses all seemed to be demonstrating autonomy in one way or another, and they realized autonomy was a desirable quality in a nurse.

It would add to nursing education knowledge to look at whether novice nurses feel they are prepared without having had an internship. It would also be interesting to see if the type of anticipatory socialization described by Kramer (1974) would smooth the

transition. Would it help if students looked at role negotiation, the competency gap, leadership skills, knowledge about the bureaucratic system and conflict management?

There is a need for more research into professional autonomy for nurses. Each participant described a quest for personal practice autonomy, and did not discuss autonomy of the profession. This seems to be logical, as they are only beginning their careers.

Summary

The education of nurses is critical to their approach to practice. As the practice environment becomes more complex, nurses need an education that facilitates the development of a solid knowledge base. It is equally important they be able to recognize when information or data is needed to individualize care for each patient.

Research into pedagogical methods is called for to discover ways of educating nurses who can "...function effectively in ambiguous, unpredictable, and complex environments...and execute a variety of roles throughout a lifetime career" (National League for Nursing, 2003). This kind of professional will not develop in an environment that is patriarchal or behaviorist. Work is still needed in nursing faculties to promote a more humanistic approach to teaching.

It is also necessary to ensure new graduates receive an appropriate orientation to the unit they will be working on. The orientation should be structured, should include goals and plans for achieving those goals. The new nurse should work with one preceptor only, and the orientation period should be long enough to ensure the novice is comfortable to begin working on her own.

Professional autonomy for nursing is an area that must be addressed. Failure to gain full autonomy has negatively impacted on the profession. It may be one factor in the declining enrollment rates in nursing programs. The American Nursing Association affirmed professionalism should be sought after and pursued to increase power, influencing legislation for improved customer advocacy, better working conditions, enhanced professional status and autonomy (Hall, cited in Wynd, 2003).

As we face an even more severe nursing shortage, the need for professional autonomy becomes crucial. If we do not improve working conditions and professional status, declining enrollment will become worse. We will erode the profession even as more nurses are needed.

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Appendix A

Letter from HREC at Urban College

Cheryl Stewart

May 2, 2006

Re: Novice Nurses' Perspectives on Nursing Education

Dear Cheryl,

On behalf of the Dawson College Human Research Ethics Committee (HREC), I would like to thank you for your recent application. Upon review, however, it seems that your request does not actually require Committee approval. As you are only seeking to recruit participants for a study that would take place once the students left the College, you are free to contact the Nursing Department directly to put forward your request.

If you have any questions or need additional information, please do not hesitate to ask.

Barbara Freedman
Chair, Human Research Ethics Committee

cc: Catherine Leisser, Secretary
Shirley Cheng, Nursing Department Chairperson
Nancy Woo, Nursing Department Chairperson

Appendix B

Consent to Participate in

Novice Nurses' Perspectives on Education

This is to state that I agree to participate in a program of research being conducted by Cheryl Stewart, a graduate student in Educational Studies, Department of Education, Concordia University.
Phone #:
Email: cstewart@dawsoncollege.qc.ca

A. PURPOSE
I have been informed that the purpose of the research is to examine the perceptions of novice nurses about their nursing education once they have been practicing for three months. The goal of the study is to understand the experiences and the perceptions of the novice nurses from their own perspective.

B. PROCEDURES
I understand I will be interviewed once, for a period of 60 – 90 minutes. The interview will be taped and will be conducted at a place of my choosing in Montreal, in September or October of 2006. My real name will not be used in the write-up of the study; a pseudonym will be given to me. The researcher, Cheryl Stewart, has explained that every effort will be made to keep my name confidential.

C. RISKS AND BENEFITS
The risks to me as a participant in the study are minimal. The benefit may be that my story, along with the stories of my peers, will be used to better understand our experiences as student nurses, and hopefully to improve nursing education for future students. The benefit to me personally will be in knowing that I have contributed to this knowledge.

D. CONDITIONS OF PARTICIPATION
- I understand that I am free to withdraw my consent and discontinue my participation at anytime without negative consequences.
- I understand that my participation in this study is CONFIDENTIAL (i.e., the researcher will know, but will not disclose my identity). The tape of the interview, along with the names of participants will be kept in a locked cupboard in the home of the researcher until no longer needed, and destroyed at that time.
- I understand that the data from this study may be published.

I HAVE CAREFULLY STUDIED THE ABOVE AND UNDERSTAND THIS AGREEMENT. I FREELY CONSENT AND VOLUNTARILY AGREE TO PARTICIPATE IN THIS STUDY.

NAME (please print) _____

SIGNATURE _____

DATE _____

If at any time you have questions about your rights as a research participant, please contact Adela Reid, Research Ethics and Compliance Officer, Concordia University, at (514) 848-2424 x7481 or by email at areid@alcor.concordia.ca.

Appendix C

Interview Questions

Appendix A: Interview Questions

Purpose of Study

- Purpose is to understand the experience of novice nurses, and whether they felt prepared to begin working after finishing training
- Did they feel they had been encouraged to work autonomously?
- Questions are not meant to be answered yes or no, but rather to understand your experience

A. Introductory questions

- What is your background: age, previous work experience
- What hospital were you working at and when did you start?
- What kind of unit are you working on? How long was the orientation period?

B. Main interview:

1. What was your orientation like?
2. What it was like to start working after the orientation period?
3. In what ways do you feel that your education prepared you to start working?
4. Did you feel ready to function alone when you finished orientation, taking care of patients, making decisions, etc?
5. What did teachers do in the clinical rotations that helped/hindered you?
6. Were there things the teachers focused on that were not helpful?
7. Sometimes students complain they need more practice performing procedures and/or skills at school? How did skill performance go for you?
8. Since you started working, have you seen any things that conflict with your values, or encountered any ethical issues?
9. Can you give me one example of an incident since you've been working which stands out in your mind?
10. Can you talk about the part that was the most difficult/problematic for you when you started working?
11. If they faculty were to ask for your suggestions of how they could improve your education or better prepare you, what would you say?

C. Interview Process:

1. Did you find the interview questions clear?
2. Do you have any suggestions for questions that might help me elicit information for nursing teachers/administrators to know to improve the experience of nurses entering the workforce?

Glossary

Canadian Nursing Association (CNA): A federation of 11 provincial and territorial nursing associations representing more than 129, 023 registered nurses in Canada

Collège dénseignement général et professionnel (CEGEP): Post-secondary institutions, exclusive to the province of Quebec

Externship: During the summer between the fourth and fifth semester in CEGEP, the student may be hired on a nursing unit as an extern. Her scope of practice is limited, and she always works with the same one or two nurses.

Internship: The last semester in the nursing program at Urban College. The student is assigned to one nursing unit for the semester. She works with a staff nurse.

Low-tenure nurses: Nurses with less than two years seniority on a nursing unit

Order of Nurses of Quebec (ONQ): The professional organization of nurses in the province of Quebec. The Order administers the licensing exams which permit nurses to practice nursing in the province.

Preceptor: A nurse who agrees to work with an intern or a new nurse, supervising that person's practice.

Problem-based Learning (PBL): a teaching strategy that encourages students to work through case studies in small groups instead of using didactic method of lecturing

Supernumerary: member of the staff who is not counted as part of the staffing quota