# The ‘Professional Becoming’ of Newly-Qualified Nurses during Preceptorship in the English NHS

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## Abstract

This thesis develops new empirical insights on the socialisation of English National Health Service (NHS) newly-qualified nurses as they enter the workplace. The NHS continues to face financial and human resource constraints on ensuring the quality and safety of patient care. Nurses are the largest professional group within the NHS, and their recruitment and retention has been problematic which has implications for the ability of organisations to deliver high quality care. Nursing has a turbulent history where changes to education and recent scandals have also raised questions about the quality and safety of care delivered by newly-qualified nurses. Within this context, Preceptorship has been introduced to improve retention and quality by supporting the transition from education into the workforce through several months of support and blended learning. This study focuses on the implementation and operationalisation of one NHS Trusts' Preceptorship programme.

Although professional socialisation has been studied extensively, there has been limited empirical research that mutually accounts for the post-qualification period and new membership of an organisation. Nursing Preceptorship is a useful case because it seeks to develop professionals' skills and knowledge whilst aligning nurses to organisational expectations. In this thesis, socialisation is theorised as 'professional becoming', where knowledge, skills, customs and values acquired through education are enmeshed with those

of the organisation as an everyday learning activity. This highlights the possibility for professional *and* organisational expectations to co-produce the professional identity and practice of newly-qualified nurses during Preceptorship.

Taking a 'practice perspective' on learning, the study focuses on the experiences of newly-qualified nurses over an eight month period. First, the study shows how particular organisational and managerial imperatives influenced the design and operationalisation of the programme. Second, it shows how the newly-qualified nurses interacted within the programme in the classroom environment where these organisational expectations were articulated and promoted as part of the induction process. The study shows how managers had to 'sell' the scheme through constructing nurses as unsafe or inexperienced. Third, it shows how the nurses continued their professional socialisation in clinical settings through interacting with the Preceptors and other clinical peers to develop their learning and challenge the assumptions promoted by the organisation.

The study depicts a period of post-qualification socialisation where the contemporary pressures of healthcare, via the Preceptorship programme, seeks to mould nurses to meet the expectations and needs of the organisation. At the same time, resource constraints make it equally difficult for Preceptorship to fulfil this aspiration, and nurses develop other strategies to develop their clinical knowledge and skills. The study also develops additional insights on

the processes of post-qualification socialisation that centre on the interplay between emotion in everyday learning, positioning in the hierarchy and reflexive identity formation. Although appearing to be socialised into the organisation, the nurses retained fidelity to an aspirational, professional version of a nurse. This thesis thus develops a more holistic understanding into the 'professional becoming' of newly-qualified nurses during the Preceptorship period.

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## List of abbreviations

| | |
|---|---|
| AIM | Acute Illness Management |
| CE | Clinical Education |
| CQC | Care Quality Commission |
| DH | Department of Health |
| HCA | Health Care Assistant |
| HRM | Human Resource Management |
| LLP | Legitimate Peripheral Participation. |
| NHS | National Health Service |
| NICE | National Institute of Clinical Excellence. |
| NLMS | National Learning Management System |
| NMC | Nursing and Midwifery Council |
| RCN | Royal College of Nursing |
| RGN | Registered General Nurse |
| SLT | Situated Learning Theory |
| SWOB | Strengths Weaknesses Opportunities Barriers |
| UKCC | United Kingdom Central Council |

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# Chapter 1 Introduction

## Introduction

There is increasing interest in the complex nature of becoming a professional in the contemporary context of public services such as healthcare, a period described as "turbulent times" (Evetts, 2012:2). This is characterised by greater attention to performance, competition and a move away from centralised authority to line management, often described as New Public Management, (hereafter NPM) (Hood, 1991; Dunleavy and Hood, 1994; Clarke *et al*., 2000). The change has led to increased organisational controls and tensions for professionals who now find themselves lower or higher in the hierarchy than before, depending on their organisational role (Clarke *et al.*, 2000). A professional in this sense broadly refers to members of a recognised profession who "display a high level of competence or skill" (Collins, 2012:631). Professional knowledge in these current conditions can be difficult to define and learn. This is further exacerbated by the effects of globalisation which blurs knowledge boundaries so that 'know-how' is no longer defined by professions, but can be constructed by multiple agencies (Knorr-Cetina, 2007). This current context of healthcare has particular implications for newly-qualified professionals. Although they have completed their education and gained an understanding of the skills and competencies expected of them, taking full responsibility for their practice in new employment is challenging.

They have to learn to fit into and identify with a specific organisational context whilst overcoming knowledge gaps. This is also a period often structured by processes such as induction and specific training programmes.

In this thesis I explore the socialisation of newly-qualified nurses as they enter the clinical workplace and learn the knowledge, practices and identities expected of them in the prevailing context of professional norms, organisational induction and wider health service priorities and pressures. The thesis specifically focuses on socialisation in the context of Preceptorship, an example of a recent policy initiative where NHS Trusts structure the early post-qualification period in healthcare professions such as nursing with a further induction and learning programme.

Socialisation can be broadly understood as:

> *The process through which societies and groups within them, reproduce themselves, creating new members who are able to participate in established routines as well as to effectively adapt to new circumstances*
>
> Preves and Mortimer (2013:151)

Socialisation is usually defined as either a professional or organisational phenomena. Organisational socialisation is often described as 'learning the

ropes' of the workplace (Louis, 1980) and tends to focus on new starters whereas professional socialisation is usually more concerned with the acquisition of professional knowledge and skills (Simson *et al*., 1979) during pre-professional education. Although socialisation has been the focus of substantial social science research (Dingwall, 1977; Van Maanen and Schein, 1979; Simpson *et al*., 1979; Melia, 1987; Ibarra, 1999; Scanlon, 2012), theories that help explain professional socialisation tend to be dispersed between different academic traditions. Although rich studies are found in the professional socialisation literature they tend to focus on the pre-professional training period. On the other hand, although organisational studies of socialisation are useful because they consider organisational induction processes, they continue to be more concerned with new starters to an organisation.

This thesis makes an important contribution to this field of study. It focuses on the empirically significant, but under-researched, phase of post-qualification socialisation; that is, the initial period following formal qualification where professional knowledge and identity is further developed within the clinical workplace. The thesis moves away from adopting a specific professional or organisational approach to socialisation. Rather, this initial period of socialisation is recognised as a hybrid process of 'professional becoming' (Noordegraaf, 2007; Scanlon, 2012) to understand how new members of a profession within a given organisational context seek to accomplish what is expected of them when they undergo Preceptorship.

As most studies agree that socialisation is a learning process, the theoretical approach follows the practice perspective on organisational learning (Nicolini *et al.*, 2003; Gherardi, 2011). This is a social approach to learning which draws attention to situated practices to show how newly-qualified nurses transform as they learn how to become a member of a practicing community (Lave and Wenger, 1991). The thesis shows how this is achieved through their participation in everyday, relational practices in the context of Preceptorship. The major contribution made through this thesis is an enriched understanding of the contemporary practices of post-qualification 'professional becoming', specifically in the context of nursing Preceptorship.

## The changing context of socialisation

There has been increasing interest in the complex nature of professional socialisation (Fitzpatrick *et al.*, 1996; Mooney, 2007; Curtis *et al.*, 2012; Scanlon, 2012). Over the last 30 years, the fields of professional work - from accounting and law to health and social care - have been the focus of significant institutional change. In other words, there have been changes to established ways of working (Scott *et al.*, 2000; Greenwood *et al.*, 2002). One of the biggest changes has been the rise of public sector managerialism, a normative belief system or ideology based on cost and efficiency in which managers rather than professionals are seen to 'know best' and hold the balance of power (Clarke *et al.*, 2000). An extensive literature points to the progressive managerialisation and commercialisation of professional services. Simultaneously there have been corresponding changes in professional

knowledge, autonomous and collegial practices, governance and regulation, and work organisation more broadly (McLaughlin *et al.*, 2002). This has led commentators to predict the demise of status and power for many professions (Freidson, 2001; Nancarrow and Borthwick, 2005). It has been further suggested that professional practices and identities are increasingly re-configured due to political and organisational imperatives rather than those of the profession (Evetts, 2003).

In the English National Health Service (hereafter NHS), the last three decades have been characterised by frequent political and economically-driven reforms and reconfigurations involving ever tighter organisational controls in areas of professional practice. This began in the 1980s with the rise of NPM (Hood, 1991), which was characterised by the introduction of politically-directed managerial prerogatives that were seen to challenge the autonomy and status of healthcare professionals, especially doctors and nurses (Cox, 1991; Elston, 1991). In the 1990s, organisational imperatives around financial accountability, competition and performance management further transformed the processes and practices of the clinical environment as professional work became the focus of managerial and market attention (Martin *et al.*, 2009). At the same time, awareness of clinical malpractice and substandard service quality increased (Vincent, 1997) which influenced health policy reforms in the 2000's. This led to new professional regulation systems, quality management and safety improvement (Waring, 2004). Again, professional work became the focus of organisational change especially through the utilisation of evidence-based guidelines and bureaucratic checking procedures to assure standards of

clinical care (Ferlie and Shortell, 2001). As such, the last three decades have witnessed profound changes in the social organisation of professional work with growing organisational and managerial controls in and over many aspects of professional practice.

Although these changes could be interpreted as eroding professional status and power, contemporary analyses suggest a more nuanced re-construction of professionalism (Gastelaars, 2009). In particular, many aspects of professional practice and identity now overlap or blur with what might previously have been regarded as the more administrative or organisational aspects of service delivery (Hunter, 1996). These changes suggest a form of hybridisation of professional and managerial practices (Noordegraaf, 2007). This is especially the case for members of the nursing profession who have taken on roles in senior, middle, and team-level management and leadership (Bolton, 2003). Such nurses can be referred to as clinical-managerial hybrids and are the focus of considerable academic attention (Numerato *et al.*, 2012, Croft *et al.*, 2015). These current conditions have particular implications for newly-qualified professionals who must develop and refine their clinical knowledge and skills whilst navigating the social, economic and political context of contemporary healthcare.

## The socialisation of newly-qualified nurses

Despite their previous educational and workplace experience, newly-qualified nurses will face 'pushes and pulls' as they develop and cement their

professional skills and practice, especially from nursing co-workers, other healthcare professions and wider organisational and managerial demands. Nurses may wonder where their responsibilities lie and "what to do next" within this complex and fast-paced organisational setting (Nicolini and Roe, 2013:67). This is a balancing act as newly-qualified professionals have to meet professional standards, organisational imperatives and expectations of peers (Fenwick, 2012). This can lead to 'shock' (e.g. Kramer, 1974) which not only has an emotional impact on individual nurses but arguably can contribute to early career attrition, itself identified as problematic for nursing (Morrell, 2005; Robinson and Griffiths, 2009).

The socialisation of nurses is currently of interest because the nursing profession has recently been the subject of scrutiny by the United Kingdom government, the public (through patient and public involvement), the profession itself, and the media due to scandals and growing concerns about the quality of patient care. For example, *The Independent* newspaper, expressed concerns about falling standards, a 'compassion deficit' and the perceived callousness of nurses (Patterson, 2012). In order to address the problems articulated in the article, it is useful to focus on how such a situation could be said to arise, first by considering the role of the nurse, and second, by looking at the context that shapes socialisation. This can be done by considering the situation of newly-qualified nurses immediately post-qualification when facing the pressures and duties of the role in practice. A good opportunity for studying this would be to focus upon the stage of learning structured by Preceptorship.

Preceptorship, a specific education programme for newly-qualified nurses was recently introduced by NHS organisations following the introduction of a national Preceptorship Framework (Department of Health (hereafter DH), 2010a). It requires a structured programme of professional education to be delivered during the first year of qualification. This comprises a blended learning approach to developing professional knowledge and skills within a specific organisational or clinical context. Health policies, professional bodies such as the Royal College of Nursing (RCN) and local NHS organisations suggest Preceptorship will ease a nurse's transition into the clinical workplace and enhance the quality of care, as well as improve employee retention (DH, 2010a). Extant studies of Preceptorship are limited in understanding how Preceptorship mediates the processes of becoming a professional nurse and the impact on the organisation (Robinson and Griffiths, 2009). Previous studies have poorly conceptualised Preceptorship, conducted small scale studies based on survey methods or interviews only and have often been narrow in their theoretical focus. For example, they do not usually consider other organisational and institutional pressures on this post-qualification period or apply sociological theories to learning and socialisation.

## The theoretical approach adopted

As explained above, numerous studies have examined the changing character of professional work amidst contemporary societal and policy conditions. For example, Evetts (2013) shows how organisations will use the language of

professionalism to try to re-align professional identities and facilitate change. However, there are few contemporary studies that have specifically analysed what happens during the early post-qualification socialisation period of newly-qualified professionals such as nurses who now participate in organisational Preceptorship programmes. Moreover, extant literature has typically been theorised from three scholarly perspectives.

The first perspective is found in the 'sociology of the professions' literature which is chiefly concerned with understanding how professions - as expert occupations - have developed, perpetuated and maintained social closure amongst other professions and occupations within the division of labour (Abbott, 1988). In this literature, new members of a profession acquire and maintain prevailing professional customs and practices which perpetuate this closure, and refrain from decisions which might threaten standards or create opportunities for other professions or entrants to challenge their collective status. Thus, potential entrants who do not have the right skills, relevant experience or exhibit the desired professional customs are excluded (Bosk, 2003; Freidson, 2001). Although the sociology of professions literature tells us something about the historical background to education and professional regulation, it tends not to consider the processes and practices of how students and newly-qualified professionals are socialised in organisations in real-time, daily work situations. One approach used, further describes and accounts for the processes of professional socialisation primarily from a symbolic interactionist perspective (Becker *et al.*, 1961; Dingwall 1977; Melia, 1987).

Some authors of symbolic interactionist studies of professional socialisation dislike the use of the term ‘socialisation’ as it implies a passive approach to knowledge acquisition. Symbolic interactionists suggest that becoming a member of an established social or occupational group involves learning complex and contingent processes of developing necessary social norms, rules and customs, and reinforcing desirable practices and identities. Such studies provide rich accounts of everyday working and learning (Dingwall, 1977, Melia, 1987 and provide an important empirical and conceptual foundation to the ideas developed in this thesis. Melia (1987), for example, draws attention to the segmentation of nursing between education and service; both have an interest in producing a ‘suitable’ nurse. Although these works contain valuable insights, this group of studies tends to focus on students (pre-qualified members) and the social customs and rituals of selecting and assuring the competencies which these ‘potential’ members possess (Dingwall, 1977). Contemporary changes in the social organisation of healthcare work, especially within the field of nursing, means that early post-qualification professional socialisation of nurses needs revisiting and enriching through additional theoretical perspectives.

Another view found within the professional socialisation literature considers the apparent separation between the sociology of the professions and the organisational understanding of expert work. This has led commentators to call for research that explores the theoretical connections between these two

scholarly traditions (Waring and Currie, 2009; Currie *et al.*, 2012; Muzio *et al.*, 2013), which arguably mirrors the emergence of professional-managerial roles (Noordegraaf, 2007; Numerato *et al*, 2012). For example, authors investigating the influence of NPM (Hood, 1991) on the social organisation of professional work have sought to clarify the changing social meaning of 'professionalism' and what happens during professional work in terms of control (e.g. Noordegraaf, 2007). The hybridisation of professionalism and managerialism has also been discussed in terms of the tacit, reflective and emergent nature of professional practice. In other words, the modern professional not only reflects the ideals, values or ideologies of the expert occupation seeking to maintain occupational closure, but also the wider, and often fluctuating organisational, political and societal imperatives within which professional work in located. As Noordegraaf (2007) argues, it is important to look at different types of control, but more specifically to understand the connections between organisation, profession and society as located within the reflexive practice of professionals. Yet, few empirical studies have researched the nuances of 'professional becoming' through an analysis of the work of newly-qualified professionals as they learn their place in the organisation and wider economic and policy setting. Despite a broad shift towards a hybrid understanding of professional work, these new perspectives continue to focus on pre-professional education.

A second important perspective on socialisation is found in the linked fields of organisation studies, human resource management (HRM) and professional development. This literature tends to focus on organisational socialisation as

the acquisition of competencies and 'insider' knowledge, drawing from individualistic and psychological approaches to skill development and identity formation (Cooper-Thomas and Anderson 2006; Saks *et al.*, 2007). A number of these studies are influenced by the aforementioned symbolic interactionist perspective and understand socialisation as 'learning the ropes', albeit from a more organisational perspective (Louis, 1980). Van Maanen and Schein (1979) for example, elaborate upon the participatory aspect of socialisation to consider how organisational values are transmitted to newcomers through hierarchical structures and rules. However, these studies tend to focus on new starters to an organisation.

A final group of studies that offers insights into professional socialisation are found in the literatures on identity and professional identity. The broad literature on identity is vast but there is a well-recognised perspective that helps us to understand identity as something which we do (Jenkinson, 1996). Studies specific to newly-qualified professionals have shown for example how newly-qualified professionals experiment as they try out different selves whilst learning their professional practice (Ibarra, 1999). However these studies often lack detail on the situational mediators of professional identity. Other organisational theorists have studied professional identity as a site of control (Alvesson and Wilmott, 2002) and are useful because they show how identity is reflexively accomplished according to organisational processes such as induction.

Each of the three literature areas offers some insights into professional socialisation and although they vary in focus, they implicitly or often explicitly see socialisation as a learning process. A new approach can help to understand professional socialisation as 'professional becoming', a hybrid and reflexive learning process that takes place within contemporary pressures and new forms of induction such as Preceptorship. One group of theories that holds promise for understanding 'professional becoming' as learning are practice-based studies (Gherardi, 2001; Schatzki, *et al.*, 2001; Miettinen *et al.*, 2009; Nicolini, 2009) because they attempt to overcome the dualism of agency and structure by understanding the world through routine activity as connected practices (Nicolini, 2012). In this way, practice theory can explain reflexive working and learning in a way that shows how the everyday setting shapes people and how they respond, learn and shape the setting. In organisation studies, practice theory is often used to understand the hidden aspects of work, such as tacit knowledge that supports on-going learning (Corradi *et al*, 2010). A practice approach to organisational learning can thus offer a better understanding of the dynamics of becoming a professional in an organisation because it accounts for tacit knowledge and takes situated, daily activity as the starting point for analysis rather than a professional or organisational perspective.

'Professional becoming' involves learning how 'to be' a professional within a given organisational work context. Practice perspectives on organisational learning are useful because they understand that socialisation is a situated learning activity whereby practices reflect and reconstitute wider professional and organisational institutions (Nicolini, 2009; 2012). Institutions in this sense

can be described as any arrangements of rules, regulations and norms which stabilise organisational practices (Antonacopoulou and Pesqueux, 2010). This would include professional standards, education and societal norms. This means that new professionals will learn what has been stabilised through institutions; stability however is affected by the way practices are always emerging due to individual ideologies, hopes, passions and identities which collectively influence practices (Antonacopoulou and Pesqueux, 2010). The practice perspective on organisational learning is also useful because it acknowledges the ongoing construction of identity through daily working practices (Gherardi and Nicolini, 2003). The following section justifies nursing as a case for understanding contemporary 'professional becoming'. Specifically, this case will make a clear contribution to an enriched understanding of the contemporary practices of post-qualification socialisation during Preceptorship.

## The case: the 'professional becoming' of newly-qualified nurses undergoing Preceptorship

This thesis argues that a practice-based approach to the study of 'professional becoming' of newly-qualified nurses in the context of a Preceptorship programme can provide an empirically-grounded understanding of the processes of professional 'becoming'. In particular, the practice perspective on knowledge, learning and identity recognises that this ongoing, contextual accomplishment of learning to 'be' a professional nurse takes place through routine practices and social interactions that involve not just people but also material artefacts and 'tools of the trade'. In particular, it helps to show the

unequal power relations within practices which highlight the struggle for nurses' position within the clinical community. Applying this perspective to everyday socialisation provides a rich account which helps us to understand the 'professional becoming' of newly-qualified nurses in the 21st century. This study is timely not only because of the recent introduction of Preceptorship programmes, but also because of challenges presented by recent scandals (Francis, 2013), frequent changes in policy, service reconfigurations and current financial austerity (Walshe and Woolfe, 2012). These disrupt ways in which healthcare work is organised and how care is delivered by professionals. Such instability further serves to highlight our current lack of understanding about its effects on the every-day work of the 'becoming' of newly-qualified nurses in this context.

## Aims of this research

This thesis argues that nurses 'newly-qualified' period is better understood as a process of 'becoming' where professional knowledge, activities and identities are learned through participation in social practices, including prevailing organisational and professional induction practices. A practice perspective on organisational learning is a useful theory-methods 'toolkit' to study this phenomenon (e.g. Nicolini, 2012). It brings out the richness of 'becoming' and turns complexity into a 'talkable' account. Although practice-based studies of occupational and organisational socialisation are increasingly evident in the literature (e.g. Gherardi and Perrotta, 2010), there are few rich empirical studies of the post-qualification period. The case of nursing Preceptorship in its

historical, political and professional context provides a unique opportunity to develop a contemporary understanding of the 'professional becoming' of nurses in the 21st century.

The thesis addresses the following research question:

*What are the practices of 'professional becoming' in the context of novel organisational socialisation and induction policies?*

It does so by asking:

*What are the practices of 'professional becoming' for newly-qualified nurses as they enter the clinical workplace and participate in an NHS Trust's Preceptorship programme?*

The thesis uses an ethnographic case study approach to a group of newly-qualified nurses as they commence working within an acute healthcare organisation (Trust) operating within the English NHS. These nurses were automatically enrolled within a Preceptorship programme aiming to support professional development in the immediate post-qualification period. This is conceptualised in this thesis as a process seeking to align professional knowledge, practices and identities to prevailing policy and organisational imperatives.

This study makes important contributions to knowledge. First, the research is novel because it empirically studies how contemporary organisations guide the socialisation of newly-qualified professionals with programmes such as Preceptorship. Second, the study shows how Preceptorship manifests amidst organisational, professional and public pressures which frame how newly-qualified professionals negotiate and legitimise their position and identity within the clinical workplace. The third contribution is a developed understanding of 'professional becoming' by showing the relationship between emotion, position and identity as a significant dynamic of newly-qualified learning and socialisation within contemporary organisations. Although learning is gradual, I have shown there are particular moments when this dynamic relates to proactivity and transformation.

This research contributes to three areas of literature. The first is to organisation studies in which there are calls for greater understanding of the practices of hybrid professional 'becoming' in organisations (Noordegraaf, 2007). The approach taken in this research is particularly novel through its focus on the post-qualification period. Second, the research contributes to the professional development and learning literature where practice-based studies of "professional becoming" in the 21st century are of interest currently. Finally, and perhaps most importantly, this research contributes to the policy and nursing literature as it builds upon the earlier work of authors such as Melia (1987) by using a contemporary, ethnographic account of post-qualification nursing during Preceptorship.

## Structure of thesis

In Chapter 2 I review the literature relevant to 'professional becoming'. This includes current theories of professional socialisation and explores contemporary research conceptualising professionalism as a hybrid phenomenon. This also helps explain how post-qualification socialisation might be better understood as a process of 'professional becoming'. I note however that these studies tend to focus on pre-professional education. This is followed by a review of the literature on organisational socialisation and identity which offers useful insights into socialisation but tends to focus on the processes of new organisational members. However, taken together they make valuable contributions to our understanding of socialisation. The literature review found common ground between both areas because they both tend to agree that becoming a professional is an activity that involves learning new skills, professional and organisational norms and identities. Hence, understanding the post-registration socialisation of newly-qualified professionals as learning allows us to include both professional and organisational aspects of the phenomena. Following an exploration into knowledge and learning, the usefulness of a practice-based approach to is proposed to show why, and how, a practice-based approach helps us to reach a more holistic understanding of 'professional becoming' as learning. I explore different theories of knowledge and learning in organisations to explain how practice theory differs from traditional approaches. Finally, I show the practice

approach to learning relates to professional identity, which is understood as a fundamental part of 'professional becoming' in everyday practice.

Chapter 3 describes the case of nursing Preceptorship in order to explain what makes it suitable for a study of contemporary 'professional becoming'. The chapter is structured to discuss professionalisation in nursing history, its education strategies and the significant policy developments which have influenced the development of Preceptorship. The chapter shows how practice perspectives on learning (e.g. Gheradi, 2001) are able to build upon previous studies of nursing socialisation and Preceptorship to provide a more nuanced account of the immediate post- qualification period.

Chapter 4 explains my philosophical approach and why ethnography in the context of nursing Preceptorship provides an opportunity to create a nuanced understanding of the practices of 'professional becoming'. As practices are complex and multi-faceted, studying them necessitates exploring normative learning and the practical concerns of actors (Nicolini, 2012). A toolkit of methods is thus needed as part of a "theory-methods" package that can address the multi-faceted nature of everyday working and learning (Nicolini, 2012:216). I explain how a Preceptorship programme was studied over a 12 month period. Around 200 hours of observations were conducted of interactions in the classroom, different ward areas, the offices of the clinical education and professional development team and other areas such as corridors and cafes. In addition, I undertook documentary analysis of Preceptorship

policy and local clinical education documentation, held 33 group interviews with newly-qualified nurses and conducted 20 interviews with nurses, managers and other practitioners involved with Preceptorship such as a patient safety manager and a nursing lecturer.

Chapters 5 describes the local context of the NHS Trust in which the Preceptorship programme was based. Chapters 6 and 7 show the journey of the nurses undergoing Preceptorship and 'tells the story' using observational data, vignettes, interviews and group interview data. Chapter 6 describes learning in the classroom and Chapter 7 shows how learning and 'becoming' took place on the wards. I thus provide a rich description of the everyday practices of the 'professional becoming' of nurses in their Preceptorship period. In Chapter 8, I discuss my findings. The three emergent themes drawn out contribute to a richer understanding of post-qualification professional becoming. The first is the dynamic of emotion, position and identity. The second is hybrid 'becoming' between profession and organisation. The third is how the findings develop an understanding of Preceptorship. In Chapter 8 I conclude this thesis, discuss the limitations of this research and the implications of the findings for practice.

# Chapter 2 Professional socialisation in an organisational setting

## Introduction

In this chapter I review the literature on the socialisation of newly-qualified professionals. By drawing on the sociology of the professions, organisational and management research, and some of the identity literature it is possible to gain insights into the ways in which these literatures address different facets of the processes of professional socialisation within organisational contexts. Finding links between these perspectives, the chapter explores a more inclusive and holistic understanding of professional socialisation, to re-examine socialisation as involving ongoing practices of learning how 'to be' a professional in an organisational setting.

Learning the skills, competencies and practices required to become a professional usually begins through participation in the formal and informal curriculum of vocational higher education (Eraut, 1994). Whether in medical, nursing, or law school education, student professionals acquire an understanding of the expert or esoteric knowledge that informs their future practices, as well as gaining practical work during placements in an organisational setting. Over time, they also acquire the shared cultural values, norms and motives which characterise their profession. Understood in this way, professional socialisation might be seen as comprising three elements: abstract

knowledge, practical know-how and skills, and cultural values and identity. However, as I suggest later in this chapter, these elements are often intertwined within everyday practice as a complex form of social learning.

Despite having met the standards expected for registration, newly-qualified professionals only become fully accountable practitioners when employment begins. For nurses, this is when they register with the Nursing and Midwifery Council (NMC) and begin to work to professional codes of conduct and performance (NMC, 2008). This group of new workers inevitably lack the more extensive experience of the wider community; they are novice professionals. Entry into the professional workplace is not simply about becoming a member of a profession, but also about taking up work within an organisational setting. The experience of joining an organisation and being thrust into the 'real world' can be stressful. Newly-qualified professionals are able to put their theoretical knowledge into use, yet are also faced with large gaps in their understanding about how they should practice in the 'real-world', how they should work with others, and how they are positioned within the wider organisation. This phenomenon has long been described as 'reality shock' (Hughes, 1958; Kramer, 1974) commonly blamed for the attrition of newly-qualified workers (Robinson and Griffiths, 2009). Unlike many past studies of professional socialisation which emphasise how new members acquired the skills, practices and customs of their profession, the contemporary organisation of expert work sees professionals and their organisational contexts as being closely entwined and co-constructed (Noordegraaf, 2007; 2011; Noordegraaf *et al*., 2014). This means that newly-qualified professionals must

acquire the necessary knowledge, practices and cultures of *both* their profession and the organisation.

As previously noted, over the last three decades the organisation of professional work has been subject to substantial changes from developments such as New Public Management (NPM), demands for greater efficiency and increasing knowledgeability of clients (Numerato *et al.*, 2012). Many see these changes as running counter to the ideals and practices of professionalism (Exworthy and Halford, 1999), and this suggests that organisational expectations for newly-qualified professionals might be at odds with the expectations of the particular profession. As such, the newly-qualified professional is arguably positioned at an interface or site for conflict between professional and organisational modes of working. In this chapter I develop the theoretical and conceptual tools necessary to further develop this line of reasoning, identify gaps in knowledge and suggest how we might better understand early post-qualification professional socialisation.

Part 1 of this chapter explores the concepts of 'the professional' and 'the profession' by drawing upon perspectives from the sociology of the professions, including those concerned with professional traits, professional power and the professional project (McDonald, 1995). I highlight specific studies on professional socialisation, chiefly from the symbolic interactionist tradition, and a critique of traditional notions of professional socialisation is developed as I move towards an understanding of 'professional becoming'. To

progress my argument, I draw upon recent work that has sought to better understand how organisations and professions are co-constructed. Authors have studied contemporary professional work and its esoteric and relational character (Evetts, 2009; Noordegraaf 2007; 2011; 2013; Brock *et al.*, 2014) and in doing so, account for pressures arising from issues described in the previous chapter such as financial constraints, markets, globalization, power and management controls. I discuss the work of Noordegraaf (2007), who suggests that professional work is hybridised. That is to say, professionals work reflexively amid entwined organisational and professional imperatives and are in a continuous state of learning and 'becoming'.

Unfortunately, these recent studies still do not tell us enough about how newly-qualified professionals learn to 'be' professionals amidst these multi-faceted pressures. It was thus helpful to study the literature on organisational socialisation, thereafter concluding that this group of studies also falls short of providing a satisfactory explanation of 'professional becoming' as they focus on new members of an organisation. Nevertheless they share a common view with the professional socialisation literature by acknowledging that socialisation is a learning process. Finally I explore some of the literature on professional identity to show how identity is an ongoing reflexive accomplishment and is central to 'professional becoming'.

The second half of this chapter develops a learning perspective on 'professional becoming'. I outline the key epistemologies of knowledge and

learning, highlighting three distinct views - structural, processual and practice-based. These views are used to structure my argument in Part 2 of this chapter which shows why a practice perspective on organisational learning (Gherardi, 2001, 2011) is worthwhile when studying the nuances of 'professional becoming'.

# Part 1

## Defining a profession and professionals

A useful starting point to discuss professional socialisation is to define the meaning of 'profession' and 'professionals'. In social science, professions are understood in a number of different ways, often reflecting different theoretical and analytical perspectives. Importantly, these perspectives have particular implications for how professional socialisation is understood. Many studies use the terms 'profession' and 'professional' to describe, in general, expert workers or highly skilled occupations (Perkin, 2002). This might be regarded as an 'everyday', 'lay' or 'folk' understanding that has widespread normative appeal yet lacks specificity as it could be applied to almost any type of expert work (Becker, 1970). Nevertheless, management studies of professional work commonly use a broad or taken-for-granted view of what constitutes a profession, tending to refer implicitly to established expert occupations with high degrees of status or power (Scott, 2001).

Sociologists have long been interested in the professions within the division of labour (Durkheim, 1957) and early accounts defined trait-like characteristics that might be symbolic of a profession, such as expert knowledge, codes of conduct, autonomous practices and contribution to societal function (Carr-Saunders and Wilson, 1933; Parson, 1953). However, the dominant sociological approach, inspired by empirical studies within the symbolic interactionist tradition, see the professions, or rather professionalisation, as occupational strategies of social closure and control within the division of labour (McDonald, 1995). From this perspective, professions are occupations which have secured a degree of monopoly and control through their claims to expert, exclusive and esoteric knowledge, as well as their claims of serving public interests and adhering to moral imperatives. Freidson's (1970) influential work argues that this professionalisation results in occupational closure but importantly also leads to high degrees of technical autonomy in the organisation of work, and the capacity for professions to self-regulate their conduct with limited interference from other occupations. However, it has been argued that Freidson's analysis is difficult to apply to the nursing profession which is heavily influenced by the authority of other professions such as medicine or management (Dingwall *et al.*, 1988). The question of professional autonomy is thus unresolved; indeed, a debatable concept for the professions (Evetts, 2012).

Abbott (1988) expands upon Friedson's approach to consider the wider system or ecology of work and how occupations compete for jurisdiction. He studied the strategies used by professions to establish and defend their jurisdictional

boundaries. Abbott (1988) observes that a profession needs to strike a balance between developing abstract scientific knowledge as a basis for its legitimacy claims whilst also maintaining a sense of indeterminacy so that it is hard to standardise practice and therefore benefit professionals in retaining power.

Many authors (Dingwall, 1977; Melia, 1987; Evetts, 2011) have argued that against trying to define 'profession' or 'professional', because of the problems of classification and theorisation, and because of the everyday, normative use of the concept. Evetts (2011) concludes that there may be little difference between a 'profession' and an 'occupation' and draws attention to the internationally different cultural perspectives seen in the literature. Evetts (2011) describes how American and English studies tend to consider professionalisation as closure, whilst other European countries draw attention occupational identity and how the occupations train and develop themselves.

Next, I explore traditional theories of professional socialisation some of which have also debated the idea of the 'professional' and show how they inform an understanding of 'becoming' in the post-qualification period.

## Professional socialisation

The literature on professional socialisation originates in the functionalist tradition of sociology which seeks to understand how the individual internalises the values of their profession (e.g. Parsons, 1953; Goode, 1957).

Merton *et al.*'s (1957) *The Student Physician* examines how medical students acquire their professional role, skills and values when taking different options within medical education. Unlike other approaches to professional socialisation, this study acknowledges the practical aspects of medical education and hence the need to adapt it to the changing nature of professional knowledge in order to account for social factors in disease and its management (Atkinson, 1983). Like other studies of its time, *The Student Physician* (Merton *et al*., 1957) it could be argued that it remains functionalist in orientation, seeing the professions as sharing static identities and values, a view of the professions that is no longer generally accepted (Atkinson, 1983). Nevertheless, the study is understood to have paved the way for a new generation of socialisation research within the symbolic interactionist tradition (Atkinson, 1983). This development can be seen as a progression in our understanding as it began to account for context which was previously unexplored.

*Interactionist studies of professional socialisation*

As a critique of the functionalist approach, symbolic interactionist studies have drawn attention to the processual and situated aspects of professional socialisation. They question whether 'professional socialisation' is the most helpful term to describe the process of becoming a member of an expert occupation (Dingwall, 1977; Melia, 1987). One famous study that emphasised this process is *Boys in White* (Becker *et al.*, 1961), which sought to understand how student doctors acquired their clinical knowledge and skills, paying

particular attention to the interactions between medical students and their mentors. Becker and his team observed a group of medical students over their training period and richly describe their culture, how they tackled learning challenges and gradually acquired the values of their peers (Becker *et al.*, 1961). There are interesting points arising from this ethnography. First, Becker and colleagues conclude that training schools are an inferior place to learn how to be a member of the profession and that students are more likely to learn in them how to be students (Becker *et al*., 1961). This conclusion is reached as learning to be a professional is achieved in relation to the people whom students interact with at a particular time and in a particular institution, such as a medical school. Second, in *Boys in White* (Becker *et al.*, 1961) and in a later essay, Becker (1970:92) treats professionalism as a "folk concept". That is to say, it has a very particular and situated meaning to those who work in a given community. Despite this, it has been suggested that Becker maintains an acceptance of objective social structures, and professionalism appears to be a fixed concept rather than something that takes on different meanings at different times (Dingwall, 1977). The question that could be asked is not 'who' professionals are but 'when' and 'how' members of an occupation relate to the profession (Dingwall, 1977).

Becker *et al.'s* (1961) study is a classic account of medical student culture during socialisation within the hospital and medical school settings. Its' contribution richly shows the complex ways in which the students develop a perspective on their training and future profession. This helps us to understand how a student group will respond to a formal curriculum and develop their

particular and often pragmatic perspectives on their learning. However, as the aim was to focus on the student perspective, the emphasis is on pre-qualification learning. This leaves space for an empirical study of post-qualification professionals that could complement existing work that takes an inductive approach to understanding socialisation. This work could also reveal the influence of current policies as they unfold in the course of learning traditions, norms and expectations of an organisation.

Since *Boys in White* (Becker *et al*., 1961), there have been other seminal 'interactionist' studies of socialisation. For example, Bosk's (1979) *Forgive and Remember* examines how student doctors acquire the social rules and customs for understanding and responding to patient harm as a means of reinforcing professionals' norms and informing student progression. Other studies have moved the focus of exploration beyond traditional medical, male-oriented professions and it is useful to turn to these to see what they can offer to our understanding of professional socialisation.

Dingwall (1977) observed the social world of health visitor training and how student health visitors become competent members of their professional community. This study critiques the notion of 'professional socialisation' because it implies a more passive process of "enculturation" (Dingwall, 1977:12), and suggests that instead the phenomenon could be described as "acculturation". This explains how newcomers experience an uncertain environment and have to 'work out' the required occupation competencies in

order to ‘belong’ to their chosen occupation. Another important point that Dingwall makes is to acknowledge that whilst new entrants need to identify with their occupation, the blurring of professional boundaries and the subjective notion of professionalism means that what matters is how a member of an occupational group identifies themselves at that particular time, hence the ‘when and how’ of professionalism. Similar to Becker *et al.* (1961), this perspective moves away from trying to define the professionals. Instead it tries to understand professionalism as fluid and grounded in everyday activity. By invoking the work of Garfinkel (1967), Dingwall (1977) shows how students learn to write appropriate records and manipulate the information necessary to meet performance expectations, thereby achieving the certificate of competence. This is an early and substantive contribution to the social phenomenon of ‘record keeping’. Perhaps the one of the most important contributions of Dingwalls’ study is that it highlights the differences between students’ original expectations and what they were actually are able to learn amidst the prevailing conditions of health visiting. That is to say, similarly to Becker *et al*., (1961), it shows how students were under strong pressure not to disrupt the *status quo* and were also often unable to put their innovative ideas into practice. This contribution of Dingwall (1977) is particularly relevant for this thesis and it is later shown how the approach taken to nursing Preceptorship builds upon this type of perspective by switching focus to the post-qualification period.

A further study of socialisation with particular relevance to this thesis is Melia’s (1987) account of the occupational socialisation of student nurses, a

study also based in the interactionist tradition. Melia uses the concept of 'segmentation' (Bucher and Strauss, 1961) to highlight the differences between idealised versions of nursing work presented by the 'educational segment' and the 'service segment' constrained by hospital pressures. The term 'socialisation' is also critiqued in Melia's study which instead focuses on the interactive processes of 'learning the ropes' and understanding the tension between socialising into the 'occupation' and the 'service'.

Melia's (1987) study shows how the occupation of nursing consists of loose and heterogeneous sub-groups rather than one unified profession. The implication for students is that nursing colleges present a more professionally-orientated version of nursing work that is closely associated with competencies and autonomy. On the other hand, the workplace demands the student nurses' compliance with organisational requirements. As such, the students learn how to cope with these often conflicting models of nursing by adapting their own work in accordance with the situation. They have little choice in learning this skill as they need to demonstrate their ability to work as a member of a work community as well as to pass exams. Hence, socialisation is seen as being characterised by learning to negotiate these two pressures which Melia (1987) describes through several categories of student activity. For example, the category of "learning the rules" (Melia, 1987:8) shows how student nurses learn the unwritten rules of working quickly and making sure they take their share of the workload, even if this means they are have to appear busy during quiet periods. The category "getting the work done" (Melia, 1987:30) shows how students practically accomplish the workload by learning the official and

unofficial routines of the ward. Importantly, this is achieved according to organisational timescales such as particular shift times rather than "the essential nature of nursing" which supports a model of holistic patient care (Melia, 1987:44). Using these categories and others such as "nursing in the dark" (Melia, 1987:80) which describes a lack of clear available information, Melia highlights the tensions when trying to echo the practices of experienced senior nurses. Melia concludes that it is difficult for the student to learn to be an autonomous nurse whilst seeking to emulate the practices of others.

A major observation Melia (1987) makes is that unlike her study, other studies do not focus on socialisation as a learning activity in the context of both profession and the health service. Melia (1987) argues that her work and similar interactionist studies overcome this error, showing, for example, how students find out and respond to expectations of both the profession and the health service. She shows that public expectations are also important in shaping the self-esteem of students which suggests how forces external to the organisation exert influence. Similarly to Becker *et al.* (1961), Melia (1987:162) observes that *"they learn how to be student nurses and not how to be nurses"*. That is to say, they end up not being socialised into either profession or service. This suggests that the period of newly-qualified socialisation into the profession is particularly intense, comprising important interactions for learning how 'to be' a professional.

Although a useful study, since Melia (1987) there have been important developments in nursing education and policy which are outlined in the following chapter. One of the main developments has been that the education of nurses moved first to a diploma format and more recently to a degree-only qualification. As I show, this change is seen as a progression for the profession but arguably creates new pressures both for nurses and organisations in the early post-qualification period, for example because of concerns about their amount of practical experience (Willis, 2012). Therefore, a new study that follows in the ethnographic tradition and which includes first-hand observation of the learning of newly-qualified nurses could make a valuable empirical contribution to our understanding of post-qualification socialisation.

The above interactionist studies have contributed to a rich understanding of pre-professional socialisation in the period before developments such as NPM. Their inductive approach has helped to reveal the detail of everyday professionalism as a process contingent on the setting. This is an important development because it demonstrates how learning to be a professional is fluid and how professional norms are interpreted by individuals and through group culture. However, in seeking to understand what it means to socialise as a professional in a contemporary NHS organisation, it is useful to turn to new developments in the field of organisation, management and social policy studies. This literature area is important because it explains contemporary forms of professionalism drawing attention to how professions and organisations are co-constructed (Waring and Bishop, 2010), something which

is agreed to be an important when studying contemporary socialisation in an organisational setting (Saks and Ashforth, 1997).

*Professional 'becoming' in an organisational context*

Contemporary theories of professionalism have turned to the organisation studies and management literature to try to understand the relationship between professionals and organisations. Professionals and experts have featured significantly in this literature, especially where professions influence the wider institutional field within which organisations operate and manage. A prominent example is Mintzberg (1979) who develops the idea of the 'professional bureaucracy' to describe how experts and administrators co-exist within many types of organisations. The influence of institutional theory within organisational sociology has also directed attention to the ways experts and professions act as powerful institutional agents capable of shaping the organisational environment and creating isomorphism (Di Maggio and Powell, 1991; Scott, 2001). However, these perspectives are often pluralistic and unspecific in how they describe and explain professions, tending towards more general notions of expertise and including differing occupational groups such as accounting, marketing and management consultants (Reed, 1996). Nevertheless, within the field of organisation studies, professions and experts have been examined in terms of identity formation, workforce reconfiguration and organisational dominance (Alvesson and Wilmott, 2002). I return to this literature later in the chapter when I discuss identity. A prominent strand of management research is concerned with the processes of professional education and development within organisational contexts (Raelin, 1994; Boud

and Hager, 2012). This stems from an individual and educational perspective and is often aligned with developments in HRM. These studies are often concerned with how professionals acquire the necessary knowledge, skills and competencies required to perform their work (Ashforth *et al.*, 1998; Cooper-Thomas and Anderson, 2006). In these studies, the focus is not on the wider social, cultural and political aspects of the professions but rather on the acquisition of desirable competencies, behaviour traits and values (Anderson-Gough, *et al*., 2000).

It has been noted that the traditions of the sociology of the professions and organisation studies often 'talk past' one another so that theories and approaches are developed separately (Kirkpatrick and Noordegraaf, 2015). Moreover, each tradition has been shaped by particular theoretical origins such as neo-Weberian approaches (Heugens, 2005) and neo-institutionalism (DiMaggio and Powell, 1991) without always exploring the parallels and common ground between them. In recent years there has been growing recognition of the need to reconcile these approaches, especially given that expert occupations work within particular organisational contexts, and that changes in these organisations can have a dynamic impact upon professional work. For instance, Noordegraaf (2014) argues that this 'analytical dualism' that often sees professions and organisations as being in conflict misrepresents the ways in which they are co-constructed (e.g. Gleeson and Knights 2006; Waring and Currie, 2009). As such, there are now growing calls to see the professions as reflecting not only the expectations or ideals which are advanced by the occupation (and its associated professional bodies), but also by the

organisations, managers, clients and the public with whom these professions interact (Evetts, 2011; Muzio *et al*., 2013).

Research on the ways that professions and organisations might be co-constructed draws on different theoretical traditions and marks a shift in focus away from professions to professionalism. This shift is important because it focuses less on what a profession 'is' as an analytical concept or occupational group, but rather what it means to 'be' professional in terms of expected practices and identities (Alvesson, 1993). Interestingly, this approach reflects Becker's (1963) earlier observation that the common language of professionalism serves to articulate moral imperatives about 'desirable' expert work. Recently, Evetts (2003) has argued that where previous theories of professionalism were framed by those occupations claiming professional status in the contemporary workplace, professionalism is now constituted by a range of organisational and political stakeholders. As such, where 'occupational professionalism' centred on notions of expertise, autonomy, collegiality and self-regulation, "organizational professionalism often centres on targets, performance indicators, tactics, accountability and hierarchy" (Faulconbridge and Muzio, 2008:7). For the above reasons, contemporary professionalism also becomes subject to standardisation in the organisational setting (Evetts, 2011). As such, some literature has drawn upon Foucault (1980) to show how professional practices and identities are constituted by various organisational and managerial actors as a form of 'control at a distance' (e.g. Anderson-Gough *et al*., 1998; Fournier, 1999). The significance of this perspective is that it highlights how being, or becoming a professional, centres on the acquisition

and maintenance of certain desirable or expected practices and identities and functions as a form of organisational control (Alvesson and Wilmott, 2002). I return to this subject shortly in this chapter.

It is within this contemporary understanding of professionalism that Evetts (2011:409) suggests scholars should look instead to "the appeal of professionalism" (in other words, how professionalism is used by individuals and groups, particularly when affecting change). This invokes McClelland's (1990) argument that professionalism can be seen in different forms, and hence may be seen from "within" (where the profession can manipulate the market) or "above" (dominated by other forces such as the organisation) (Evetts 2011: 407). The important issue becomes one centring on how professionalism is invoked by both professionals and by the organisations they work in. This is significant for two reasons. First, it recognises that professional education and training can become a medium through which the organisation can play a role in making professionalism appealing as an occupational value. Second, this perspective recognises that professionalism becomes important as something that the occupations identify with and invoke to get the work done among situated and often conflicting pressures. This is a central issue when thinking about *how* and *when* this manifests during the socialisation of newly-qualified professionals and remains empirically under-explored.

The work of Noordegraaf (2007) is helpful in understanding contemporary professionalism as it raises the important point that the professions literature

sees professionalism as either organising structures external to the organisation (e.g. Abbott, 1988; Elliott, 1972; Freidson, 2001) such as professional bodies or situated within the organisation (Larson, 1977). Noordegraaf (2007) argues that professionalism in the public sector should be seen as a hybrid entity. In other words, it should be seen as situated, but with connections to aspects of professionalism beyond the organisation. This perspective moves beyond recognising that professional autonomy can be undermined by organisational routines (e.g. Melia, 1987) and places it in wider frames of reference. Contemporary authors now conclude that professionalism in today's public sector organisations such as the NHS is a 'hybrid' practice because of ambiguity surrounding issues of control, ethics, safety, knowledge and knowledge domains (Evetts, 2003; Noordegraaf, 2007; Brock and Saks, 2015). In other words, professionals are faced with an uncertain environment in which they have to work reflexively (Schon, 1983). As Noordegraaf (2007:770) argues:

> *Encounters, meetings, and paper flows that are used to establish clear concepts and codes produce fuzzy categories. Knowledge about safety, health, and education has objectifiable sides, but it is difficult to determine what must be objectified and how.*

The above point is interesting as it highlights the difficulty in understanding what and when certain knowledge is legitimised by the organisation, something which could be in conflict with what is taught during professionally-orientated

pre-qualification education. This is particularly significant during socialisation when newly-qualified professionals have to try and learn the meanings and importance of certain organisational practices and rules. Hence, the orientation of education has the potential to change when it moves from pre-qualification to post-qualification professional education. In a later paper, Noordegraaf (2011) concludes, similarly to Becker *et al*. (1961) and others, that professional education is a central pressure on becoming a professional. In an empirical study of professional medical education, Noordegraaf (2011) sought to understand how doctors are oriented towards organisational issues. Despite the introduction of "hybrid guidelines" and lists of required competencies that could potentially bridge the gap between organisation and profession, the authors found that organisational references were only present in a 'weak form' in education driven by the professional associations which tried to reinforce a traditional approach to healthcare work, such as improving medical practices, rather than issues like inter-professional working and communication.

Noordegraaf's (2011) study is useful because it draws attention to the relationship between competing organisational and professional logics in professional education. In the doctor's case, the professional association remained dominant. Logics in this sense can be understood as the rationale behind practice. The dominant professional logic is concerned with 'doing good' for the patient and becoming a better professional; the organisational logic is an efficient well-co-ordinated system (Noordegraaf, 2011). Noordegraaf's (2011) study points to the potential role of professional educators in moving beyond traditional professional concerns to try to shape

professional behaviours into ones that allow for the strategising and co-ordination of the whole system, and to change their practice where needed. Professional associations are argued to either help or hinder this process, depending on how they posit organisational change and legitimise the activity of professional workers.

Although Noordegraaf's (2011) paper draws attention to 'outside' professional and organisational logics and the potential role of professional educators in (re)shaping the professional, it only offers some insights relevant to professional socialisation in the post-qualification period. Pre-qualification professional education is different to professional education for qualified staff. In the latter, professional education takes the form of professional development which is decoupled from formal educational structures aimed at national registration. The study, though insightful, does not explore the newly-qualified period. Moreover, although it discusses the importance of educational practices and the clinical setting, reflexive, real-time practice was not studied, a limitation that was acknowledged by the author.

Despite the above findings, pre and post qualification education are located as sites that connect working and learning between organisation and profession. In recognising the hybridity of professionalism, and locating the site of professionalism in reflexive practice, Noordegraaf (2007) joins the growing number of authors (e.g. Mulcahy, 2011; Scanlon, 2012) who suggest that

professional becoming is a useful metaphor through which to study situated professionalism as a complex and ongoing social process with no end point:

> *This is not so much about being a professional in modern times, as it is about becoming one, or more precisely, about showing that one is becoming a professional without necessarily ever becoming one*
>
> (Noordegraaf 2007:774)

This perspective is different to other studies of professional socialisation which have suggested that there is an end point to the process (Ibarra, 1999; Duchscher, 2008). Noordegraaf's approach helps us to understand how professionals adapt to the ever-changing conditions of learning in the public sector, and shows how professional education in an organisational setting can influence 'becoming'. Yet this perspective still leans towards the sociology of the professions perspective in terms of influence and orientation because it theorises about the professions and professional work first and foremost.

In summary, although this literature invites us to engage with the organisational literature, it also tends to focus on pre-professional education rather than on what happens during post-qualification processes of socialisation. I suggest that more could be learned about how organisational policies and processes, e.g. HRM interventions and specific professional

socialisation programmes such as Preceptorship, play a part in the early post-qualification period of 'professional becoming'. Such studies might show empirically how 'professional becoming' might manifest as newly-qualified professionals negotiate their way through performance-driven processes whilst at the same time learning to belong to a community of practitioners. The following section explores the literature on organisational socialisation to see what this can tell us about 'professional becoming' and considers whether it helps us to understand professional socialisation in the post-qualification period.

## Organisational socialisation

From the 1970s, research on organisational socialisation has gained momentum, particularly in the fields of Organisation Studies and HRM (Saks and Ashforth, 1997). Where professional socialisation is broadly concerned with understanding how new workers acquire the expected knowledge, skills and cultures of their occupation, organisational socialisation is concerned with how new workers develop similar knowledge, skills and cultures with reference to the expectations of the organisation or their employer. Early studies of organisational socialisation for example, looked at how newcomers adjust to their role and learn the organisation's culture (Katz, 1978; Louis, 1980).

Saks and Ashforth (1997) acknowledge there is no grand theory of organisational socialisation and found that most studies are driven by four collections of theories. First, they point to the popularity of uncertainty theory (e.g. Falcione and Wilkinson, 1988) which assumes that organisational tactics such as 'information giving' can reduce uncertainty and anxiety for the new organisational member. For example, Saks and Ashforth (1996) concluded that a well-executed initial training programme can reduce worker anxiety, a view which may explain the proliferation of induction programmes that are now seen in organisations. These programmes work on the premise that the more information is given, the better the new employee will adapt to their new situation, and settle in and conform to expectations. In a recent study, a positive relationship was found between HRM practices (such as induction) and compliance. Hence, if individuals perceive that the organisation cares about their welfare, they are more likely to be compliant and thus exhibit co-operative behaviours such as helping their colleagues (Snape and Redman, 2010). Interestingly, a mediating factor of the relationship between HRM practices and employee behaviour was found to be perceived job influence (Snape and Redman, 2010). This suggests that organisational HRM interventions such as staff inductions and training can foster compliance but the interventions may be less effective if there are feelings of reduced influence and autonomy on the part of the inducted individuals.

A second type of theory influential in organisational socialisation research as identified by Saks and Ashforth (1997) is informed by social cognitive theory which considers how behaviours are influenced by the work context and *vice-*

*versa*. A relevant concept within this tradition is self-efficacy, a construct that centres on the degree of self-belief someone has and which is influenced by concepts such as persuasion, personal mastery, vicarious feelings and psychological conditions (Saks and Ashforth, 1997). This socio-cognitive theory is influential in the HRM literature; for example, McNatt and Judge (2008) studied management tactics that took the form of both a persuasive interview and sympathetic-sounding written communications. They found that these tactics helped the retention of professional financial auditors who had been employed in the organisation for a while, rather than new employees. This is interesting because it suggests that the critical time for supporting retention is not the initial period but rather, after work becomes more established.

A third theory often cited in the organisational socialisation literature and identified by Saks and Ashforth (1997) is Van Maanen and Schein's (1979) model of socialisation tactics, a study that arises from social psychology but also has roots in symbolic interactionism. Van Maanen and Schein (1979) show the processes involved when organisations try to find ways to limit the ideas and possibility for change, so that their culture is not disrupted through the entry of new organisational members. Thus, the focus for this literature is to look at socialisation tactics, for example how organisations give and withhold information. Interestingly, this type of study identifies "divestiture tactics", which are conscious organisational tactics that isolate the newcomer from old work ties, encourage established members to beleaguer the newcomer (to make sure they work hard), and allocate them menial tasks, thus encouraging allegiance to the organisation's demands (Van Maanen and Schein

1979:236). On the other hand, organisational "investiture tactics" such as endorsing and actively building upon previous experience and skills were found to be organisational tactics that occurred later in the socialisation process (Van Maanen and Schein 1979: 236).

The approach of Van Maanen and Schein (1979) was later adapted by Jones (1986), who argues that the phenomena of organisational socialisation are more complex than originally theorised. This adaptation shows how self-efficacy (belief in one's abilities) mediates the organisational tactics, thus adding an individual aspect to the theory. However this reinforces the dichotomy between individual and organisation, something which contemporary learning theories try to overcome (Nicolini, 2012). There also appears to be a tension in this traditional approach as it suggests that socialisation has an end point. Yet by acknowledging socialisation as a learning process, authors such as Van Maanen and Schein (1979) implicitly recognise that learning is a continuum, and thus individuals are always involved in some form of socialisation. This also supports the notion of continuous professional becoming (Noordegraaf, 2007) from a learning perspective.

The fourth group of socialisation studies identified by Saks and Ashforth (1997) relate to the broad area of organisational research on cognitive and sense-making theories (e.g. Weick, 1995). These are evident in the HRM field where they have been used to explore the role of mentors in sense-giving. Harvey *et al.* (1999) examine whether long term mentoring would help to build

self-efficacy, promote emotional resilience and also provide vicarious experiences for the newcomer to develop the appropriate 'mental schema' needed to deal with unfamiliar cultural experiences. The study concludes that mentoring can be useful in this respect as mentors can help with ongoing sense-making. The study echoes other HRM and educational studies (Louis, 1980, Thomas and Lankau, 2009) that mentoring shapes the way that local information is understood and is seen as speeding up the process of individuals becoming encultured (Harvey *et al.*, 1999). These sense-making studies also acknowledge the emotional challenge of socialisation and mentors are suggested as helping newcomers avoid feelings of failure (Harvey *et al.*, 1997) or burnout and stress (Thomas and Lankau, 2009).

Significantly, mentors are thus seen to play a role in helping newcomers learn the informal rules of the context and negotiating relationships (Feldman and Bolino, 1999). Although studies highlight the close conceptual relationship between socialisation and training, this relationship often appears to be conflated within management literature in terms of improving an individual's well-being. Further, newer forms of interventions similar to mentoring, such as Preceptorship, are not as well understood in terms of the processes of everyday learning.

As previously noted, contemporary socialisation can be perceived as much more complex. Today's organisations are subject to the turbulent conditions of the current economic and political climate and may seek to 'mould' the

newcomer to meet these current, complex organisational concerns. Studies of contemporary professionalism have noted that professionals work reflexively in light of the ideas of both the profession and organisation, and this perspective resonates with some of the literature on organisational identity and socialisation. In the following section, I discuss why identity is an important concept in 'professional becoming', and draw upon authors from sociology and organisation studies to support my argument.

## Socialisation and identity

Another important and relevant way that authors have tried to understand professional socialisation is to recognise it as a process of learning a new identity. In social science, identity is understood from a range of perspectives and has been central to many theories either at individual, group, organisational, or national level (du Gay *et al.*, 2000). In organisation studies, identity is often informed by the perspective of social identity. This broadly theorises the similarities and differences of humans. In terms of identity at work, it has long been accepted that people identify with the groups in which they participate, a process which involves labelling oneself and subscribing to the ideology of the group to which they belong (Strauss, 1997; Lave and Wenger, 1991). However, traditional theories often see identity as something that is acquired in relation to the occupation rather than the organisation. For example, Becker and Carper (1956) studied the acquisition of professional identity by students in physiology laboratories and note that occupations are well defined and a significant element of identity will be influenced by

symbolic ties with a profession. Hence, similarly to Evetts (2011), professionalism can be symbolically powerful and appealing to a newly-qualified worker as it can guide them towards certain ways of 'being'. The development of an occupational identity is an important 'rite of passage' (Becker and Carper, 1956), however there are also tensions if expectations of the new role do not live up to the ideological belief about the occupation or profession.

It is problematic that many perspectives such as Social Identity Theory (Tajifel and Turner, 1985) assume an end point of acquiring a new identity or that the new role identity offered to them is rejected (Ibarra, 1999). Contemporary theories of identity suggest that identity is ongoing and reflexive, as Jenkins (1996:4) argues:

> *Identity can in fact only be understood as process, as being or becoming. One's social identities […] for who we are, is always singular and plural - is never a final or settled matter.*

Understanding what the processes of 'professional becoming' are, involves understanding that identity is co-constructed within the context in which individuals work, and hence context has to be studied in order to make sense of how people's sense of self emerges through interaction between the self, profession and organisation. However, the context is more than just a physical location of work. Recognising that institutional norms shape people's

identities, this process can only be understood by studying the historical way social norms are distributed and organised (Saunders, 1997, cited in du Gay, 2007). As such, du Gay (2007:11) suggests that becoming a person is achieved through immersion into "normative and technical regimes of conduct". In other words, we are shaped by customs, rules and how we are disciplined, which is seen as an ongoing and fluid process. This is important for studying the newly-qualified period of 'professional becoming', given that the newcomer is subjected to pressures described earlier such as organisational and HRM processes.

Some authors suggest that identity is provisional during early socialisation (Ibarra, 1999; Scanlon, 2012). Influenced by Cooley (1964), Mead (1934) and Goffman (1969), Ibarra (1999) takes the position that socialisation is concerned with learning a new identity that is negotiated through social processes. Ibarra (1999) suggests that people will experiment by first observing their role models, then act out different selves and then evaluate their performance based on the reaction they obtain. They act out possible selves and ask themselves, "Did I act like the person I want to become?" (Ibarra, 1999:768). Experimentation is achieved through three processes. "Variety creation" explains how the professionals in the study who were more open to different models of work could create more possible selves (Ibarra, 1999:785). "Variety retention" shows how 'possible selves' lead to the creation of more possible selves, whilst others who experimented and failed, could nevertheless continue acting out the inadequate roles (Ibarra, 1999:785). Individual antecedents include past experiences, personal choices and prior learned skills whilst

situational experiences include the practices of socialisation, role models and the nature of those relationships (Ibarra, 1999:785). Ibarra's study highlights some of the processes involved in identity change during an early professional career. First, professionals who work in service organisations (which could include hospitals) are on show and thereby appearing competent is central to new work transitions. Second, professionals also have to perform the identity of the organisation and according to Ibarra (1999), these processes occur through improvised interactions. The findings of Ibarra's study add to the view that individuals can exercise agency in identity construction, but that this is restricted by the norms associated with the various activities that define the occupation.

Ibarra's (1999) study is useful but it has limitations in the context of this thesis on new forms of mentoring such as Preceptorship. First, it is unclear who the role models are in professional situations; this is particularly important when there is blurring of professional boundaries. Second, this study assumes that experimenting with provisional selves will stop at some point. However, in current conditions of uncertainty, experimentation could also continue for professionals who work in new situations. Possible selves are a condition of the post-modern professional, who it could be argued embody a "parliament of possible selves" (e.g. Nicolini and Roe, 2014:70). Finally, in Ibarra's (1999) study, identity issues were uncovered through narrative interviews. As the study design is limited by a single data collection method, this creates space for further research utilising other ethnographic methods which might be better suited to observing how socialisation happens and how the novice achieves

identity-making and identity-taking as a deeply-situated accomplishment. This would provide detail on the mediators of identity at the organisational level and does not show how the professional learns, responds and shapes the context in which they work. This is important because becoming a professional in the post-registration period is a learning activity heavily mediated by current conditions in everyday practice.

A second perspective coming from organisational socialisation is identity regulation as a site of control. This encompasses the notion that contemporary management is concerned with managing identity as a form of control (Alvesson and Wilmott, 2002). Whilst much of the HRM literature sees new employee induction as a positive intervention for the organisation, more critical perspectives see interventions such as induction programmes as a form of control that moulds the individual to the needs of the organisation (Alvesson and Wilmott, 2002). This is an important viewpoint in this thesis that seeks to understand more about Preceptorship. Preceptorship is similar to induction in trying to reduce uncertainty for professionals or subject them to increased organisational control.

Identity regulation explains how organisations use induction and training to influence practices that affects the social processes of identification. This relates to the observation that today's professionals will often refer to themselves as an employee of a certain organisation rather than being defined by the job that they do (Casey, 1995). Alvesson and Wilmott (2002:8) draw

from Giddens (1991) to show how identity is a "reflexively organized narrative, derived from ongoing participation in competing discourses and various experiences". This participation is achieved using available cultural material and interactions which include signs, symbols and texts associated with organisational processes of managerialism. Self-identification is seen to be an active, ongoing process in which people seek to makes themselves feel secure in the uncertain conditions of late modern times (Giddens, 1991; Wilmott, 1994; Alvesson and Wilmott, 2002). This is a similar approach to the hybrid notion of professionalism proposed by Noordegraaf (2007), who also invokes reflexivity as a process that occurs amid contemporary pressures on professionalism (reflexivity in this sense means that professionals search for the meaning of professionalism in an organisational context). These perspectives highlight how socialisation can become a site for control and how education, induction and other HRM processes can legitimise some skills rather than others as a way of regulating professionals' identity for organisational ends (Alvesson and Wilmott, 2002). Socialisation is thus recognised as a learning process whereby the norms and rules of the community are learned at the same time as experiencing organisational control which can cause conflict. This recognition is helpful because it acknowledges the changing nature of professionalism and how professional becoming is shaped by organisational practices. However this perspective is concerned with understanding organisational discourses and does not focus on the newly-qualified practices of identity regulation as learning in real-time and how this is influenced by early socialisation. I return to reflexivity and identity in the second part of this chapter when I discuss social learning.

To conclude this section on organisational socialisation and identity, with the exception of identity regulation (Alvesson and Wilmot, 2002) this field primarily focuses on new starters to the organisation rather than specifically on the professional. Studies also tend to be rooted in psychology and take a positivistic, quantitative approach in terms of methodological design (McNatt and Judge, 2008). There are several valuable points from this literature which including the role of power and control in socialisation and how organisations use HRM tactics to reduce uncertainty and 'mould' the newcomer to meet both organisational expectations. Identity regulation is therefore central to socialisation (Alvesson and Wilmott, 2002). Furthermore, identity is seen as provisional (Ibarra, 1999) and reflexive (Giddens, 1991; Wilmott, 1994; Alvesson and Wilmott, 2002) and is seen as constructed, albeit from an individual perspective. These concepts have resonance with the literature on professional becoming which also acknowledges how learning to be a professional involves changing identity (Noordegraaf, 2007; Scanlon, 2012). Arguably the most important theme here is that studies generally agree that socialisation involves learning the skills, norms and cultural values of the organisation and how to be an appropriate member of the organisation. However, more work could be done to specifically focus on post-qualification training programmes such as Preceptorship which as I later show, are increasingly adopted by organisations as they realise the value of taking the opportunity to use induction programmes to try to shape professional practice.

## From professional socialisation to professional becoming

To develop an understanding of contemporary 'professional becoming' I have studied three different literatures that explain professional socialisation, organisational socialisation and professional identity. A review into the literature on professional socialisation showed that there is a strong contribution to knowledge from studies rooted in two traditions, those in the sociology of the professions literature and those that understand professional socialisation explicitly in an organisational and management context. Firstly, I focused on classic studies rooted in the sociology of the professions literature which follow in the symbolic interactionist tradition and produce rich and accounts of socialisation. Although helpful in explaining the every-day practices and processes of learning to be a professional I noted how they tend to focus on pre-professional training rather than the post-qualification period. There is also space for a contemporary understanding of learning to be a professional in the context of current policies such as nursing Preceptorship. Secondly, I identified a group of studies which note the importance of understanding professional socialisation in the context of the managing the contemporary workplace. These studies have shown how professionals now have to adapt to ever-changing conditions in public service and suggest that professional socialisation is best understood as 'professional becoming', a hybrid activity characterised by reflexive learning and ongoing identity work (Noordegraaf, 2007). Although the work of Noordegraaf (2007) takes us some way in understanding this hybrid contemporary professionalism, studies such as his focus also focus on pre-professional training. As such, they do not account for the impact of other organisational HRM and induction processes

and the tactics that organisations and the profession use to mould the newcomer.

To further an understanding of professional socialisation in an organisational context, I turned to the literature on organisational socialisation. I showed how this is a broad field with many studies being informed by psychological and individually oriented theories which focus on new starters in an organisation and explore how they develop knowledge and skills in relation to the expectations of their new employer. These studies are useful because they recognise the tactics that organisations use to maintain their existing culture and encourage loyalty of the new starter. However, as noted, they focus on new starters and as such tend to assume an end point to socialisation and down-play the importance of professional education. Usefully for this study, they highlight the importance of mentors but have not yet studied new forms of professional mentoring such as Preceptorship.

The third and final group of studies that I turned to are those which study professional identity. This was considered to be important for this thesis given that the literature on professional socialisation shows that this is something which is reflexively formed through participation in the workplace. Firstly I looked more generally at defining identity and recognised it as an activity, something that we do and I thus reiterated that we are always 'becoming' (Jenkins, 1996). As such, our identity is shaped by local customs and rules as an ongoing, fluid process (du Gay, 2007). In further exploring professional

identity, the literature on identity regulation was particularly helpful because it showed how the professional identity of new starters can become a site for organisational control and is reflexively achieved, often in relation to the organisational factors rather than to the profession (Alvesson and Wilmott, 2008).

Although each literature area that I have studied offers some insights into contemporary 'professional becoming', they vary in their focus whether on pre-professional training or on new starters to an organisation. Understanding contemporary post-qualification socialisation demands a new approach that foregrounds neither the profession nor the organisation and to see it as truly hybrid and reflexive amidst fast changing conditions of work and structured by new induction policies such as Preceptorship. One way that this can be achieved is to theorise 'professional becoming' as a learning process; indeed most of the studies that I have discussed explicitly understand this, for example as seen in Melia's' (1987) study of pre-professional student nurses learning to work between service and education on a ward setting. It can be seen that newly-qualified professionals need to learn how to belong to both profession and organisation, to learn the tacit knowledge and skills that are required, to how 'to be' and act and will adjust their identity according to conditions of work. This literature has also told us that this is mediated though mentoring and influenced by other organisational induction policies. The second part of this chapter therefore aims to develop a theoretical perspective on learning, becoming and identity that re-connects the above literatures and which will offer a more holistic understanding of what happens in everyday work.

## Part 2

Part 2 of this chapter begins by discussing the nature of knowledge and is followed by three perspectives on organisational knowledge and learning. First, cognitive or 'structural' views of learning are introduced. An introduction to process approaches and a detailed analysis of Situated Learning Theory (SLT) (Lave and Wenger, 1991) follows. SLT is an interesting and useful approach that understands knowledge as culturally-embedded and which sees identity transformation as a central feature of learning and 'becoming'. Whilst SLT begins to theorise about practice, and indeed, has provoked much interest in this idea, the third and final part of this section will justify moving beyond SLT in order to take a more explicit practice-based perspective (Schatzki, 2001; Gherardi, 2001) to 'professional becoming'.

### Perspectives on organisational knowledge and learning

Knowledge is often described as 'facts' or 'information', yet remains a cloudy concept (Tsoukas and Vladimirou, 2001). Since the 1960s and 1970s, the concept of organisational knowledge and learning entered the mainstream literature (e.g. Cyert and March, 1963; Argyris and Schon, 1978) particularly in organisation studies (Easterby-Smith *et al.*, 2011). There are a wide variety of perspectives on knowledge, for example, from individual to group and from micro to macro. These can be summarised by grouping theories into different epistemological perspectives on knowledge related to the structural, process and practice views.

These perspectives are shown in the table on the following page, which also demonstrates how each of these three perspectives views social life, knowledge, the locus of knowledge, the link between knowledge and performance, focus for knowledge and tasks of knowledge.

**Table 1**: Perspectives on Knowledge, adapted from Newell *et al.* (2009:18).

| | **Structural** | **Process** | **Practice** |
|---|---|---|---|
| **View of Social Life** | Individuals navigate in an external world through cognition | Individual and collective interpretation in social roles, interactions and structures | Materially interwoven (human and non-human) practices organised around shared understandings |
| **View of Knowledge** | Knowledge as a cognitive entity to be captured | Social and organisational, socially constructed in contexts | Knowing as practice, fields of interconnecting practices |
| **Major Locus of Knowledge** | Embrained, embodied in heads and skills | Embedded in and encultured in social context | Embedded, embodied and invested in practice |
| **Link between knowledge and Organisational Performance** | Knowledge related positively to performance | Relationship between knowledge and performance | Knowledge and performance mediated through practice, sticks at boundaries |
| **Major Focus for Managing Knowledge** | Work, tacit to explicit | Share, translate and legitimise across groups | Transforming knowledge through overlapping practices |
| **Major Tasks of Knowledge** | Management Capturing/transferring | Translate across social groups | Transform knowledge through overlapping practice |

The above table presents three distinct views of knowledge and how it may be viewed in the context of organisations. The table demonstrates the assumptions made in the literature that explores knowledge and learning in relation to

'becoming' a professional. I will shortly discuss the limitations of the structural and process views of knowledge before suggesting that a practice perspective on organisational learning helps to develop a more nuanced understanding of 'professional becoming'. I begin with perspectives on knowledge and learning that can be classified, at least in part, as 'structural' theories (in other words, theories that give knowledge a structure or form).

## Structural views of organisational knowledge and learning

The most dominant view of knowledge which is shown in the above table is the structural view, also described as the "epistemology of possession" (Cook and Brown, 1999:381). This perspective sees humans as 'containers' for knowledge, a view often found within the academic and consultancy literature that has dominated learning perspectives for many years (Newell *et al.*, 2009). Knowledge is seen to be easily extracted and transferred, often through training and development initiatives. Knowledge is seen to be an independent and explicit entity, a 'thing', which is seen as having a particular 'shape' and structure. In relation to learning, knowledge is seen as a 'thing' that is acquired by an individual who then makes meaning of the knowledge, developing an individual frame of reference (Newell *et al.*, 2009). Knowledge is also viewed as something that needs to be extracted to benefit a group in an organisation; hence studies adopting a structural perspective often talk about making tacit knowledge more explicit and codifying it for the purpose of transfer.

As such, studies of organisational learning that adopt this perspective often draw upon the work of Polanyi (1961;1966) who makes the distinction between 'tacit' and 'explicit' knowledge and how they are used in learning. To explain tacit knowledge Polanyi draws on Kant's description of personal knowledge as "an art hidden in the depth of the human soul" (Kant in Polanyi, 1961: 467). In other words, tacit knowledge is personal and hard to describe - unlike explicit knowledge which can easily be codified. Polanyi (1962) questions how people acquire this knowledge, how they come 'to know', distinguishing between knowing and doing. As the mutual constitution of tacit and explicit knowledge is stressed, either can lose their dynamism if isolated (Polanyi, 1962). This is demonstrated in the famous example of riding a bike, something which people cannot easily describe how they do because much of the knowledge that enables this activity is tacit. Yet when teaching others to ride a bike, some tacit knowledge can be made explicit and used, such as explaining how to turn the handlebars (handlebars are an object). Thus, there is an element of knowledge that is personal and 'to know' occurs when personal knowledge is linked with objective reality (Polanyi, 1962).

The above idea is closely linked with Polanyi's (1962:88) well known description of experts who "know more things than they can tell, knowing them only in practice as instrumental particulars, and not explicitly as objects". This difficulty in surfacing and sharing tacit knowledge is important when thinking about professional becoming as it shows that experts who teach others would not necessarily be able to describe all of the skills required in professional practice. Yet despite his description of tacit knowledge, Polanyi

(1961) also argues that we only come to 'know' through a hierarchy of education, beginning with a few important people whose work provides a framework and thus act as 'pointers' through which we are educated. Undue weight is given to the importance of classroom teaching as identified in the more recent literature on implementation (e.g. Rowley *et al.*, 2012) that suggests knowledge needs to be generated collaboratively and not separated from practice. Therefore, Polanyi does not attend to the social or material aspects of knowing, such as the importance of tools and technology (Nicolini, 2012).

One of the most important studies of this genre is Blackler's (1995:1023) typology which describes knowledge as "embrained", "embodied", "encultured" "embedded" and "encoded". Embrained knowledge is cognitive knowledge (hence the structural view) which is abstract or tacit knowledge. Encultured knowledge is found in the shared symbols of a community. Encoded knowledge is explicit knowledge for example, in texts. Embodied knowledge is practical knowledge (Blackler, 1995). In this typology, all types of knowledge are important however some will be more important than others depending upon the purpose. For example, the embodied skills of a professional worker will be dominant in a hospital that requires specialist expertise (Blackler, 1995). Blackler's framework is an interpretation of knowledge that is easy to understand and acknowledges the interplay of different types of knowledge in use. However, the framework seems too neat in its distinctions and does not explain how these forms of knowledge come into play within a given context. Although this framework has a cognitive element,

Blackler (1995) does acknowledge the contemporary shift in thinking about the nature of knowledge and learning in organisations, thus paving the way for a more processual view of knowledge.

A further study that takes the structural view of knowledge and learning is Nonaka and Takeuchi's (1995) model which has been described as achieving "paradigmatic status" (Gourlay 2006:1415). The SECI model is concerned with Socialisation, Externalisation, Combination and Internalisation as transformative processes through which individual knowledge becomes group knowledge and then moves back to the individual again, in a cycle of learning. In particular, it examines how tacit knowledge can be transformed into explicit knowledge. This takes place through externalisation and reconstitution into individual practice through socialisation and internalisation to be used as a resource for the organisation (Newell *et al.,* 2009). Despite the social element of this model, it remains in the structural group of theories of knowledge as at its core it is a very individual 'container' model of knowledge. It often separates tacit and explicit knowledge, thus contradicting Polanyi's (1961) intent (Newell *et al.,* 2009). This can be argued to be a fundamental mistake as tacit knowledge cannot easily be articulated (Tsoukas, 2011). Although the SECI model recognises the practical aspects of learning, it does not account for creativity and focuses on emotion without offering supporting evidence (Gourlay, 2006; Newell *et al*., 2009). Nonaka and Takeuchi (1995) see organisational knowledge as created by managers, thus limiting a broader understanding of tacit knowledge (Gourlay, 2006). Finally, the SECI model is difficult to apply in Western situations of learning (such as the NHS) because it

does not explain the power and politics of knowledge and learning in everyday practice.

Another area where the structural view of knowledge is prominent and often seen in approaches to training and development are perspectives which centre on reflection as the means of learning about practice (e.g. Argyris and Schon 1974; Schon, 1983; Kolb, 1984). For example, reflection 'in action' is articulated by Schon (1983) as a sequential process of acting routinely, being surprised by a problem, reflecting on the problem and then being able to take appropriate action. Conversely, reflection 'on action' is accomplished afterwards. Schon (1983) is one of the first authors to detail aspects of learning through professional practice, and in particular to explain reflection as a practical activity (Yannow and Tsoukas, 2009). Schon (1983) thus addresses the flaws of the dominant, linear problem-solving approach to work as problems at work are instead viewed as 'messy'. Schon (1983) highlights the tacit nature of professional practice arguing that we routinely reflect 'on action' after practice but we neglect 'in action', i.e. reflecting during practice which becomes more tacit and problematic as we gain experience of making sense of situations. Schon's (1983) model of reflective practice, although influential is criticised as being too narrow in its focus (Eraut, 1995; Yannow and Tsoukas 2009). As Cotton (2001) also notes, such models do not explain exactly what reflection is nor how to actually do it in detail, and models such as these have become 'catch-all' terms for a process that is very ill-defined (e.g. Bleakley, 1999).

Such modes of reflection continue to be used during the education of professionals for example, nurses who use models such as Johns (2000) and Atkins and Murphy (1993). These show reflective practice as personal during which individuals are asked to look hard into themselves to understand what they know about practice as a representational 'mirror image' (Nicolini and Roe, 2014). However, this does not account for the tacit dimension, the multiplicity of practice (e.g. Nicolini and Roe, 2014) and the social aspect of working in a community. As such, reflection can be very frustrating for individual practitioners (Cotton, 2001). Furthermore, reflective models do not account for the influence of the wider context such as national policy. Issues of power could also make a difference to how the self is viewed in relation to the social context. Although the reflection during practice perspective is at least a move away from the cognitive separation of reflection from the activity itself, there is still a lack of attention paid to the role of artefacts and other networks in this process and such a view of knowledge is largely acquisitive. For this reason, and for its lack of effective impact upon learning, contemporary scholars such as those who study professional education have become more critical of this simple approach (e.g. Bradbury *et al*., 2009) and are starting to turn to contemporary learning theories.

This section has shown the assumptions about the nature of knowledge that are often made in approaches to learning and development. These assumptions are important to remember when considering the tactics that organisations use to

shape the early period of professional becoming. In the following section I explain different approaches to knowledge and learning which are seen in process and practice approaches.

## Process views of organisational knowledge and learning

Process views of knowledge are different because they centre on the social aspect of learning and recognise the social construction of knowledge which is understood to take place through human interactions. This view criticises the perspective where knowledge is seen as something that is purely cognitive; knowledge becomes something that is acquired through becoming part of a working culture (Brown, Collins and Duguid, 1989). Many process approach theories tend to make a direct link between knowledge and performance (Senge, 1993) and often see translation as a central activity in the transmission of knowledge (Greenhalgh *et al.*, 2006). However, a moral radical strand of process theories are ones which take an approach to learning as a situated activity. In this view, the outcome of the processes of learning to become a member of a community involves a change of identity (Jordan, 1989; Brown and Duguid, 1991). The seminal example is Lave and Wenger's (1991) work on situated learning. It represented a radical shift in epistemology and perspective that offers an insightful foundation to understand learning, becoming and identity through everyday practice.

*Situated Learning Theory (SLT)*

Lave and Wenger (1991) develop their particular view of learning and identity through synthesising data from ethnographies which studied the learning of midwives, quartermasters, tailors, meat cutters and alcoholics. SLT describes learning as embedded in daily activity; thus learning does not have an intrinsic quality, there is only "changing participation" in everyday life (Lave, 2009:201). As such, SLT is fundamentally different to cognitive theories because it suggests that 'real' learning takes place in the context of the nuanced practices of a community. The context for learning is historical, cultural and social, where learning is co-constructed through artefacts and symbols, agents and activities, and in a context that is dynamic and always reconstituting (Gherardi *et al.*, 1998). Learning is thus holistic and involves 'learning the ropes' during which the person is defined, and in the process constructs a certain identity within the context of a particular "community of practice" (Lave and Wenger, 1991:42). The next three sections explain SLT's particular approach to knowledge, identity and participatory practice.

*SLT and Knowledge*

SLT (Lave and Wenger, 1991) critiques the traditional, cognitive view of knowledge which locates knowledge as a social construct in a particular context (Newell *et al.*, 2009). However, the presence of structures is not dismissed completely; rather, these structures are seen as located in, and as organising the practices of, a community (Hanks, 2001). The authors do not deny that there is generalised, decontextualized and abstract knowledge; they

argue that the use of this form of knowledge is limited because it is contingent on the situation in which it is used. In SLT, to 'know' always entails relationships with other people and activities. However, this is different to standard models of apprenticeship which view the internalisation of knowledge as a linear process, thus excluding issues of culture or any boundaries to its knowledge transmission (Jordan, 1989). Drawing upon activity theory of Vygotsky (1980), and the concept of mediation, Lave and Wenger (1991) contest the notion that knowledge can be transmitted from person to person and internalised in an unproblematic way. Consequently, learning is argued to take place in a collective context, where the socio-cultural transformation of knowledge is relational and is situated in the (changing) relationship between the novice and expert. The creation of knowledge as activity is thus an on-going process of improvisation, learning skills and accountability. However, it relies on contextual resources and it depends on the logic that is used by a particular social group (Suchman and Trigg, 1993).

Crucially SLT displaces pedagogical approaches to learning, thus resonating with the work of Frière (2000), who criticises the traditional model of classroom learning (Lave and Wenger, 1991). Indeed, the language of the concept of SLT is inherently Marxist (e.g. in referring to historicity, empowerment and praxis), an approach which is argued to have enhanced mainstream learning research (Hay, 1996). In a similar argument, Friere (2000) claims that formal instruction oppresses the creativity of the student. This has implications for professional and practice development, when workers are expected to develop correct behaviours and practice during classroom activity

and forms of blended learning. In SLT, meaning can only be made in the classroom through the instructor's external perspective and thus classroom learning is seen as a prescriptive and instructive formula.

*SLT and Identity*

SLT argues that as people come to know, their identity is transformed as they adopt the shared identity of their community within which they work. As Lave and Wenger (1991:115) stress, "learning and a sense of identity are inseparable, they are aspects of the same phenomena", identity is found between action and meaning and transforms with knowing and social membership. SLT argues that the ability to form an identity involves a reconciliation of personal history with the norms of the group (Lave and Wenger, 1991). These can conflict and need to be negotiated and resolved before a feeling of belonging occurs (Handley *et al.*, 2006).

Some authors criticise SLT as theorising the concept of community as singular while not exploring the relationships between communities of practice (Osterlund and Carlisle, 2003). This is an important point when considering professional identity. For example, novice nurses may manage their identity between communities of practice (as they are members of a wider profession). It is therefore important to consider their interactions within a hybrid notion of professionalism (Noordegraaf, 2007). It is for this reason that Wenger (1998:218) later expands this understanding by suggesting that identity develops as "a living-bridge, the dynamic locus of alignment". In other words,

a person aligns his or her different ways of belonging in multiple communities of practice. Lave and Wenger (1991) note that the concept of transforming identity was not addressed by Becker *et al.* (1961), and hence this is a key area where adopting and developing their perspective can enhance an understanding of professional becoming as changing identity.

*SLT and Participation*

Central to SLT is the concept of "Legitimate Peripheral Participation" (LLP) (Lave and Wenger, 1991:29), the process through which a novice moves from the periphery of a community through to becoming a full member of it by mastering the activities which are legitimised by more experienced members. LLP is where the activity of learning is located and is "a way to speak about the relations between newcomers and old-timers, and about activities, identities, artefacts and communities of knowledge and practice" (Lave and Wenger, 1991:29). Through an analysis of ethnographic studies, Lave and Wenger (1991) showed that the relationship between a novice and a particular master is not the basis for learning; it is the master's act of legitimising the novice that is more important. Working on the periphery of the community is important for the development of practice because the novice can ask questions that may prompt critical reflection on aspects of his or her practice. This is seen as the 'essence' of LPP, and it takes place as a dynamic interaction between people and activities in practice (Goody, 1989, cited in Lave and Wenger, 1991).

As such, in SLT participation is the key to learning, rather than the observation and copying of the expert's practice. Participation in the periphery of a community allows the novice to learn the rules, adopt the norms and habits of the experts and know what motivates them (Lave and Wenger, 1991). This is an evolving and dynamic process as participation is not static but involves negotiating access through different aspects of work. If participation is the key to learning the habits and norms of a community, access is crucial in learning the tools, artefacts and technical aspects of daily work. Not only is access important but the transparency of the 'tools of the trade' is pivotal to learning, as these can be made visible or invisible to the learner. This access can be withheld by experts resulting in power struggles. Experts not only have the power to withhold access to resources, they may also create a discursive community that the novice cannot access.

Nevertheless, a lack of attention paid by an expert to a learner, this can cause "benign community neglect" (Lave and Wenger, 1991:93) which results in more active and productive relationships between novices. The novice may not wish to become a 'clone' of the 'old-timers' and instead will manage their identity in-between communities of practice, yet symbolically interact where there is conflict between themselves and the 'old-timers' (in other words, 'going through the motions'), a practice that goes largely unseen. Thus, the novice is using their power and could also withhold the sharing of information and inhibit the circulation of knowledge. This is different to identity regulation (Alvesson and Wilmott 2002) where the imbalance is seen to favour management. Hence a more dynamic understanding of the study of power

relations in communities is crucial to understanding socialisation into communities.

Lave and Wenger, (1991) appear to recognise the centrality of power relations when they note how resources are dominated. Moreover, legitimacy involves the learner being awarded a status, the process of which is power-invested (Contu and Wilmott, 2003). Despite attention paid to the conflict of interests between novice and experienced practitioners, some authors have argued that SLT under-emphasises power relations in learning (Contu and Wilmott, 2003; Cox, 2005; Handley *et al*., 2006; Nicolini, 2012). This criticism may be unfair because it is always more difficult to explain power relations which arise from wider institutions and conditions of practice (Nicolini, 2012). This is an important consideration when trying to understand 'professional becoming' as influenced by the broader pressures described earlier which affect the conditions in which the newly-qualified are legitimised.

SLT is also argued to be less able to explain rapid change due to its focus on the slow reproduction of practice (Nicolini, 2012). This is because accessing resources can sometimes present a dilemma; the novice needs to 'fit in' to the community and to participate legitimately, thus creating continuity in the reproduction of practice. However they may also wish to develop the practice; they may have new ideas about what they want to do and how they want to be. In other words, they are looking at a futuristic notion of themselves in a tension known as "continuity-displacement contradiction" (Lave and Wenger, 1991:

113). This conflict takes place during participation, where novice and experts have to work through their different interests. However, as Lave and Wenger (1991) note, the novice will often put on a show of imitation while remaining unconvinced. This is important because it shows that the novice can appear to be reproducing practice when they are in fact, resisting and may make change once they are in a position of authority, however this is seen a slow process.

SLT hold much potential for understanding ‘professional becoming ‘as a situated, contested activity, and can well describe the gradual processes of learning in a defined community. However an alternative approach could better able to account for reflexivity in professionalism (in other words, how professional know-how is learned, stabilised and then redefined as the learner responds to current conditions), in a more developed understanding of socio-material practice (Gherardi and Nicolini, 2002). As such, the following section suggests that the third and final perspective on organisational learning - practice theory - offers a route to studying contemporary ‘professional becoming’ between organisation and profession that connects learning, identity and practice.

Practice theories have become increasingly visible in organisation studies, professional education and human geography. Modern practice theory is both an epistemological approach and a useful methodology to study social phenomena (Corradi *et al.*, 2010). It is helpful to understand its epistemology, principles and origins to make sense of this approach because it can initially

appear complicated without this background information. This also helps to understand how practice theories can vary in their orientation and as such are a connected group of theories from which a particular approach needs to be defined.

## Practice theories and knowledge

Practice theories have been defined as any approach that "develops an account of practices, either in the field of practices or some subdomain thereof or treats the field of practices as the place to study the nature and transformation of their subject matter" (Schatzki *et al.*, 2001:2). Practice theories always begin with the principle that some sort of recurrent practical activity or performance is central to the social world and all social arrangements such as organisations and institutions (Nicolini, 2012). Practice theories thus understand that the human world is created and recreated through the practices of 'what we say', 'what we do' and 'what we use to do it with' (Nicolini, 2012).

The practice-based approach to knowledge assumes that knowledge is interactive, involves multiple actors and takes place in a situated, socio-material context (Easterby-Smith *et al.*, 2000). This is articulated in the "epistemology of practice" which understands 'knowing' as an action that is complementary to knowledge, (an active manifestation) thus avoiding the need for dualisms of individual/group knowledge and tacit/explicit knowledge (Cook and Brown, 1999: 381). Learning is thus a "generative dance", an action

that does not privilege any part of the individual, the group, tacit or explicit knowledge; instead, all are all seen as important (Cook and Brown, 1999: 381). Knowledge 'as a possession' is not dismissed; rather, it is completed by practice, and each form of knowledge has a different function. The epistemology of practice reframes what cannot be captured by any of the tacit/explicit, group/individual categories. Instead, practice is a co-ordinated (and "concrete") action that is dynamic (Cook and Brown, 1999: 387). Hence this is an approach that meshes well with understanding hybrid work as it does not resort to trying to understand categories and dualisms but rather, studies what happens in everyday work.

Since the 1980s, theorists have used the concept of practice not only as a starting point to explain social phenomena but also to avoid dualistic thinking between structure and agency (e.g. Ortner, 1984; Schatzki, 2001; Nicolini, 2012). The approach overcomes dualistic theorising about subject and object by focusing on their mutual dependency (Gherardi, 2011) and talks about a whole system. Practice theorists commonly draw from two influential authors to make this argument. First is Ortner (1984), who argues that society is a social systemic space that constrains activity on the one hand, and on the other, generates activity that shapes the space (Nicolini, 2012). This whole system approach recognises that the social system is unequal in terms of relationships and power, which Nicolini (2012) argues makes this different to symbolic interactionism, as all practices are in some way political. Second, Rouse (2007) is invoked because he claims that the natural and social 'worlds' are so enmeshed that not separating them affords a more relational understanding of

the social world than many other theories acknowledge. In particular, Rouse (2007) insists that knowing cannot be separated from action; action requires knowing what, when and how to act.

The recent popularity of practice theory has been described as a 're-turn to practice' (Schatzki, 2001; Miettenen *et al.*, 2009), as studying the human world through what is said and what is done was evident in much of the sociology of symbolic interaction, ethnomethodology and phenomenology research from the 1950s onwards. However, an important feature of practice theory is its distinctness from other theories of interaction. Whereas interactionist studies have often been concerned with the way relational practices frame the constitution of meaning and order, they do not fully account for the ecology of relationships including those with materials and technology (Gherardi, 2011). The world is constructed and recreated in mundane, daily activity, involving people and 'things'.

Practice theory draws upon many sources for example Foucault (1980) and Lyotard (1984) emphasising the discursive activity that is central to practice. This perspective is helpful as it is not the words or language of practice that are most important, but rather the conditions of power that frame the language. To understand practice theories better, it is useful to explore the movement behind the more recent proliferation of practice-based studies and concepts which are central to this perspective. The following section looks more closely at these influences on practice theory, as this helps us to understand how contemporary

practice theory has emerged from earlier iterations and to consider what this offers in terms of analytical insight.

## Influences on practice theories

Practice theories are influenced by the philosophies of Heidegger, Marx and Wittgenstein. These traditions centre on praxis, and agree that practice is over-determined and 'speaks for itself' (Wittgenstein, 1969, No 95 in Nicolini, 2012). Wittgenstein gives the example of rules, noting that people do not think about the meaning of rules, but they just follow them. For example, people do not usually stop to consider the symbols, letters and possible meanings of a sign before deciding what to do; rather, they use their common sense and experience and act immediately. Wittgenstein insists that this dissolves the possibility of thought before an action because so much of what we do is unarticulated (1953, in Rouse, 2007). Although there are a range of approaches in practice theories, they often share similar contemporary influences. These include, but are not limited to, Giddens' (1984) theory on 'structuration', ethnomethodology (e.g. Garfinkel, 1967) and Cultural Historical Activity Theory (CHAT) (Engestrom, 1999). These contemporary influences are explained in this thesis because they are important for understanding practice perspectives in organisational learning.

The concept of "structuration" has been hugely influential as an attempt to consider structure and agency as a duality of structure that is "both enabling and constraining" (Giddens, 1984:70). Reflexivity is seen as a central feature

of the recursive social order. On the one hand, we are pre-reflexive and get on with the matter in hand and on the other, we have to discursively account for and thus monitor our own activity. In other words, we talk about what we do, which in turn reconstitutes the context (Giddens, 1984). This has influenced Orlikowski (2002) who argues that people act knowledgeably, purposefully and are reflexive in their action against what they and others are doing in both a physical and socio-cultural setting. Learning is thus a teleological, ongoing, and collective accomplishment (Orlikowski, 2002). Giddens argued that in late modern times, we work reflexively according to labour conditions such as institutions, organisations and people and we try to create more space to be in control of our identity. Although Giddens' work cannot be discussed in more detail here for reasons of space, it is worth noting why structuration was not more widely taken up as an empirical approach. His work has been described as too rational and with a lack of attention to issues such as conflict and emotion (Nicolini, 2012). However, modern practice theories share the desire to avoid dualisms and see reflexivity as a feature of institutionalised practices.

Ethnomethodologists such as Garfinkel (1967) and Lynch (1993) have influenced practice theory as they question the *status quo* in mundane activity, thus breaking the structural constraints on action by examining in detail the particular setting wherein practice is located (Schatzki, *et al.*, 2001). Ethnomethodology also explains that social order requires people to be morally accountable. This can be seen during interactions and highlights the presence of reflexivity during which the context shapes and is shaped in return through interaction (Garfinkel, 1967). This creates a deep understanding of micro-

practice as it unfolds and can expand our understanding of phenomena such as communication in healthcare using a 'bottom up' and contextual approach to practice as an embodied accomplishment (e.g. Hindmarch and Pilnick, 2007). However, this approach can also be limiting, due to its focus on micro and meso (e.g. group level) practice, which is difficult to connect with wider phenomena such as social policy (Nicolini, 2012). Nevertheless, elements of ethnomethodology help us to understand that newly-qualified practitioners come to know what it means to be an *in situ* professional through using their whole bodies (e.g. Goodwin, 1994). The notion of accountability (Lynch, 1993) is crucial in practice as it shows how we have to perform activities so that they are recognisable and can be understood as acts of accountability to those who legitimise our work. This is important when considering what new practitioners do, particularly when performing different competencies than expected by both profession and organisation in the conditions of real-time work. Some authors who take a practice perspective draw upon this approach as part of a 'toolkit' approach to understanding practice (e.g. Nicolini, 2009).

A further influence on practice theory is CHAT (Engestrom, 2000) which describes how human activity is mediated in a system. The concept of mediation is influenced by Vygotsky (1980) who stressed that humans do not react to the environment. Rather, the reaction comes once the activity is mediated by something that is culturally produced. Thus we create stimuli such as artefacts (e.g. a nurses' desk), signs (e.g. a name on a door) and symbols (e.g. an assessment form) which determine our (recursive) activity. Thus CHAT reaches a systemic understanding of our world and shows how there

would be no interaction without the stimulus humans create. This makes all practice social, historical and contextual. According to Nicolini, (2012:107) "mediation, history, culture, institutions and power are all concretely manifest in human action" and language is important in this process. This approach differs from the discourse-orientated theories of Wittgenstein as it uses a material concept of mediation. This is a different material epistemology to those of traditional learning theorists such as Piaget (in Engestrom, 1999) to whom objects are simply what we use to create a Cartesian duality between people and the social structures of our world (Engestrom, 1999). Hence for Piaget 'us' and 'things' exists, for Engestrom 'things' affect us and cannot be separated as easily. The materiality of CHAT is important for practice based studies of learning as it shows how even simple everyday objects matter.

Activity systems consist of goal-oriented activities, for example, towards patient care in a hospital (Engestrom, 2000), have multiple voices through different cultures, traditions and interests which transform over time. To show this Engestrom (1999) draws attention to how local history and the wider history of the medical profession are important mediators of medical work. Engestrom (1999) uses contradictions as a trigger of transformation which accumulates historically, for example when a new element to the activity system occurs, such as a technology. Latterly Engestrom (2005) considers this transformation expansive, as individuals question the norm and make a collaborative attempt at change. This is achieved through the "zone of proximal development" (Vygotsky, 1980:86). CHAT is concerned with how consciousness is developed not in the tradition of psychology but rather in

issues of "context, situation and practice", a broader system where consciousness is developed in relation to material, situational conditions (Nardi, 1996:8). CHAT is a useful way of thinking about the accomplishment of practical mastery, e.g. in socialisation, but it has also been criticised for being too 'smooth' a model of activity, and does not accept resistance and conflict which are also sources of action and part of our world (Nicolini, 2012). Despite these criticisms, it is through the influence of the above tradition that practice theory considers knowing at work to be historically and culturally mediated and that 'tools of the trade' can only be fully understood when they are being used.

These theories or perspectives explain some of the central ideas which underpin practice theory such as avoiding dualism, the importance of mundane practice and accountability, the mediating possibility of history and power, and the role of artefacts and tools. These ideas help to understand how the practice perspective on organisational learning has emerged. To continue this holistic understanding of learning, the next section discusses the practice-based approach taken to understand 'professional becoming'.

## Practice-based studies of organisational learning and socialisation

Organisation studies are increasingly influenced by practice-driven approaches including the fields of strategy (Johnson *et al*., 2003), technology and science (Latour, 2005; Orlikowski, 2002) and learning (Gherardi 2001; 2003; Nicolini, 2009; 2012). Within organisation studies, practices have been described as both

"a state and a stream, organisation and organizing"; in other words, practices are the "substance of the organization" (Antonacopoulou and Pesqueux, 2010:11). Practice theories appear to be proliferating as they expand the possibility for thinking about organisational phenomena in a deeply contextual and intricate way. They bring different aspects of the organisation of work together such as what people do and say, how they make sense of it, what they are trying to achieve, the role of power, conflict and the materials we use, which all recur in space and time. A return to practice may therefore be a reaction to the theory-practice gap (Yannow, 2006; Nicolini, 2009).

Practice theories have become popular in approaches to learning in organisations (Gherardi, 2001; Carlisle, 2004; Nicolini, 2009, 2012). A practice perspective on learning centres on the assumption previously described namely that knowing and doing are mutually-constituted and comprised of situated relational activities (Gherardi and Perrotta 2011:596). In this view, knowledge transcends the individual, groups and the organisation and becomes the 'knowing' found in the ongoing, participatory and relational practices of people, materials and technologies they interact with. This suggests that an understanding of 'professional becoming' cannot be fully realised unless a study is able to describe the practices (human and non-human) of knowing at work. Hence, when a newly-qualified professional joins an organisation, he or she becomes immediately involved in more than just their own learning and becoming. His or her becoming is also enmeshed with that of colleagues, how they make sense of the world and the tools, materials and artefacts that are used in everyday mundane work.

A practice based study of learning is concerned with everyday mundane activity as a site of learning to understand how knowledge is transmitted through social and cultural relationships, through the logics of communities of practitioners and the use of shared tools and artefacts. This is understood though observing what people do and listening to how people talk at work and is thus not only a theory but also a method (as explained in Chapter 4). The attraction of practice theory is that it takes complex phenomena and is able give it a more recognisable 'story'. The advantage of using this approach in 'professional becoming' is that it does not foreground profession or organisation, individual or group. Crucially it is able to account for reflexivity, a central feature of hybrid, 'professional becoming' (Noordegraaf, 2007), because it shows how practical knowledge becomes both institutionalised and transformed through the practices of accountability of individuals described earlier.

However, the word 'practice' is perceived to be too simplistic and the 'practice turn' has been called a "bandwagon" (Corradi *et al.*, 2010:265). Nevertheless, practice approaches can be defended on many levels. Firstly, as Whittington (2011) argues they have multiple but very strong traditions in their development, where notions of practice are now widely accepted as highly theoretical. Secondly, practice theories focus more on tacit knowledge than many other broad approaches. Finally, as Whittington (2011) notes, the advantage of this multi-disciplinary approach is that it allows researchers to engage with an understanding of work that is transferable between different

fields of research. An example of this occurs between the organisation studies and workplace learning literatures which share many similarities in practice-based approaches. Finally practice-based studies are a reflexive approach, as the observer of practice has to constantly consider their own position, unpick what they are seeing to get beyond normative and descriptive readings of what is going on and to reach an intimate understanding of the way the subject and object constitute each other (Whittington, 2011).

Some practice-based studies have already begun to explore socialisation or 'becoming as practice', for example Antonacopoulou and Pesqueux (2010) suggest that a practice approach can help show the tensions when workers navigate different organisational and professional priorities. The authors also define how professionalism should be seen as practices and skills which incorporate both professional and organisational logics as hybrid activity, similar to Noordegraafs' (2007; 2011) contemporary analysis of professionalism. Professional identity is central to learning how to 'be' a professional as it is co-constructed through the relational practices between profession and organisation, which are often in tension amidst conflicting priorities.

Gherardi and Parrotta (2010) studied the practices of induction in three different types of organisations to show how the organisation intentionally inducts new employees, whilst at the same time employees are 'seduced' by the profession. Interestingly, one of the organisations was a hospital and the

socialisation of medical interns was studied over a year. In this case, 'seduction' by the professional community through hierarchical relationships was found to be a stronger mediator of practices than the organisation's formal induction programme. Emotion is an important issue in this. As Gherardi and Parrotta (2010) argue, people can become emotionally attached to practices, and way of doing something found to be present when professional communities 'seduce' the newcomer.

The above studies offer a promising start to developing practice perspectives on contemporary 'professional becoming', and offer a route to address and explain some of the complexities involved. However, empirical research is needed, in particular a more detailed analysis of the ongoing learning and identity practices of newly-qualified professionals. Specifically, there is a clear gap in the literature that explores 'professional becoming' as hybrid practices in the context of Preceptorship and the contemporary NHS.

## Conclusion

I have explained why the early post-qualification period of work is an area of interest and concern in current conditions in the NHS. To develop an understanding of understand what the existing literature says about this period, I studied three literature areas that encompassed professional socialisation, organisational socialisation and professional identity. First, I explored the meaning of 'the profession' and 'professional' and concluded that the more interesting question is how professionalism is invoked (e.g. Evetts, 2011) and

enacted in situated activity. Classic theories of professional socialisation were then reviewed before the particular contribution of important ethnographies from the symbolic interactionist tradition were explored. Although these studies are rich accounts of socialisation I argued they tend to focus on pre-professional training. There is also a gap for understanding more contemporary socialisation that understands post-professional training programmes such as Preceptorship that are delivered by the employing organisation. Next, I explored the literature from authors such as Noordegraaf (2007) who argue that contemporary professionalism and professional work is hybrid - and is where connections are found between organisational and professional logics. I presented the argument that the post-qualification period could be better understood as 'professional becoming'- a hybrid activity. This activity involves the ongoing reflexive learning of professional know-how and identity, in other words, how 'to be' a professional in an organisational context. Although this hybridity has been studied in professional education outside of organisations, there is a need for empirical studies which see 'professional becoming' as everyday situated practices in the post-qualification period. However, this literature appears to be orientated more towards the professions rather than accounting for the organisational perspective on managing new starters. The organisation studies literature was therefore reviewed which helps us understand issues such as organisational tactics with new recruits, HRM and training initiatives, power and control. However, these studies are often individual in orientation and tend to focus on new starters to the organisation, assume an end point to socialisation and commonly downplay the role of professional education in the post-qualification period. The final literature

review studied professional identity and concluded that identity is an activity and as such, supports the argument of Noordegraaf (2007) that professionals are always 'becoming'. Hence, we can recognise that identity can become a site for organisational control and be reflexively organised in relation to strong organisational pressures (Alvesson and Wilmott, 2008).

Each literature area I have studied offers useful insights into post-qualification 'professional becoming' but vary in their focus. To draw these insights together I argued that the common theme is an understanding that 'professional becoming' is an ongoing learning process. To progress this theoretical perspective, the literature on learning was reviewed by focusing on three perspectives on knowledge and learning in organisations: structural, process and practice. I showed how SLT (Lave and Wenger, 1991) is important because it emphasises that participation and changing identity are central to learning. However, SLT concentrates on the gradual acquisition of knowledge in a community rather than accounting for dynamic change, i.e. the fast, in-the-moment, temporal part of becoming or wider pressures. I therefore moved to a practice perspective which locates learning at the site of everyday, relational, dynamic and material practice. A practice approach to learning can bring together previous insights from the sociology of the professions, newer theories of professionalism and organisational socialisation and the professional identity literature to study 'professional becoming' in the contemporary NHS. This approach addresses the clear gap in the literature for studies which explore 'professional becoming' to show that multiple tensions are negotiated as the newly-qualified professional transforms though relational practices within the

organisational setting. In the following chapter, I introduce the case of nursing Preceptorship and explain why this makes such an interesting and timely case for progressing an understanding of ‘professional becoming’.

# Chapter 3: Nursing Preceptorship

## Introduction

This chapter explains what nursing Preceptorship is and clarifies why it is an appropriate case for studying 'professional becoming'. Preceptorship can be described as a policy and a development programme (Department of Health, 2010a) (DH). In addition, as outlined in the previous chapter, Preceptorship structures the early post-qualification period of healthcare practitioners by providing an initial period of support and mentoring for newly-qualified professionals entering the workplace. Although Preceptorship is increasingly found in allied professions such as occupational therapy, and sometimes midwifery, it has become standard practice in the nursing profession (Whitehead *et al*., 2013).

I begin with an overview of nursing, to understand how Preceptorship has become embedded in the post-qualification period. Both a historical analysis of the nursing profession and a review of more recent policy and events is undertaken. These show how interrelated historical and contemporary pressures play a part in the 'professional becoming' of nurses, and how these pressures reflect some of the wider tensions in present-day professional work, as discussed in the previous chapter. This analysis draws out the hybrid nature of contemporary 'professional becoming' (Noordegraaf, 2011) in nursing and the possibility of "new professionalism" where the organisation plays a more

central part in shaping professional work (Evetts, 2011:407) through development programmes such as Preceptorship.

This chapter has four main sections. The first three provide historical context for the development and national roll-out of Preceptorship; the final section closely analyses the Preceptorship Framework (Department of Health, 2010a). In the first section I explore what nurses do and how new entrants in the profession are educated and become qualified. In the second section I present a historical overview of nursing and its turbulent history of professionalization, drawing particular attention to the work of Florence Nightingale. As a historical figure, Nightingale is often seen as the symbolic leader of nursing (Versluysen, 1980; Goodrick and Reay, 2010) however her contribution to the profession has been debated. By showing conflicting accounts of Nightingale's work, I illustrate how the appeal of her story was later used to compete with a newer and more scientific model of nursing. By drawing upon these debates, it is possible to offer a plausible explanation for subsequent efforts to separate education and paid work during training. This is relevant in current debates about how to produce the 'right' professional nurse in an unsettled health service.

In the third section of this chapter I explore later policy developments in nursing, the issues around recruiting and retaining newly qualified nurses and the implications of recent scandals and pressures on the profession. In the final section I examine the concept of Preceptorship and the Preceptorship

Framework (DH, 2010a) which provides guidance to NHS Trusts and practitioners. I draw attention to a number of complications associated with the aims and claimed outcomes of Preceptorship, and examine whether and how Preceptorship might support learning 'to be' a nurse. This is important because there are limited sources of information and research available about this as a resource for stakeholders of Preceptorship.

It is within the context of these historical themes and the development of policies such as Preceptorship that I suggest a study of the 'professional becoming' of newly-qualified nurses is timely. Finally I show how the practice perspective on organisational learning (Gherardi, 2003; Nicolini, 2009; 2012) discussed in the previous chapter can build upon classic studies such as Melia's (1987) to provide a rich, contemporary account of becoming in the context of Preceptorship.

## An introduction to the nursing profession

Nurses form the largest group of workers in the NHS, occupying different roles and ranks within the healthcare system and working in diverse settings including hospitals, care homes, schools, the workplace and their own homes (Bolton, 2004). Nurses used to be known in terms of their title, e.g. staff nurse, senior staff nurse, sister, or matron (in ascending order of seniority). However, nurses roles are now sometimes more difficult to define by their title because the profession aspires to create a more flexible workforce (*Modernizing Nurse*

*Careers*, DH, 2006). Nurses are sometimes defined by their pay band, e.g. entry level nursing is Band 5 which meets the minimum standards but is not as skilled as a modern matron, who has more specialised and theoretical knowledge. In explaining what nurses do, the general awareness is that they carry out caring tasks for patients; however, understanding the detail of a nurses' work is complex (Allen, 2015).

Over the last century the nature of nursing has changed considerably, evolving into a highly technical profession that works across occupational and organisational boundaries (Allen, 2015). Although most people would understand that nurses provide care through clinical and communication skills, some of their work is more intangible and poorly understood. This aspect of nursing work is argued to be invisible, with nursing being the intersection through which much hospital work passes. Hence nurses learn to translate and mobilise activity using their understanding of the healthcare organisation and system (Allen, 2015). The work of nurses has also been studied in the management literature (Bolton, 2004; Croft *et al*., 2015) and it is argued that nurses "shape the interface between the hospital and its customers" (Bolton, 2004:318). It is clear that nursing work involves complex practices which make it difficult to analyse *how* nurses learn the skills, values, norms and cultures of their profession. The question this raises is whether post-qualification education can standardise, teach and support the further learning of skills and competencies which both the profession *and* the healthcare organisation require in times of political and economic pressures and change. On the one hand, the profession needs to maintain its own standards and jurisdiction; on

the other, the organisation needs to be assured of the standards of nursing care on grounds of consistency, quality and safety. It is important to explore the current system of education, and then understand this within a historical perspective, in order to understand the situation nurses are in at present.

## Contemporary nurse education

Nurse education now sits within higher education (HE); to qualify as a nurse, individuals must undertake a nursing degree followed by registration with the Nursing and Midwifery Council (NMC). The formal curriculum takes place within an HE Institution (HEI) in combination with practical learning placements in hospitals and community settings. The implementation of compulsory degree education for students occurred in 2013 and coincided with the writing of this thesis. This reflects the recommendation by the World Health Organisation (WHO) (2009) that all nurses should have a university degree. The need for global educational standards arose due to "the increasing complexities in healthcare provision, the increasing number of health professionals at different levels and the need to assure more equitable access to health care" (WHO 2009:8). The WHO state that undertaking a degree empowers professionals and helps to guarantee that their practice is based upon evidence. Degrees and previous nursing diplomas taught between 1989 and 2013 have sought to combine two modes of learning. The first mode is the teaching of theoretical knowledge related to health, acute and long term care, leadership and management by HEI's. Experiential learning takes place within healthcare organisations supported by formal mentoring and is assessed, for

example by Objective Structured Clinical Examinations (OSCE's) and reflective portfolios. Nurses have to choose and qualify in one of four specialities: adult, children, mental health or learning disability nursing (Nursing Careers, 2015).

The NMC sets basic entry requirements such as a standard of numeracy and literacy, and recommends that HEI's meet the nursing applicants (NMC, 2010). Beyond that, HEI's are able to set entry requirements (Willis, 2012). Although there is no national standard entry qualification, applicants usually need one of the following: at least two A-levels; an equivalent qualification such as a Higher National Diploma (HND), a Level 3 General National Vocation Qualification (GNVQ) (Nursing Careers, 2015), or sometimes other recognised prior learning. This means that it is possible for Health Care Assistants (HCA's) who may not have A-Levels to gain entry to the degree course with non-traditional qualifications (NHS Careers, 2015). Therefore, students socialise into the profession with different life experience and practice backgrounds but this heterogeneous group needs to meet standardised competencies within a set framework and time once undergoing study.

Achieving an optimum balance between learning theoretical knowledge and practical know-how has remained controversial and there have been many debates over nurses' preparation for employment in a healthcare organisation (Willis, 2012). These debates have often centred upon "reality shock" (Kramer, 1974:40), which manifests as distress when faced with the reality of work

experienced in the newly-qualified period, and which is often argued to lead to attrition (Kramer, 1974; Price, 2009). The quality of care delivered by less experienced newly-qualified nurses is also frequently debated (Maben *et al*., 2006). Shock and newly-qualified nurses fitness to practice is discussed later in the chapter, however to understand these concerns, it is important to explore nursing history in order to put these debates into their full context. The move to a degree-only profession has been a progressive and often stormy journey for nursing. I now discuss this journey in relation to nursing's history of professionalisation and associated struggle to separate education from employment.

## Nursing's history of professionalisation and education

The nursing workforce in the eighteenth century was made up of family carers, male apothecaries or paid support workers, the poorest of whom were sometimes involved in criminal activities (Dingwall *et al.*, 1988). Nursing did not have a good reputation at this time and its image was argued to be tainted by the largest group of nurses: lower-class workers described as 'handy women' (Dingwall *et al*., 1988:13). In popular accounts, these nurses were often perceived to be lazy, lacking in skills and untrustworthy. For example, the fictional nurse and midwife Sarah Gamp portrayed in *Martin Chuzzlewit* (Dickens, 1867) was a famously grotesque character of the period (Williams, 1980). Yet Dickens's description of this drunk, dirty and abusive nurse was apparently inspired by a realistic description given to him by a friend. As such, Dickens (1867, cited in Hawes, 2007) later argued that this was an appealing

story in which people recognised an element of truth as some nurses indeed shared similar characteristics. Not all nurses were like Sarah Gamp because there is evidence that some hospitals at the time stipulated nurses needed to be of good character (Dingwall *et al*., 1988).

The proliferation of the hospital as an institution and the introduction of the Nightingale system of nursing from 1853 signified a change in the working practices and structure of the occupation (Dingwall *et al*., 1988). Before the nineteenth century, little could be done for serious conditions, with most patients dying from their illness at home. However, the gradual advance of medical science led to the introduction of more hospitals and as doctors began to focus on treatment they thus needed reliable support to monitor the patient's condition. Accordingly, doctors began to improve the working conditions of nurses and separate their work from that of domestic staff (Dingwall *et al*., 1988).

Florence Nightingale is frequently described as the heroine who transformed nursing into a disciplined occupation through the establishment of a training school system recruiting women of 'good character' (Dingwall *et al*., 1988). Since 1853, Nightingale has been seen as the figurehead of nursing (Versluysen, 1980; Goodrick and Reay, 2010). Although Nightingale's work contributed to the promotion of public health, her other achievements appear to divide authors. For example, the value of Nightingale's work during the Crimean War has been considerably debated and the impact of her nurses on

care may have been overstated (Olsen and Whittaker, 1964; Dingwall *et al*., 1988; Allen, 2001; Williams, 2008). Nightingale organised care and improved sanitation. However, it is argued that her nurses did not actually dress wounds and that Nightingale was used as a caring symbol for political reasons in order to distract the public focus away from the disastrous war (Dingwall *et al*., 1988). Despite establishing the first training school, the Nightingale system is argued to have changed the control of nursing work (ceding it to the hospital) rather than improving nurses' actual practices (Williams, 1980).

One of the problems with unravelling this historical picture of Nightingale's work and nursing is that much of the evidence is based in biographies and the press (Dingwall *et al*., 1988; Williams 2008). It is important to recognise this, as authors have since argued that it appears to be the appeal of Nightingale stories rather than historical facts that is more significant during education and socialisation. For example, Olsen and Whittaker (1964) showed how different aspects of Nightingale stories were used to invoke a certain kind of nurse. Traditional schools of nursing (based in the hospital) used the 'lady of the lamp' story to support the caring model; universities would use Nightingale's work on sanitation to promote a more evidence-based version of nursing. Hence, it can be argued that these stories have been used in different ways by the early profession and the hospital to try to mould nurses' developing professional identity despite them being questionably true stories. On the one hand, the hospital based nursing school needed to maintain the *status quo* of the compliant, well-disciplined, employed nurse, whereas on the other, the university was trying to invoke a different kind of nursing, one that was more

'scientific' and in line with professionalising the occupation (Larson, 1977). The Nightingale story still remains relevant to nursing socialisation despite changes in the profession which have promoted a more autonomous role. Her story is used, albeit in an altered version, to inform rhetoric promoting a unified version of nursing in textbooks (Goodrick and Reay, 2010). This relates to the argument in the previous chapter describing professionalism as an 'appeal' that can be invoked (McClelland, 1990; Evetts, 2011).

Although the Nightingale era elevated the status of nursing, it was not until after World War I that the contribution of nurses was recognised more widely (Allen, 2001). In 1919, the state registration of nurses was finally driven through Parliament following fierce debates over who should control nursing work. This is an issue which is argued to be, in part, one centring on gender (Witz, 2005; Allen, 2001) because the Nightingale devotees who advocated the hospital's control over nursing felt that the hospitals could control the 'female'-appropriate behaviours that centred on the close care of patients. Conversely, in 1887 Mrs Bedford-Fenwick, a pioneer of nursing, formed the British Nursing Association and canvassed vigorously for a single registration of all nurses following the completion of three years of training rather than the one year previously advocated by The Hospital Association (Witz, 1974). Hence registration, as proposed by Mrs Bedford-Fenwick and colleagues meant that formal education was more closely tied to the needs of the profession rather than the hospital, although this was not fully realised in the profession (Wiltz, 1992; Allen, 2001).

Notwithstanding the Nurse Registration Act (1919), it was 1943 before the responsibilities and boundaries of the profession were eventually set by the General Nursing Council (GNC) and registration became compulsory for all nurses (Davies and Beach, 2000). The long period between registration and the move to GNC standards for nurses was due to continuing disagreement about the nursing model (Allen, 2001). Mrs Bedford-Fenwick had the vision of nurses being scientifically competent and knowledgeable but this was at odds with the dominant Nightingale model of nursing. Nightingale's version of nursing was seen as a moral vocation and operated as a "domestic academy model" focusing mainly on character rather than competencies (Allen, 2001: 2). Hence, registration did not lead to the transformation that many had hoped for and instead acted to streamline education for the future National Health Service (Dingwall et al., 1988; Allen, 2001). As Allen (2001) notes, people could still work as nurses without being State Registered, which paved the way for nursing assistants. This is significant because although registered nursing has been transformed, tensions concerning the boundaries between the work of Registered Nurses and Health Care Assistants continue to be a feature of the project of professionalising nursing (McMurray, 2011).

Without the establishment of professional registration it was impossible for nursing to educate trainees to an agreed standardised set of competencies and responsibilities. The period before compulsory registration shows that formal nurse education was not a priority in 1919, nor had it ever been, for economic

reasons and due to a historical lack of government support (Davies, 1980). Taking nurses off the wards to educate them with qualified tutors was expensive and, as Davies (1980:102) suggests, education was a 'constant casualty' as it needed strong resources and the drive from authority, which remains important today. To understand this long standing mentality, the legacy it left on the profession and its relevance to the contemporary profession necessitates a deeper study of early nursing education.

Although the Florence Nightingale era of modern (trained) nursing is associated with the teaching hospital school of nursing, a widespread unified style and place of education was far from the reality in nursing at the time. For many years, limited resources were allocated to nurse education and doctors would carry out the teaching. Nurse education was therefore significantly compromised as no extra time was allocated to doctors in addition to their usual duties (Davies, 1980). Doctors were powerful and rarely challenged by nurses who accepted the discipline, and trainee nurses came to staff a large part of the hospital workforce, working long hours to keep up with the expanding hospital system (Davies, 1980, Dingwall *et al*., 1988). Although teaching hospitals such as St Thomas's in London (founded by Nightingale) became famous for nurse education, there were many ways one could train as a nurse, and such education took place in workhouses, religious institutions and with collectives of community nurses (Dingwall *et al*., 1988). It was not until registration and the setting up of the GNC in 1919 that nurse education began to be structured around standards, entrance criteria and a final exam. Although this was largely seen as progress, Davies (1980) argues that nursing continued

to be under-resourced and that nurses did not recognise the institutional forces which prevented change, whilst at the same time were blamed for being old-fashioned and that there was a sense that poor work terms and conditions were regarded as the professions own fault. This resonates with modern tensions within the profession; nurses often appear to be blamed for incompetence that can be argued to stem from historical problems.

In examining early nurse education Williams (1988) draws attention to the competing narratives which described the progress of nursing and its education. The first accounts centred on Florence Nightingale's reforms described earlier and highlighted the change from the image of the 'bad nurse', such as Dickens's (1867) Sarah Gamp (an old, drunken, lazy, unskilled servant) to the image of the Nightingale nurse (young, hardworking, angelic). The second accounts appeared in medical journals and revealed the critical viewpoint of doctors who saw nursing as an unscientific and heterogeneous occupation. Importantly, Williams (1988) suggests that there was also a lesser known third account of nursing which was found in media and public debates. This centred upon nursing characteristics, the reputation of the profession and the need for the training of appropriate individuals. Importantly, in this third account, the state of nurse education was debated in the context of the pressurised hospital system and hence was not just a discussion about the profession. Although these accounts took place during the late 19$^{th}$ century, there are striking parallels with the current situation where nurse education has been debated in the context of a pressured NHS (Willis, 2012).

This exploration into early nursing and early nursing education is important because it has shown that nursing has struggled to professionalise, and that there are competing narratives which explain how the profession was shaped. The debates over the control of nursing education and work can be reframed in the relationship between managerialism and professionalism, with the Nightingale model focusing on the management control of the profession and the Bedford-Fenwick model on the control of the profession through scientific knowledge (Allen, 2001). This reflects the tensions during 'professional becoming' described in the previous chapter, as student nurses with only supernumerary experience face difficulties when thrust into the organisational setting. The following sections show how this has continued to manifest as tension affecting the contemporary era of nursing and its system of education.

*The nursing profession and education in the twentieth century*

The apprenticeship style of nurse training that emerged throughout the late nineteenth and early twentieth centuries continued until the 1990's. During the twentieth century a series of policy developments contributed to incremental changes in the education and career structures of nurses ultimately leading to a separation of education and work. These developments are first visible in the Athlone Report (1938) which examined nursing services and was partly instigated in response to the high level of attrition observed during training (Dingwall *et al*., 2002). This report proposed a separation of nurse education from local needs, a committee to decide on the salaries of nurses, and a register

of nursing assistants at the GNC (Baly, 1973; Rafferty, 1996). Following this, the Nurses Salaries Committee was implemented but soon became ineffective in later years because the structure was set up in the context of war (Baly, 1973). There was little movement on changes to nurse education due to the expense of the onset of the Second World War (Baly; 1973; Dingwall *et al*., 1988). In 1943, a committee was set up by the Royal College of Nursing (RCN) consisting of nurses and other stakeholders (Baly, 1973; Rafferty, 1996), led by Lord Horder, and commissioned to investigate the state of nurse education. It concluded that student nurses should not be seen as employees, noting how they were disciplined by archaic traditions and suggesting they should have full student status, i.e. not be employed to work at the same time as learning (Baly, 1973; Rafferty, 2002). The committee suggested the consolidation of a number of Schools of Nursing, the creation of formal education committees, and the introduction of minimum entry requirements (the equivalent of modern GCSE's), thus transforming the system of education, which would also require more trained staff to supervise student nurses in clinical settings (Baly, 1973; Rafferty, 1996; Clark *et al.*, 1997). The report also created an opportunity to become an enrolled nurse, (an 'assistant' nurse with fewer responsibilities) by taking a two-year course. Minimum entry standards were produced following the report although the training itself was not lengthened at this time, as it was seen as too great a change, particularly in war-times (Baly, 1973, Rafferty, 1996). This report is seen as an attempt to mould the nursing profession into a more intellectual one, which Rafferty (2012) argues represented plans for a 'super breed' of society in line with Horders' interests in eugenics. Although Horder's views were extreme,

attempts to mould the characteristics of a nurse is a theme I return to throughout this thesis.

The next policy development concerned with the education of nurses was the Wood Report (1947, cited in Baly, 1973) which reviewed the requirements for nurse education in the post-war period within the context of the new NHS (Dingwall *et al*., 1988). This inquiry recommended a two-year programme that entailed more academic training consisting of a broad foundation period before specialism (e.g. midwifery) during which recruits would be awarded full student status (Baly, 1973; Dingwall *et al*., 1977). Further recommendations were that nursing research departments were formed, and a common register of nurses organised. This common register would include male nurses who had their own register up until this point (Baly, 1973). According to Dingwall *et al.* (1988), professional associations such as the RCN were not asked to be involved in the Wood Report, and both they and the GNC protested and disputed the recommendations, arguing in favour of a longer length of training and against a more academic education. The reaction of the RCN and GNC is ironic, especially since they took what is now recognised as a more contemporary view of the profession, although at this time they may have been concerned that the two-year training proposed was shorter than that of other professions (Dingwall *et al*., 1988). These debates are important to note because they show how difficult it is to judge the ideal balance between formal education and practical experience. Hence, the profession had little power in reforming nurse education which remained under the control of the NHS. Although the Wood Report's recommendations were not implemented, they

nevertheless supported the reform of nursing education and are argued to have led to the Nurses Act (1949, cited in RCN, 2015) which brought together all nurses under one register (Willis, 2012). This Act was important as it allowed the length of training to be tailored to previous (e.g. military) experience, thus creating a more flexible model that could cope with workforce demands. However, according to Dingwall *et al* (1988) this workforce approach reinforced an orientation of education to being controlled by the hospital rather than the profession. The GNC is argued to have failed to understand this and hence missed the opportunity to exert influence from a professional perspective (Dingwall *et al*., 1988). The above reports appear to be reactions to the crisis in the health service in the 1940's, and neither was successful in separating work from education and creating full student status for trainee nurses (Dingwall *et al*., 1988; Rafferty, 1996).

Further developments include the Platt Report (1964, cited in Davies and Beach, 2000) which reiterated earlier demands for a student status for nurses, increased entry requirements and a consolidated group of nurse training schools. Following this, the Salmon Report (Ministry of Health, 1967) proposed a new nursing career structure which was supposed to abolish the matron role (the matron is a very senior nurse) and replace it with the introduction of Nursing Officers. However the consensus was again to maintain the status quo rather than introduce radical change (Davies, 1977; Melia, 1987). Against a background of increasing industrial turbulence in the nursing profession, the Briggs Report of the Committee of Nursing (1972) also explored the state of nurse training (Davies and Beach, 2000). At the time,

there was general unrest in nursing and the NHS due to a movement for increased pay and better working conditions. The report proposed a greater research focus in nursing education which signified the beginning of the profession trying to attract nurses who might have otherwise gone to university. It also heralded an era when the award of five GCE's became the standard entry criteria to the profession (Davies and Beach, 2000). In a further significant move, the Nurses, Midwives and Health Visitors Act (1979) finally brought together nine bodies to establish the United Kingdom Central Council (UKCC) and associated English National Board (ENB) which would regulate nursing education and its entry requirements. This was an important development as it demonstrated a change in ideology, shifting from a detailed prescription of what training should consist of, towards a focus on nurses accepting responsibility for their own professional development and acquisition of competencies (Bradshaw and Merrimen, 2008).

There are striking features which symbolise this struggle to separate education from the control of the hospital. First, nurses were hardly involved in the policy process initially and were often represented by doctors (Dingwall *et al*., 1988) characteristic of the unequal power relationship between nurses and doctors in the period (Stein, 1967). An example of the low importance of nursing during policy decision-making is seen in the Beveridge Report (1942) that preceded the foundation of the NHS. This made little reference to the nursing profession, ignored nursing education, and remained focused on the medical profession (Abel-Smith, 1992). Second, progress of nursing reform was strongly influenced by the war, the cost of the new NHS and issues arising from general

industrial unrest following the Conservative government's 1961 freeze on public sector pay (Dingwall *et al*., 1988). At the same time, governments were also increasingly looking to control the work of occupations in the NHS in the name of efficiency, not unlike the development of managerialism discussed in Chapter 2. This shows how turbulence in the NHS appears to be cyclical but is also closely connected to the political climate of the day.

Allen (2001) proposes that it was New Public Management (NPM) that allowed the final push to separate nurse education from ward-based service, and which resulted in 'Project 2000', a diploma education programme explained below. As a result of the Griffiths Report (1983) advising on how the NHS should be managed, followed by the NHS and Community Care Act (1990), the way the NHS was organised, and controlled was changed and the work of professionals became more of a management concern (i.e. professionals' power was constrained) (Allen, 2001). Following changes to the structure of the NHS, which included a new management board and the introduction of managers who would control budgets and performance through district health authorities (Griffiths, 1983), nurses and other professionals were encouraged to support the agenda with little scope for their expression of professional or personal judgment (Dingwall *et al.*, 1988). One of the changes to nursing that arose from this re-structuring was an increasing emphasis on HRM and individual NHS Trust decision-making about pay levels and the skills that Trusts needed (Allen, 2001). As discussed in Chapter 2, this period was not experienced smoothly by professions, in part because these changes were seen to challenge autonomy; new organisational demands created

pressures of competition, financial accountability, and performance management on practice (Waring, 2004; Martin *et al.,* 2009). The desire for greater control of practices and resources was challenged by nurses (Bradshaw, 1995) and more emphatically by doctors who recognised that their professional status was jeopardised (Harrison and McDonald, 2008). It has also been argued that NPM changed the competencies needed in nursing practice because it introduced a need for enhanced political skills. For example, Hewison (1999) suggests that nurses needed to become more skilled at rhetoric and have a good understanding of the policy process, to shape and implement policy. This can be seen when nurses take advantage of further professional development, such as MBAs, as part of a 'mobility strategy' to further their career into management (Evetts, 2012:25). These political skills are arguably difficult to articulate and teach during nurse education.

The above changes were a turning point for the profession. In the same decade, the Judge Report (Royal College of Nursing, 1985, cited in Willis (2012:4) recommended the "uncoupling of education from direct and persistent control of the [National Health] service". Education was finally separated from service when Project 2000 Education was implemented in 1989 and was followed by compulsory degree education from 2013. The next section explores the significance of this change.

*Project 2000 education and degree education*

Project 2000 was a diploma of nursing that became the single route to qualifying as a nurse between 1989 and 2013. The primary changes from the old system of hospital-based learning were a repositioning of nurse training within HEI's, the abolition of enrolled nurses, the introduction of a supernumerary status for students and a focus on promoting health rather than a focus on treating disease as associated with medical work (Clark *et al*., 1997; Allen, 2001). The new nursing programme culminated with a diploma that ran alongside a registration process and allowed students to qualify and become a practising nurse. This new model of nursing focused on a holistic process rather than on procedures, and put more emphasis on clinical skills that could be devolved from doctors (Allen, 2001). Consequently, Project 2000 education is seen as a professionalisation strategy designed to raise the status of nursing and define its boundaries with medicine (Allen, 2001). It is also argued to be a "marriage of convenience" between the nursing profession and new managerialism which would create more flexible and knowledgeable nurses who would make savings for the government (Allen and Lyne, 2006:16).

Although degrees in nursing have long been available, the recent introduction of degree-only nursing education has been controversial, particularly regarding fitness to practice upon qualification (Willis, 2012). Although Project 2000 education emphasised clinical skills, the issue of assessing competence was neglected and thus the use of simulated learning and Objective Structured Clinical Examination's (OSCE's) was gradually introduced by HEI's. The

issue of skills deficits has continued to plague nursing and this has appeared in media and public debates centring on nurses' fitness to practice (Coward, 2012). These discussions and interlinked debates about nursing education recently resurfaced in the Willis Commission Report (2012). The report attempted to resolve these issues, which emerged nearly 20 years after Project 2000's launch. The report presents a positive review of degree nurse education but notes variation in the quality of practice placements (Willis, 2012).

Nevertheless, as Phillips *et al*. (1994) argue, nursing has always expected newly qualified nurses to be immediately ready to take on their new role despite variation in practice placements during training. This is a well-documented problem in nursing (e.g. Kramer, 1974; Melia, 1987; Upton, 1999) and Maben *et al.* (2006:465) refer to this as the "theory-practice gap" that can significantly contribute to attrition of newly-qualified nurses. Although the nursing profession has taken greater control of education, this has remained controversial, and the organisational control of nursing work has remained strong due to NHS managerial structures and related influences on work. In the following section, I elaborate on the contemporary pressures on nursing, particularly recent scandals and issues of recruitment and retention before looking at how policy now addresses some of these concerns.

## Contemporary pressures on nursing

Earlier, I described the similarity between 19th century debates about the organisation and skills of nursing and developments in the contemporary era in

the light of financial pressures on the system. Recent scandals connected to nursing include the Mid Staffordshire NHS Trust crisis in which systemic failures caused harm and death of patients (Francis, 2013). In a report on this crisis, attention was drawn to severe failings of nurses and lack of compassionate care, such as patients lying in excrement for hours and other failures which affected patient dignity, quality of care and safety (Francis, 2013). The impact of this on the reputation of the profession has been seen in media critiques. For example, a *Guardian* report (2013) stated that "the nursing profession have [sic] a massive mountain to climb. They do not appear to have the empathy, the will or the leadership skills to reach the top of that mountain" (Vinegar, 2013). This view critiques both the profession and personal attributes of individuals within it and was one of many articles at the time which debated the characteristics and values nurses should possess. Media debates have often criticised the diploma and degree style of education, despite the findings of the Willis Commission (2012) which looked favourably on them. This is suggestive of the deep-rooted stereotyping of nurses noted in the nursing literature (Hoeve *et al.*, 2103), and also the tendency of nurses themselves to look back to a 'golden era' of nursing, (Dingwall and Allen, 2001; Aranda and Law, 2007) thus reinforcing the modern image of nursing as inferior in terms of compassionate care.

Public pressure has been studied in the nursing literature (Cabaniss, 2011; Weaver *et al*., 2013). For example, research into the impact of the media on the identity of the nursing profession showed that reports in the USA and UK media were consistently found to focus on staffing levels and patient safety

(Cabaniss, 2011). In such reports, the technical aspect of nursing was ignored and nurses were seen to be portrayed only for their 'soft' skills, which were subject to criticism (Cabaniss, 2011). This historical observation and recent research shows that not only does the profession and the employing organisation have something to say about nursing and nurse education but that this issue is also of concern to the media and the public as stakeholders in healthcare, even if they may not always understand what nurses actually do. This is important to note because the portrayal of the profession has the potential to play a role in the identification processes of nurses during socialisation as discussed in Chapter 2. To further develop an understanding about the particular problems of becoming a newly qualified nurse, I now draw attention to the issue of 'shock' on entry into work, long-theorised yet arguably more relevant today than ever before. As this relates to attrition and thus retention of staff, I also discuss these issues in the following section.

*The problems of retention and shock*

The retention of newly qualified nurses remains extremely important to the NHS which relies heavily on their recruitment to fill naturally-occurring vacancies as older nurses retire for instance (Baillie *et al*., 2003). However, retention is a well-known problem (Buchanan and Secombe, 2011; Charnley, 1999) and the three to six months post-qualification period is understood to be the most critical time for retaining newly-qualified nurses (Charnley, 1999), although I found it impossible to discern a national trend on attrition, due to a lack of published data. Attrition has long been accredited as a result of the

shock newly-qualified nurses report upon qualifying (Lathlean, 1987; Charnley, 1999; Gerrish, 2000). This was originally described as 'reality shock' (Kahn *et al*., 1966) and explained as "expectation-reality generated stress" (Kramer 1974:53) encountered during new roles. Shock is characterised by multiple problems such as mental and physical exhaustion and problems with work-life balance in the newly-qualified period. Ashforth (2012:103) identifying the limitations of a pedagogic approach, defines this shock as 'unrealistic expectations' because much of learning how to enact a new role remains unknown and abstract until new workers can put their knowledge into practice. However, this approach to shock explains the individual and psychological facets of the experience and sees the person as a container for knowledge, an approach critiqued in Chapter 2.

The issue of shock has more recently been discussed in relation to Project 2000 education and the theory-practice deficit described above (e.g. Clark *et al*., 1997; Gerrish, 2000; Maben *et al.,* 2006). Most of these articles refer to 'reality shock' although this has recently been re-theorised as 'environmental shock' to account for the pressures of working in a modern healthcare system (Kramer *et al*., 2011:2). These perspectives show that newly-qualified nurses are always likely to experience some sort of shock no matter what style of education, but that this may have been exacerbated in recent times and therefore their retention will be an ongoing concern.

Although newly-qualified nurses may feel discomfort when faced with opposing tensions from the profession and the organisation described earlier, they may also face public and media pressure, particularly since the Mid Staffordshire crisis (Francis, 2013). This situation could feasibly apply to any professional; shock is therefore a common feature of organisational life for the newly-accountable professional, it is also likely to be heavily-mediated by local organisational arrangements and issues such as those evident in the current NHS and nursing. This is problematic because of the real distress caused by the new experiences faced by newly-qualified nurses, which may be heavily influenced by the wider NHS context. This new situation may also be challenging because a deep understanding of one's own experience may not be possible due to the complex and contradictory nature of practice and the difficulty of being able to reflect in real time (Nicolini and Roe, 2014).

For the reasons I have described, retention of newly-qualified nurses is likely to be problematic. However their recruitment is also a concern and one cannot assume that all newly-qualified nurses will go directly from education into an NHS location of their choosing, a factor which I later show is significant during the practices of professional becoming.

*The recruitment of new nurses*

Although nurses are described as the 'backbone' of the NHS providing an invaluable contribution to patient care (Lansley, 2011), the recruitment of

qualified nurses in the UK has been episodically problematic (Shields and Ward, 2001). The proposal of Project 2000 education, for example, created concerns about adequate staffing numbers. Further insight provided by a commissioned Price Waterhouse Cooper (PWC) consultation (1987) showed that the nursing profession suffered much wastage and relied on high levels of recruitment, and further, that nursing depended upon a good supply of students. The ratio of qualified nurses that PWC recommended for clinical settings was 64-75% with the remainder being unqualified; however, this was immediately rejected by the government (Davies, 1995). The prevailing model of recruitment apparently needed to be transformed to meet the needs created by Project 2000, which meant finding ways to make nursing more attractive to male applicants (and therefore boost numbers), and preventing attrition through nurses leaving the profession. Carter and Tourangeau (2012) note similar problems are likely to continue surfacing due to difficult economic conditions and the aging population.

There has been much disagreement over the recruitment of nurses and the RCN vocalised concerns about cost-cutting in 2011, drawing attention to a number of policy reports that have directly attributed staffing levels to lowered patient safety (Buchan *et al*. 2013). The National Advisory Group on the Safety of Patients in England report (Berwick, 2013) focused on NHS staffing levels and highlighted the need for the National Institute of Clinical Evidence (NICE) to produce guidance on staffing levels. This never fully materialised and at the time of writing, responsibility for producing this guidance was transferred to the auspices of NHS England (NICE, 2015). Concerns about recruitment and

staffing levels have re-converged in NHS England's (NHS Employers, 2014) NHS Qualified Nurse Supply and Demand Survey, which implied that recent NHS scandals, such as the Mid-Staffordshire case, may have affected the attractiveness of nursing to potential applicants. The survey reported a 10% national average vacancy level, and Trusts stated that they would recruit nursing staff from abroad in order to fill gaps in clinical areas such as surgery or neonatal care which are hard to fill. Addressing these specific issues of unpopular specialities would therefore be critical in attracting and retaining nurses to work in the NHS (NHS Employers, 2014). Although the survey reported serious concerns about retention, it should be noted that only a 43% response was received. It is also unclear what local strategies are in pace at Trust and hospital levels to address these concerns through local workforce development planning.

This is an important issue because it shows why the retention of nurses is so relevant. As such, it is against this background of concern over retention and recruitment, along with the principles of managerialism and the new culture of quality and safety described in Chapter 2, that the strategy of Preceptorship has been developed and rolled out at pace in the NHS. In the following section, I explore Preceptorship, its development, implementation and the implications of it for nurses and organisations. I conclude this chapter by explaining why Preceptorship makes an interesting case study for studying contemporary 'professional becoming'.

## Preceptorship

The term ‘Preceptorship’ originates from the Latin ‘Preceptor’, which means ‘instructed’ (Oxford English Dictionary, 2011). Preceptorship is defined as “the process through which existing nurses and midwives provide support to newly qualified nurses and midwives” (NMC, 2008:46). In its modern form, Preceptorship has developed as a programme of post-registration support now offered to most newly qualified nurses and generally delivered through a combination of classroom/e-learning, and supervision/reflective practice (Department of Health, 2010).

A Preceptor is a more experienced Registered Nurse who offers focused, one-to-one support to a newly-qualified nurse -the Preceptee. Preceptorship is also increasingly offered to Allied Health Professionals such as occupational therapists but in the UK figures summarising this are hard to establish. There is a limited understanding of the concept of Preceptorship beyond those to whom it is relevant in the NHS. In countries such as the USA, Australia and Canada, it appears to be better understood and well established in a slightly different form as a pre-registration model which is offered to students of medicine and nursing (Myrick, 2002).

An early reference to a Preceptor was made by Mrs Bedford-Fenwick (1933: 187):

> *We nurses are especially favoured that our great Preceptor, Florence Nightingale, was a mystic, and thus her teaching penetrates beyond the veil. She has revealed to us a vista of possible advancement.*

The above statement suggests that Nightingale, 'the original Preceptor', was a role model who perpetuated good practice in ways which were somehow magical. This also suggests the importance of 'experts' and leaders as sources of identification. Although Florence Nightingale is described as the original Preceptor, as discussed earlier in this chapter, myths appear to have surrounded her model of care and Nightingale's reputation has arguably become inflated over time (Williams, 2008). This helps us understand how her story was used in different ways but also suggests that leadership and role modelling can be overstated as objective concepts. Therefore as I show, much of the literature on Preceptorship does not critically appraise the concepts it introduces such as the value of role modelling.

Despite the findings of Kramer (1974) and later research studies on the potential of Preceptorship (Lathlean 1987; Armitage and Burnard, 1991; Myrick, 1998), the first recommendations for formalising Preceptorship were not made by the United Kingdom Central Council for Nursing and Midwifery (UKCC) -now the Nursing and Midwifery Council (NMC) -until 1993. The need to support newly-qualified nurses was also acknowledged in *Modernising Nursing Careers* (Department of Health, 2006), albeit in the form of the *Flying Start* programme, a national development programme. However, in recent

years the drive for national Preceptorship, proposed by the NMC (2009) appears to have accelerated in line with NHS reforms, particularly in terms of quality and safety. For example a driver for Preceptorship is *High Quality Care for All* (Darzi, 2008) which promotes the development of staff and states that quality is 'at the heart of everything we [in the NHS] do' (Darzi, 2008:7). It also aligns with documents such as the *NHS Constitution* (NHS, 2011:13) that pledges 'to provide all staff with personal development, access to appropriate education and training for their jobs, and line management support to enable them to fulfil their potential'. More recently, *Enabling Excellence: Autonomy and Accountability for Health and Social Care* (DH, 2010b:40) which focuses on valuing "staff who are empowered, engaged and well supported provide better patient care" also appears to support Preceptorship. Consequently, the move of new nurses from education to employment is situated in the wider arena of major policy and organisational changes within the NHS that have affected the education, experience and practice of nurses (Gerrish, 2000). For example, shorter patient stays, an increase in the use of technology and patients requiring higher levels of care all occur within market-driven policies, consequently creating new demands on nurses (Bartels, 2005). Although some NHS Trusts already had a Preceptorship programme in place, a generic Preceptorship Framework (DH, 2010a) was formalised in 2010. Since then most Trusts have started to implement a programme, although it is difficult to obtain exact figures on this because having a Preceptorship programme remains optional for Trusts despite calls to make it compulsory (Robinson and Griffiths, 2009; Snow, 2013).

The Preceptorship Framework (Department of Health, 2010a) defines Preceptorship as:

> *A period of structured transition for the newly registered practitioner during which he or she will be supported by a Preceptor, to develop their confidence as an autonomous professional, refine skills, values and behaviours, and to continue on their journey of life-long learning.*

The Framework states that it aims to enhance the "competencies and confidence of newly registered practitioners as autonomous professionals", and also recognises the changing context of nursing and requires "a more independent, autonomous, and innovative practitioner to meet the changing requirement of future healthcare provision" (DH, 2010:6). The framework acknowledges the changing context of nursing and hopes that Preceptorship will lead to nurses increased learning and knowledge of wider NHS policies (DH, 2010a). In terms of NHS organisations, expected benefits include an increased commitment from nurses, greater retention, safer care of patients and a more transparent culture. Preceptorship also aims to modify the attitudes and behaviours of newly-qualified nurses, thus helping them to access the values and expectations of the profession (Department of Health, 2010). At the time of my data collection nursing values had not been made explicit, and in the light of concerns over recent crises, the Chief Nurse of England in consultation with

the profession introduced values for nursing (Cummings and Bennet, 2012, NHS England, 2012).

*Unpacking the concept of Preceptorship*

The nursing literature, including a commissioned scoping review (Robinson and Griffiths, 2009) and a systematic review (Whitehead *et al.,* 2013), reveals a range of issues regarding Preceptorship. First is the lack of a succinct definition of Preceptorship which has long been the subject of debate (Armitage and Burnard, 1991; Bain, 1997; Pfeil, 1999; Firtko *et al*., 2005; Robinson and Griffiths, 2009). Within the Preceptorship Framework (Department of Health, 2010a) Preceptorship is defined by what it is not. For example, Preceptorship is suggested to be distinct from training, coaching, mentorship, clinical supervision or distance learning (on its own), and not intended to be a substitute for good education. This lack of clarity is also reported in Whitehead *et al.*'s (2013) systematic literature review on Preceptorship and the lack of theoretical foundation is highlighted in the nursing literature (Robinson and Griffiths, 2009).

The lack of theoretical foundation for the concept of Preceptorship is one of the biggest challenges to implementing it, aside from the issue of whether or not it is perceived to achieve the stated outcomes (Robinson and Griffiths, 2009). The challenge exists because organisations may not understand what they are implementing and thus how to embed it within organisation processes. Studies

on Preceptorship have often been small and evidence somewhat patchy, with some research being more internationally-focused (Robinson and Griffiths, 2009). The number of studies is growing however, e.g. seen in a recent study based in traditional understandings of symbolic interactionism (Carlson, 2012). Moreover, as I argued in Chapter 2, this type of study offers a limited understanding because it does not fully account for the dynamics of learning, practice and identity in an organisational setting. Due to a lack of strong evidence of how Preceptorship fulfils its expectations beyond support, the design of an effective programme remains essentially experimental.

That said, the evidence base for Preceptorship is growing, and despite reported operational problems such as a lack of available Preceptors, it is generally welcomed by newly-qualified nurses (Robinson and Griffiths, 2009; Whitehead *et al*., 2013). However, the Preceptorship Framework (DH, 2010a) has not been studied from a social science perspective, especially regarding sociological approaches to learning. Using theories from sociology and organisation studies, for example, could help to shed light on the dynamic practices of Preceptorship as a central phenomenon of the 'professional becoming' of nurses situated in hybrid organisational and professional practices (Noordegraaf, 2007). Although it would appear that Preceptorship has well-founded aims which would appeal to multiple stakeholders, I offer further thoughts on why Preceptorship might be problematic and why it is interesting to study as a case.

*The flexibility of Preceptorship*

This section explores the extent to which Preceptorship is a flexible programme that can be tailored to meet local and individual needs, because official guidance states that 'Preceptorship should be planned in the context of the individual's professional responsibilities and the needs of their employer' (DH, 2016:16). However, the generic explanation in the Preceptorship Framework (DH, 2010a) shown earlier conveys a sense of a standardised approach to support the general workforce rather than something tailored to nurses, and indicates the importance of how the framework is interpreted, translated and implemented by individual Trusts. The possibility of Preceptorship being tailored to individual needs is also debatable because the structured approach needs to be translated through links to key skills frameworks driven by local policy. Although the design may be considered flexible, the extent to which a 'bottom-up' approach is adopted by Trusts is unclear. Thus, it can be argued that understanding flexibility should be central to planning a Preceptorship programme, particularly in relation to grasping the nature of organisational learning. For example, Preceptorship emphasises the Preceptees' responsibility for learning and reflection, yet Preceptees rely on the organisation, management and commitment from others who are subject to organisational pressures.

The discursive strategy of nursing management in translating Preceptorships aims and implementing it locally is important, as the history of nursing is often presented in a way that gives the novice a 'rosy picture' of nursing to gain

loyalty to the profession or organisation (Davies, 1980). This tendency may also be found in Preceptorship and raises questions of how it is promoted to the novice and how Preceptees are persuaded to invest time in engaging in formal learning during the newly-qualified period.

One of the most questionable aims of the Preceptorship Framework (DH, 2010a) is the promise of professional autonomy. Since Project 2000, nurses may be better at challenging medical authority (Gerrish, 2000) and Preceptorship may support this through increasing the confidence of new nurses to put theory into practice. However, as noted above, the professional status of nurses has been challenged and coupled with institutional pressures; professional autonomy could be an unrealistic goal. Although autonomy is explicit in the discourse of NMC standards (2008), it is considered to be an outcome of Preceptorship (DH, 2010a). Professional autonomy is also an issue that was discussed in Chapter 2, as it has been challenged by NPM. Preceptorship may therefore set up unrealistic expectations, because the rhetoric promotes autonomy but in practice this may not be achievable.

*The Preceptor-Preceptee relationship*

Preceptorship relies on a model of support that centres on a structured yet contextual relationship between Preceptor and Preceptee. This indicates that Preceptorship is seen as a 'novice to expert model' (Benner, 1982:402) which relies on smooth knowledge acquisition critiqued in Chapter 2. Preceptors are

expected to show leadership and be role models, yet role modelling and leadership can be problematic if the structural understanding of knowledge described in Chapter 2 is adopted. It may not be possible for one key person to act as a leader and role model as they simultaneously work in the context of other organisational practices (which may be difficult to control). The concept of leadership is also much critiqued in organisation studies. For example, Alvesson and Spicer (2012:370) question functional suppositions of leadership as the 'dominant social myth of our time' whilst also condemning models of distributed leadership that show leadership is everywhere. Instead, Alvesson and Spicer (2012) see leadership as socially constructed, negotiated, and accomplished through practice.

*Institutional and managerial challenges to Preceptorship*

The impact of institutional and managerial challenges on the implementation of Preceptorship also appears to be under-theorised, despite the fact that learning and socialisation have long been considered to be a reflection of wider institutional forces (Berger and Luckman, 1966; Geertz, 1973; Di Maggio and Powell, 1991). As Antonacopoulou and Pesqueux (2010:11) suggest, socialisation and institutionalisation are both crucial in the human act of organising and note 'it is the way through which agents are connected in a given social body' whilst stressing that socialisation is a purposeful tactic used by organisations. This makes a significant difference to learning and socialisation in organisations because it means that purposeful activity is carried out with a higher (i.e. organisational) goal (Antonacopoulou and

Pesqueux, 2010). This shows that Preceptorship has the potential to be used as a site for mobilising organisational tactics, a crucial point which becomes evident in the findings.

A further example of managerial challenges to 'professional becoming' in the NHS are HRM practices. As discussed in Chapter 2, HRM tactics include those seen in interventions such as induction and training. Performance management is another HRM practice which is important to consider during Preceptorship. In nursing, the need to monitor performance led to the disbanding of the UKCC and the emergence of the NMC, which is better able to monitor and discipline bad practice (Harrison and McDonald, 2008). Although the Preceptorship Framework (Department of Health, 2010a) claims Preceptorship is distinct from performance management, performance is closely monitored during Preceptorship and at times, when nurses are subject to performance reviews, one could argue they are not separate. Performance management in the NHS has been argued to be hidden surveillance (Harrison and McDonald, 2008). Therefore, the completion of Preceptorship, which is validated by Preceptors, could be used to inform performance management and enable a Trust's management team to observe the performance of newly-qualified nurses more easily, albeit through covert means.

A further challenge arising from managerialism is the problem of managing knowledge in the NHS. Preceptorship appears to assume the smooth transmission of professional 'know-how' from a Preceptor (an experienced

nurse), supplemented by formal education, to the Preceptee. However, as already discussed in Chapter 2, knowledge is often tacit and socially-embedded in material practices. Knowledge transmission is further complicated because UK governments have increasingly encouraged learning in healthcare across traditional professional and organisational boundaries to encourage innovation and improve efficiency and quality (DH, 2011). The problem of how to effectively manage knowledge gained through learning across institutional boundaries has been a popular focus of studies (Newell *et al*, 2009; Easterby-Smith and Lyles, 2011). For example, using neo-institutional sociology, boundaries between healthcare education and the healthcare setting have been examined to see how policy, procedure and practice are influenced by societal regulations, norms and culture (Currie and Suhomlinova, 2006). It was found that institutional pressures create convergence through isomorphism yet also inhibit knowledge sharing between professional groups. Hence, institutional conditions can influence how newcomers learn in organisations in education, training and development. This has important implications for Preceptees who learn from peers and other professions as well as their Preceptors regarding what it is and how to 'be' a nurse. Preceptorship conveyed in policy appears to be a homogenising process that uses a national framework to align the behaviours and values of nurses with the profession, the organisation, or both. While this might seem to have positive implications for quality and safety it may also stifle innovation and the promise of autonomy. This could be perceived as a form of domination in which nurses are persuaded they can be autonomous by an organisation keen to retain control (Wilmott, 1993).

*Further critique of the policy of Preceptorship*

A notable gap in the Preceptorship Framework (DH, 2010a) is mainly that the period of socialisation may not be a one-way process. By this, I mean that the framework is heavily orientated towards what needs to be done *for* the Preceptee, without considering that Preceptees might be able to offer something to organisations. Preceptorship is described as an opportunity for the organisation to spot leadership talent and support the learning of Preceptors in addition to the supervision and mentoring skills they gain (DH, 2010a). However, the Preceptorship Framework (DH, 2010a) is ambiguous about the hopes of, expectations about or possibility that the organisation can learn from Preceptees. When newcomers start work, they have 'fresh eyes' with which to see the world and can ask naïve questions that trigger reflection in others (Lave and Wenger, 1991); this in turn can lead to transformation. This possibility appears to be a neglected and a poorly researched dimension of Preceptorship.

## Conclusion

This chapter has explored the nursing profession through its history of professionalisation, the fight to separate education and employment, policy developments in education, pressures and shock, and the more recent roll-out of the Preceptorship Framework (DH, 2010a). Nursing is presented as an uneasy profession whose historic struggles between the profession and managerialism continues to effect practice and education, while recent scandals in the NHS have surfaced in media and public criticism. I have shown that new

nurses are still considered (by some) to lack the skills and experience which allow them to smoothly transfer into their new roles.

As noted in the previous chapter, there have been many studies on the socialisation of newcomers into organisations. However there is a gap in knowledge that studies post-professional 'professional becoming' in the context of new policies such as Preceptorship which recognises that newly-qualified professionals are also new starters to an organisation. Socialisation is therefore both a professional and an organisational concern. Preceptorship is important to study because it is an explicit policy attempt to shape professional practice and identity. The case of Preceptorship is also important and timely because it has emerged from nursing's turbulent history, and contemporary pressures on the NHS. However, to capture the dynamics of how newly-qualified nurses learn whilst undergoing Preceptorship in an organisation setting, a new research approach - a practice perspective on learning - is helpful.

The practice perspective on learning (Schatzki, 2001; Gherardi 2001, Gherardi and Nicolini, 2002) is promising because it acknowledges the importance of tacit knowledge, power, the contestation of knowledge in a community and participation in becoming a professional in real time. Becoming an accountable practitioner in the workplace means that professionals gradually become aware of what it means 'to be' a nurse and professional 'know-how' is thus highlighted to novices through relational participation in mundane everyday

nursing work. Some of this wisdom involves nurses developing a conscious understanding of work but other phenomena are often 'hidden' and tacit. This learning also involves a transformation of identity as newly qualified nurses practice at the interface of the profession, the organisation and the public, and learn 'to be' a nurse in a given context. The standardisation of Preceptorship is a relatively new development and is not well understood. A practice approach to learning which explains the nuances of learning offers an opportunity to explore this process in rich detail.

**Research question**

The 'professional becoming' of nurses is explored through the case of Preceptorship. The thesis answers the following research question:

> *What are the practices of 'professional becoming' in the context of novel organisational socialisation and induction policies?*

It does so by asking:

> *What are the practices of 'professional becoming' for newly-qualified nurses as they enter the clinical workplace and participate in an NHS Trust's Preceptorship programme?*

The following chapter explains the methodology that I use and elaborates on the ontology and epistemology of the practice perspective on organisational learning which shapes my research approach and methods.

# Chapter 4 Research Methodology

## Introduction

This chapter describes the approach I took to understand the practices of the 'professional becoming' of newly-qualified nurses in the context of nursing Preceptorship. Studying 'professional becoming' using a practice perspective is methodologically demanding because knowledge, identity and learning cannot be separated from context and studied in isolation (Handley *et al.*, 2007). Moreover, trying to understand the role and influence of knowledge and learning in day-to-day practice is problematic because much of its inconsistencies and ambiguities remain hidden in the mundane (Nicolini, 2012). As practices are complex they need to be studied through a 'toolkit' of methods (Nicolini, 2009) to explore the 'when' 'who', 'where', 'how', 'what' and 'why' that make up the "compass of relational research" (Antonacopoulou, 2009: 167). First, I build on my discussion of practice theory by explaining the research philosophy underpinning this methodology and the reasons why I chose ethnography as an approach. Following this, I describe in detail the methods I used to collect the data and how I analysed it. Next, I explore the authenticity of the study through a reflexive account, acknowledging my role as a former nurse and 'research instrument'. Finally, I show how I ensured that the study is rigorous and ethical. The following section discusses my research philosophy and shows the development of my thinking.

## Research philosophy

In order to decide my research philosophy I considered paradigms as a way to clarify where the study was located. Studying paradigms is useful because they can help to highlight the assumptions made when considering a research philosophy and appropriate methods (Burrell and Morgan, 1979). As Lincoln and Guba (1985) note, research should always be paradigm-led because it takes place around a particular collection of ideas based on ontological and epistemological assumptions; in other words, in paradigms. Burrell and Morgan (1979) demonstrate the incommensurability of paradigms meaning there are assumptions within each paradigm that are metaphysically distinct from one another (Shepherd and Challenger, 2013). With this understanding I first considered situating my research solely in the interpretive paradigm to draw upon the philosophical principles of social constructionism. Increasingly seen in the business and management literature, this approach takes into account the multiple realities of actors (Bryman, 2008). Social constructionism seeks to understand "how reality is precisely constructed" (Alvesson and Skoldberg, 2009:15); this means that we stop taking the world for granted and question our assumptions, seeking to understand the world through an historical and culturally specific lens (Burr, 2015). Our particular knowledge of the world will lead to different patterns of social action, (some of which will endure, depending on how they are constructed and accepted). Hence, some people are excluded from social life, for example if they fall outside these social norms (Burr, 2015). This is important in my study because from the

constructionist perspective "all knowledge is contingent on human practices" (Crotty, 1998:42).

Nevertheless, social constructionism is a very broad approach associated with diverse perspectives, e.g. post-modernism, phenomenology and grounded theory (Alvesson and Skoldberg, 2009). Hence, I was aware of the dangers of relativism and that my viewpoint was often critically-inclined due to previous exposure to Critical Management Studies (Wilmott, 1992). The incommensurability of paradigms has been criticized by authors who suggest that blended approaches are legitimate (Weaver and Gioia, 1994) and for that reason I have situated my perspective as broadly interpretive-critical (Alvesson and Skoldberg, 2009). Accepting and drawing together social constructionism with a degree of criticality is suitable for a reflexive study of socio-cultural phenomena (Seale *et al.,* 2004; Alvesson and Skoldberg, 2009) as it led me to question assumptions I made about everyday life.

This study avoids dualistic thinking and uses practice ontology (Schatzki, 2011). A practice ontology "assumes an ecological model in which agency is distributed between humans and non-humans" (Gherardi, 2009a:115). In other words the world is constituted of inter-connecting practices between people and the material objects they create and use. However, as noted in Chapter 2, it is a practice perspective on learning that provides the particular theoretical foundation for this study. As I argued, adopting an epistemology of practice means that 'knowing and action' can be seen as mutually constituting learning. Therefore, to study how people learn requires a rich description of how they act

and talk in relation to each other and how they draw on tools and other material resources. I have thus used an inductive approach in this study that helps to articulate and reveal these often hidden practices of 'professional becoming'. As Nicolini (2009:1392) notes "practices always need to be drawn to the fore, made visible and turned into an epistemic object in order to enter discourse". These practices are suggested to be 'hidden aspects' as they are relational activities and conversations between actors in everyday work which are often not recognised as learning if one uses traditional theories. Revealing this learning and becoming is an important consideration for NHS funded research such as this, and I acknowledge my responsibility to help improve healthcare services.

## Research strategy

I chose qualitative methods because the social world cannot be easily described from quantitative data (Bryman, 2008). The approach also allows for an understanding of human problems (Cresswell, 1994) and the social construction of the world through studying on-going and emergent practices. As Nicolini (2009) argues, by acknowledging the construction of power and meaning we should therefore account for what this looks like in practice. This requires a qualitative and interpretive approach that can articulate practices. Qualitative research is a broad concept and as Van Maanen (1979:520) observes:

> *"Qualitative methods have no precise meaning in any of the social sciences. It is at best an umbrella term covering an array of techniques which seeks to describe, decode, translate and otherwise come to terms with the meaning, not the frequency of more or less naturally occurring phenomena in the social world".*

This is similar to Weber's concept of 'Verstehen' which suggests that phenomena are often ambiguous and thus need interpreting by the researcher - something the positivistic or naturalistic researcher would not do (Hammersley and Atkinson, 1995). As Van Maanen (1979) notes, this requires reflexivity, not sticking to rigid categories, labels and hypotheses, and instead understanding the social processes. Once the researcher is intimate with the research setting, qualitative research can provide a rich understanding about context.

Qualitative research supports the study of all practices, including the mundane and routine, which is important when studying situated learning and 'professional becoming'. It also accepts that social reality is embodied and is "a constantly shifting emergent property of individual's creation" (Bryman, 2008:22). Understanding professional becoming as practice necessitates a study of normative learning, the practical concerns of practitioners, and how practices relate to one another (Nicolini, 2012). As Antonacopoulou (2009) observes, understanding relationships and connections calls for a focus on what relationships are and who the key actors are in them. It also calls for an examination of how, why, when and where these relationships are formed. This

approach emphasises the resilience of some practices, and that practices are "two-way" (Nicolini, 2012:3) thus accounting for their transformation.

*Ethnography*

This study is designed as an ethnographic case study. Ethnography is recognised as one of the most informative methods of learning 'how things work' in organisations (Van Maanen, 2011) and captures 'everyday' and mundane activity that helps shed light on knowing in organisations. Traditionally found in anthropology, ethnographies have been defined as "the art and science of describing a group or culture" (Fetterman, 1998:1). At the heart of ethnographic observations is the premise that the social world can be understood only by observing it over time. The focus is therefore on how people interpret stimuli rather than viewing people's response to stimuli as simple behaviours. The acceptance in ethnography is that activity is based on how meaning is made through our beliefs, values, and motives (Hammersley and Atkinson, 1995). However, I did not simply observe how people interpreted their world; I formed relationships with Preceptees to gain trust and I asked them questions as I shadowed them in order to get closer to their practices. As Watson (2011:204) notes "we can say little about organisations and identities unless we get close to human action and social interactions must surely apply even more to research which prioritises the notion of practice".

Although inductive, my interpretative approach has been framed by sensitising concepts and debates. Moreover, as my analysis progressed I compared my

emergent descriptions and interpretation of those theories with the aim of developing theoretical interpretations and extending theory. In addition, ethnography gave me the capacity to be open-minded and flexible (Alvesson and Skoldberg, 2009). Not only does ethnography allow the researcher to study culture and context though identifying, describing and interpreting localised rules, rituals and social processes, it also provides the capacity to appreciate the influence, reconstitution and transformation of wider institutions through studying them as 'fields'. Ethnography can also expose issues of language, history and power that are inherent in the social world (Contu and Wilmott, 2003). It is a holistic and emic approach and, as Hammersley (1992:23) notes, ethnography emphasises understanding how events unfold in context and that "description is explanation". However, this study does not merely describe a particular culture or reality (Hammersley (1992). Indeed, I accept that describing a purely representational view of events would only give a partially constructed 'picture'. Practice is notoriously hard to articulate as it remains hidden in the habits and routines of a community (Carlile, 2002) and when people are asked to describe what they do, practice becomes distorted and often idealised (Suchman, 2007; Nicolini 2009). Ethnography is however suited to studying practices because it is attentive to the mundane, it helps one to understand how meaning comes about through multiple connected practices (Hopwood, 2013).

As is common with ethnography, I started out with broad research aims, in this case wanting to understand more about the practices of 'professional becoming'. I started by making generalised observations in which I was

sensitive to the group of concepts that are central to practice theory (as noted earlier in the 'who', what', 'when' and 'how' questions). As I began to see points of interest where connections could be made with the 'bigger picture', I paid closer attention to certain themes, such as emotion.

As an ethnographic researcher, I was the instrument of research, a social actor who was able to learn and make sense of the 'foreign' culture, (Hammersley and Atkinson, 1995), as already noted, I was not altogether unfamiliar with a hospital context. Positivists view the 'researcher as instrument' to be a weakness, but in ethnography, this is viewed as a strength. As Bryman (2008) suggests, any method can be argued to be a product of the social world. The ethnographer is no longer under as much pressure to be objective and a reflexive view accepts the researcher's position in the research environment as being influential (Hammersley and Atkinson, 1995).

## The research setting

The Trust my study was conducted in covers one of the largest regions in the United Kingdom, employing around 8000 members of staff and providing services for over 700,000 patients. There are three large hospitals in the Trust I refer to as 'Oldshire' and services are also provided at four smaller hospitals in a county. The fieldwork took place at the three large hospitals, Burydale, Riverton and Runnysea. Burydale hospital contained the Trust Headquarters (HQ) and provided all medical specialities. It was also where the Clinical Education Team (CE Team) which was responsible for Preceptorship was

based. The previous year's Care Quality Commission (CQC) (who are responsible for monitoring compliance with national standards of care) inspection had raised concerns about patients' dignity within this hospital, and there was a further CQC inspection during my data collection period which raised more serious concerns about the quality of patient care. Much of the hospital had been rebuilt over the previous two decades and the Trust website boasted that Burydale had several new wards that were fully equipped with modern technology and facilities. Riverton was the smallest of the three hospitals and did not have a School of Nursing or allocated CE Team. It had a small library, but generally lacked educational facilities. As such, nurses who were based at Riverton had to travel to Burydale or Runnysea for training sessions. Runnysea hospital was the most geographically isolated of the three and served the population of a large region. The CE Team had an office and a local manager at Runnysea and delivered a Preceptorship programme from this site. Similarly to Burydale, the CQC reported that in 2011 Runnysea had not met requirements on 14 out of the 16 "Essential Standards of Quality" (CQC, 2010). This was significant for my study and is discussed throughout the thesis.

The Trust had experienced changes of leadership and was undergoing a period of organisational change. My involvement in this Trust arose due to a Trust research and development nurse who was keen to raise the profile of high quality research and sought to collaborate with my University. This nurse left her role before I commenced fieldwork, which had implications for the study as I then had to report directly to the Deputy Chief Nurse (DCN) who 'acted up' and whom the CE team explained was pre-occupied with the

aforementioned CQC problems. This may have explained her disengagement from my research, which meant I was trying to conduct research without significant management support. Nevertheless, I retained my sense of responsibility to the organisation and I attempted to update the DCN regularly. I was aware of the privilege of being allowed into an organisation that was going through a difficult period of transition and change and did not wish to compromise this at any time or act unethically. I return to this in the reflexivity section later in this chapter.

I had originally negotiated access to a Preceptorship cohort at Burydale. However, this cohort was postponed (financial difficulties within the Trust had led to a lack of jobs for newly-qualified nurses). As an alternative, I was invited to study a cohort at Runnysea. I agreed, though I entered the field with trepidation as this particular hospital had been in the media on more than one occasion for poor standards of care. Three months before I started my fieldwork there had been a ward closure following a review by the CQC. As a result, all of the student nurses had been withdrawn from this hospital site (this occurred with immediate effect and all nurses were told to leave the hospital premises on the spot). The CQC report demonstrated poor care in some areas and recorded clinical errors, two 'never' events (serious incidents) and many complaints from patients and their families. It also highlighted problems with the recruitment and retention of nursing staff and inadequacies identified in the skills and competencies of some existing nurses. One of the most significant findings for this study was that cultural problems were a noted impediment to improvement and change at the hospital. The CQC noted that the senior

management team was trying to work on this issue to tighten up its systems to improve accountability. The CQC acknowledged that the patient safety team was involved in training and mentoring staff to build skills and understanding of what was required by professional standards. The CQC concerns remained current during data collection. Though many improvements had been made, there were still inadequate staffing levels and minor concerns around staff support as well as moderate concerns about patient discharges. This context in which my research was conducted later provided rich data. However, it required me to take a reflexive approach during my observations as there was potential for me to become judgemental or biased due to what I had read in the news.

I received an honorary contract and was encouraged to spend as much time at the hospital sites as I needed to. I was given a title, a name badge, a laptop and a desk. This was significant for my data collection, as successful participant observation is a 'practice' in which a researcher becomes part of a group or organisation over a period of time and can engage with organisational activities, join activities and share their experiences (Watson, 2011).

I built trust with the CE Team and the Preceptees in order to be able to understand the phenomena. Although most members of the CE Team were very welcoming and inclusive, regulatory issues within the Trust had led to turmoil and impacted upon my inclusion at meetings. I had been informed by the DCN that I would be invited to attend by the CE Team, but the invitation only came once. Although I was able to build up trust, I was told that I should

not bother attending further meetings as they were lengthy and much of what was discussed at the meeting was not relevant to the Preceptorship programme. I was initially disappointed to be excluded from meetings, however, the distance helped me to win the trust of the Preceptees who did not see me as a member of the CE Team and thus felt able to confide in me. I therefore took measures to ensure that I was not seen to be too aligned with the CE Team. This included sitting with the Preceptees rather the educators during study days and making sure I guaranteed anonymity when collecting data. I also had to build up trust slowly in order to gain access to the wards. Observing the Preceptees on wards remained a significant challenge as they were new and ward staff were nervous about my presence due to inspection problems.

## Sampling for participants

As this research was an ethnographic case study, the sample was purposive and pragmatic (O'Reilly, 2009). I was funded by the NHS Trust on the condition that Oldshire was the research setting. Although I did not have a choice of research location, this condition was of benefit to the study as it was a large, diverse Trust in which I was able to study different sites. In addition, the particular case was a useful one to study because it was experiencing similar issues centring on care standards to the ones highlighted by Francis (2013). The case was an opportunity to study all of the pressures on 'professional becoming' in a "critical case" (Yin, 2014:48) which could add to an understanding of 'professional becoming' if conditions were similar.

Although I did not have the breadth of study across different Trusts, I was able to understand Preceptorship in more depth in a particular context. I was granted access by the sponsor, the DCN, to two cohorts of newly qualified nurses, which was a total of 48 Preceptees across the Runnysea and Riverton sites. All of the Preceptees, with the exception of one nurse who was leaving, chose to take part in the study. This high level of involvement may have been helped by my previously having been a nurse, and the empathetic stance I adopted that helped towards 'an exchange' for them taking part in the study: I was able to offer them a confidential space in which to reflect on their practice and 'off load' both on the wards and on their study days. I identified other key participants once I had entered the field and understood who might play an important role related to Preceptorship.

In total, sixty nine people participated in the study, including forty eight newly qualified nurses, six members of the CE team, seven Preceptors (some were clinical educators), two ward leaders, two specialist nurses, two pharmacists, a chief nurse and the Trust's Head of Quality and Safety. I undertook ward based observations of 14 Preceptees and invited their Preceptors and ward managers to be interviewed. Most of the Preceptors were difficult to contact and communicate with. I tried emailing potential participants but received few replies and I was told by nurses that they get little access to the Trust email system due to their heavy workload. To overcome this I visited wards and left messages and also tried phoning nurses. It is possible that many of those I was able to contact may have chosen to take part in the study because they were more motivated professionals who provided greater 'access to learning' for

Preceptees. This was not always the case. For example at Riverton through great perseverance I was able to speak to two ward sisters who were considered to be unhelpful by the Preceptees on their ward. I did succeed in recruiting some staff that were initially reticent about taking part in the research and their recruitment was achieved through gaining their trust over a period of time. Thus, the cohort study became an opportunistic sample and a total of 7 Preceptors (3 were also ward sisters) were interviewed. Nevertheless, the sample was representative. I studied one cohort of Preceptees over their whole eight-month Preceptorship period and the second for 4 months.

## Methods

As this study centres on practice, a careful consideration of methods which can engage with and bring out its tacit nature was required. Research methods are the techniques and instruments that are used for collecting data. Their strengths and weaknesses will depend on how consistent they are with the research philosophy and how well they help to answer the research questions. I used methods that would best address the research task (Silverman, 2010) and which were consistent with ethnography. I took a pragmatic approach to research methods known as the "bricoleur" perspective, using whatever were the most suitable tools to hand, whilst acknowledging that all results can be critical (Kincheloe *et al*., 2011 in Denzin and Lincoln, 2011:4). Thus, I was able to use a variety of methods and synthesise them through the 'practice lens' described earlier, including the use of tools and artefacts as the technology through which practice takes place (Lave and Wenger, 1991).

To collect data, I first studied the policy and wider context of healthcare and nursing through the analysis of documentary evidence such as government white papers, NHS and RCN publications. I also studied documents which were in current use within the Trust such as the behaviour framework and Preceptorship portfolio. I attended meetings, teaching sessions and observed nurses working on the wards, studying both their daily routines and specific instances of Preceptor/Preceptee engagement. I conducted 33 group interviews group interviews with the Preceptees and carried out semi-structured interviews with members of the CE team (6), ward managers (3), a patient safety expert, and a patient outreach services manager (1) and one Preceptee who was unable to attend a focus group. Some nurses also kept reflective diaries and I encouraged them to record their thoughts and ideas.

*Observations*

Taking into consideration the difficulty of introspective accounts when studying real-time practice (Nicolini, 2009), I undertook detailed observations with the CE Team and with 12 Preceptees to observe their practices. I spent two days a week over a ten-month period based with the CE Team and was given the use of a desk both at Runnysea and Burydale. I observed the CE Team working in their offices and would also sometimes stand on the corridor nearby to understand the general activity of the department. I sat in the classrooms during ten study days which lasted for seven hours each, and I would sometimes go for breaks with the Preceptees. I spent up to six hours at a

time with Preceptees on their shifts in clinical settings both during the day, at night and the occasional weekend. Most nurses agreed to be observed and I had to make a choice about where and when I would visit. To take a cross-section of ward contexts I chose large general medical and surgical wards at each of the three hospitals. At Runnysea I also observed on the Special Care Baby Unit (SCBU), Theatre Recovery, the Coronary Care Unit and the Clinical Decisions Unit. It was more difficult to gain access to specialised units and so I have fewer observations from these areas. However, I was able to gain very rich observations from data collection in the areas where I did gain access.

During the observations I would sometimes sit in a bay and watch the Preceptees move between patients; at other times, I would walk around the ward areas with them. When safe to do so, i.e. not during a medicine round, I would ask them questions about what they were doing. Most of the time, the Preceptees would chat to me freely. When they were busy administering medicines or undertaking clinical procedures they would tell me they had forgotten I was there. Consequently I felt assured that for much of the time they were not 'performing' for my benefit. Undertaking the observations was challenging at times; on the large wards, I was able to blend into the setting quite easily, unlike in smaller units where my presence was noticeable at all times, particularly at the beginning of my research. Nevertheless, in smaller units, people would engage me in conversation and I was able to win trust more easily and eventually blended in, which gave me greater access to observe practices. It was often not possible for all the ward staff to be advised

of my presence and I had to introduce myself as I met them during their work. I did not encounter anyone who did not consent to my presence.

I experimented with wearing a uniform and offered to do small tasks. When I did not wear uniform, because of my style of dress and age a number of research participants told me they assumed I was either a doctor or one of the hospital managers. I was never challenged when I wore my own clothes and some staff later confessed that until introduced, they had briefly wondered if I was with the CQC. This suggested the degree of nervousness and a lack of confidence ward staff had about the quality of their care. When I wore a uniform, I was 'one of them' yet in many ways I attracted more attention, as a potential 'pair of hands'. As I spent more time on the wards, I began to be asked to do small jobs such as helping to hand out meals, help take patients to other wards, and go to store cupboards to collect items that Preceptees needed. I would also help out by talking to confused and frightened elderly patients, whose specific needs were creating pressures for the ward staff. I thus found wearing a uniform helped me to build up trust with the ward staff that appreciated the help, and it seemed to be a fair exchange. However, it had the disadvantage that I would be asked to do jobs that took me away from the nurse I was observing. Nevertheless it at least helped me to gain a 'bigger picture' about general ward activity and gave me a sense that I was observing an 'authentic' ward situation.

Taking notes became a 'fine art' and writing them in front of staff depended upon the situation. The nurses appeared comfortable with me writing on their

study days as writing was not alien to a classroom context. However, on the wards I was sensitive to their recent CQC visits and did not want them to be under the impression I was there to criticise their practice. Hence, I rarely wrote field notes in front of them and would briefly leave the area to write down my observations. The value of taking extensive field notes has been debated in the literature and it has been suggested that we should accept that field notes of the event are at best able to stimulate memories rather than containing truths (Van Maanen, 2011).

Whilst I initially maintained a discreet distance from the activity in progress, the Preceptees often chose to come and explain to me what they were doing and invited me to observe more closely. As the patients were aware who I was and had given verbal consent to my presence, I was able to observe some clinical activities such as bladder scans, dressing changes and injections. The Preceptees frequently approached me to confide in me about their experience on shift. This gave me an insight into the daily struggle that they encountered and the relationships that they were forming and negotiating with other members of staff. I therefore undertook a series of short 'ethnographic interviews' which were possible due to the relationships I had formed which indicated that people had become more willing to talk to me *in situ*. Such moments were important because I used these opportunities to clarify situations and probe issues in depth to understand how Preceptees decided what to do next and how to do it. I recognise that these interviews were a site for co-construction; however my reflexive approach allowed me to study how meaning was made during this process (Holstein and Gubrium, 1995).

It was challenging to be present during Preceptorship activities. The Preceptees rarely worked closely with their Preceptors after the first two weeks and it was not possible for me to win their trust and negotiate the observations until their first Preceptorship study day – by which time most had been in their new jobs for a few weeks. Arranging to go onto the wards at a time convenient to both of us was problematic, the Preceptees often changed shifts at the last minute and as I lived a long distance from the site, I could not easily be there *ad hoc*. Therefore, many of my observations took place when they were not working with their Preceptors. Nevertheless, the data suggested that this was often the case for many Preceptees anyway and it gave me an insight into a common situation. Apart from one nurse, who met with her Preceptor for one day a month, Preceptorship meetings held 'off-duty' were rare and more meetings commonly took place at opportune moments on a shift. At the end of the Preceptorship programme, meetings were hastily arranged for the signing-off of the Preceptorship portfolio and I experienced only partial success in attending those meetings.

I also undertook observations across two cohorts of Preceptees during 10 classroom days, each of which lasted 7 hours including lunch. Seven study days were spent observing Cohort 1, and four with Cohort 2. This difference occurred because the remainder of the second cohorts' study days took place outside the period of data collection. Whilst it would have been useful to compare two cohorts throughout their programmes, the data I collected from Cohort 2's study days confirmed the data I had collected from Cohort 1. On the

study days I would sit with the Preceptees and participate in all of their activities such as exercises and group work. They quickly accepted my presence and would talk to me throughout the day. I would also go to coffee and lunch with them on occasions.

*Group Interviews*

Group Interviews were conducted with the Preceptees at the beginning, middle and end of each cohort's programme - a total of 33 were accomplished. The CE nurse who delivered Preceptorship scheduled time for the group interviews group interviews into study sessions. All but one of the Preceptees chose to take part. The group interviews had approximately 5 participants and the Preceptees were allowed to self-select their groups so that they felt comfortable. First, I chose themes which were driven by my research questions, particularly around how socialisation was enabled (or not) by Preceptorship, their hopes and expectations, other barriers to (or facilitators of) learning, and access to resources (see Appendices 1 and 2 for topic guides). As the research used an inductive approach, I also allowed participants to steer the conversation, so that they could talk about what was important to them. The group interviews therefore became a mode of 'having their say' during what would be difficult times and I recognise them therefore as a site of not only sense-making and knowledge transfer but also for expressing emotion and identity in relation to the context of their 'professional becoming'.

There are limitations and strengths of using group interviews to explore changing identity of the Preceptees. As noted in the literature review, identity is theorised from a wide variety of perspectives and is often seen as an individual construct originating in psycho-analytic theory (Marcia, 2007). Traditionally, authors have viewed identity as a construct that cannot be observed and needs to be measured (Erikson, 1968). In this view, semi-structured group interviews are a weak method unable to reach the 'inner self'. Interviews could also be seen as a weak method because there is no way of knowing if participants are presenting their authentic selves. Indeed, presenting a unified, coherent self is seen as one of the requirements of 21st century working as accountable professionals (Nicolini and Roe, 2014). However, the question of defining identity becomes very important when deciding appropriate methods to understand it. As also noted in the literature review, identity is now considered to be an ongoing process, and something that is practically accomplished (Jenkins, 1996). Interviews can be seen as valuable as long as they are taken at more than face value and recognised instead as situated sites of sense-making and retrospective sites of self-positioning (Silverman, 1993; Kraus, 2007). This process has been theorised as 'identity work', an active, socially complex interaction between participants and interviewer (Alvesson, 2003). I was thus able to learn how the Preceptees actively made sense of their situation and their developing professional identity within the organisational setting. In recognition of the social learning theory approaches described in Chapter 2, the group interviews were also particularly useful to recognise how identity was constructed relationally (Lave and Wenger, 1991).

*Interviews*

I conducted semi-structured interviews with managers (3) including the deputy chief nurse, Preceptors (7), clinical educators (4), ward leaders (2) and a Preceptee who was unable to take part in the final group interviews (see Appendices 1 and 2 for topic guides). I did not individually interview the rest of the Preceptees as they made it clear during informal conversations that this would be stressful because of their 12 hour shifts, lack of breaks and the long distance many of them had to travel to work. As the Preceptees freely offered to participate in group interviews I therefore took the decision not to pursue individual interviews.

I started by asking to interview all of the Preceptors and ward leaders and clinical educators on the wards where Preceptees were working. It proved difficult to contact Preceptors, let alone arrange to meet them as noted. I had more success when those Preceptees whom I observed acted as 'gatekeepers' and explained my study to the Preceptors. The Preceptees had to tread cautiously as they were worried about increasing the Preceptors' workload. Many Preceptors who agreed to interviews initially were too busy to see me once I arrived to interview them. Explanations they gave me centred on the severe time and staffing constraints on nurses at the Trust.

I invited other key actors involved with the programme to be interviewed as their significance became apparent during my fieldwork. I had few responses from senior managers which could reflect the difficult times that the Trust was facing. For example, I had no reply from the Chief Executive of the Trust and I

invited the Chief Nurse to participate but it transpired that she was on long term sick leave (from which she never returned). Fortunately, I was able to interview the Deputy Chief Nurse who was 'acting up'. I also interviewed all of the senior members of the CE Team, and the nurse responsible for delivering Preceptorship. I also interviewed the Head of Safety and Quality and the specialist nurse who ran the sessions on managing acute incidents. I was able to interview four ward leaders although this proved very difficult to organise.

Participant interviews were thirty to sixty minutes long. I asked interviewees about their background, working life, understanding of Preceptorship, involvement with the programme and opinions of the challenges with and for newly-qualified nurses (see Appendix 1 for topic guide). I started out with questions which arose from my research questions and the concepts that I was sensitised to in my literature review, such as identity and learning. I tailored the interviews according to the respondents' roles. I also introduced questions based upon what I had observed during fieldwork, such as asking the Trust's Quality and Safety Manager about newly-qualified nurses and safe practice. Thus the questions were tailored according to the data and often became more like ethnographic conversations. Indeed, ethnographic conversations *in situ* were as much a source of data as formal interviews. A research philosophy of practice also limits the possibility for the exclusive use of interviews as a way to understand organisational life due to the distance from every-day practice and the tendency for practitioners to idealise what they do. Nonetheless, as I was both "zooming in" and "zooming out" of practice, there remained an opportunity to use different conceptual tools (Nicolini, 2009:1392) to answer

the research questions. The interviews were also used to inform the observations and *vice-versa* to understand more about the construction of identity and practice.

*Documentary analysis*

Documents can be seen as a central part of modern daily life and are therefore an important dimension of ethnographic research (Hammersley and Atkinson, 1995). Documents that were chosen included media reports, Department of Health (DH) publications, professional publications, NHS Trust literature and more informal documents such as the diaries of the newly qualified nurses. I did not use any policy documents that were more than eight years old and all of them had direct relevance to Preceptorship. The media reports detailed specifics of the CQC inspections at the Trust and national media reports about 'the state of nursing' and debates over education were also included. Professional publications included the NMC's *The Code for Nurses and Midwives* (NMC, 2008) and DH publications included government white papers and other policy documents specific to nursing. I viewed documentary analyses as a way of making connections between practices and the wider policy context and understanding how Preceptorship policy is translated.

## Data analysis

The analysis is reflected in the writing up of the data; however my reflections began during data collection. I did not follow a grounded theory approach,

rather, I synthesised my original theoretical approach with themes emerging from the data to achieve a 'funnel effect' as it became more focused (Hammersley and Atkinson, 1995). Although I began by using NVivo software to look for themes, I found this removed nuances and context from my analysis. I thus did not code data in the traditional sense, but rather I drew my themes from rich description of the practices from my field notes and 'sayings' recorded from group interviews and interviews. Much of the field work involved studying the micro-level practices of Preceptees and other actors' interactions, for example what they did and said, the rules they followed and recreated, the materials they used. Examples of such practices include how they navigated the environment, learned to use resources and learning with Preceptors.

## Authenticity

This study does not claim validity. Rather as Lincoln and Guba (1985) state, I accept that a study is strong if it can be described as authentic. Validity is hence reframed, and qualitative research is now discussed in terms of "credibility", "transferability", "dependability" and "confirmability" (Lincoln and Guba, 1985:219). If phenomena can be accurately identified and credible to those who construct realities, if the research is transferrable to another setting, changing conditions are taken into account, and if the data is evaluated taking into consideration the theories, a study is more rigorous (Seale *et al.,* 2004). This study is credible and the data transferable because the research was conducted in a typical NHS trust. Although Oldshire Trust was encountering

regulatory problems, this could be interpreted as a common issue relating to the pressures hospitals were facing at the time. The study is dependable as it was a reflexive and I questioned my assumptions and interrogated the data as needed. I discussed my anonymised findings with other researchers involved in healthcare research and nurses to make sure the way I had interpreted my findings was credible.

## Reflexivity

I accept that due to my former career as a nurse I naturally had sympathy with the Preceptees. This is not an atypical position and the researcher will usually have sympathy with those with less power (Bryman, 2008). Therefore the researcher needs to acknowledge the impossibility of a completely balanced approach and take action instead to try and avoid bias and ensure scientific rigour (Hammersley, 2001). It was vital for me to have a partial membership role within the organisation. However, my study was not action-research. I therefore reflected upon my involvement with the Preceptees and the development team and was aware of the dangers of "going native" (Adler *et al.*, 1986:18). Although I became friendly with many of the staff I was observing, my priority remained to collect data.

I have therefore used a 'minimal' version of a critical approach to stimulate reflexivity (Alvesson and Skoldberg 2009:160). This is important when studying concepts such as Preceptorship as it highlights the importance of mentorship and leadership to newly-qualified nurses. The concept of

Preceptorship appeared to be becoming institutionalised and it is important to question the social processes which are accepted without question and used by management (Alvesson and Wilmott, 2002). My position as an ex-nurse also helped me to engage with the complexity of the context because I already had a degree of familiarity with normal hospital activity and understood many of the medical conditions, abbreviations and nursing processes I saw. It had been seven years since I had practiced as a nurse and 17 years since I had worked in a hospital; this gave me an advantageous "inside-outsider" perspective (e.g. Thomas *et al*. 2000). I did not need to process too much new information to make sense of what I was seeing, whilst I also experienced a contextually unfamiliar setting. Although I had been allocated a desk by the professional research and development nurse, I was treated with caution by the team and I felt very much an outsider, which to some extent gave me an advantage in observing them in a more objective way.

Included in my reflexive approach is an acknowledgement of my feelings and emotions about what I observed or heard. This recognises that fieldwork itself is identity work which becomes personal and can be very emotional (Coffey, 1999). There was a need for me to frequently 'impression manage' in order to keep the fieldwork running. Reflexive interpretation thus became a focus of my research strategy.

It is important that as a former nurse, ethnographer and 'research instrument' (Hammersley and Atkinson, 1997) I am able to reflect upon the impact of my presence and how my role changed whilst undertaking the observations of

practices. I found that each area in which I worked had different implications for undertaking the observations. For example, there were different practices of accessing certain units. Theatres and Special Care Baby Unit (SCBU) were high security, Coronary Care Unit (CCU) were also very diligent and challenged visitors. Conversely, many of the big wards had no security at all and it was easy to wander on and off them. As a result of closer working conditions, on small units, such as SCBU and CCU I was less able to blend in until staff accepted my presence. Even in theatre, where I was required to wear scrubs, people would ask me who I was if they were passing through, or I had not had the chance to introduce myself. This was partly to do with curiosity, but also because of high security measures. Observing on large wards was very different. On these, I would often sit in a bay and talk to patients. This worked well when the nurse was in the bay. However, Preceptees would move around so fast that I was not always able to track what they were doing or saying, or see all of their interactions. At other times I would wander up and down the ward corridors, read notice boards and look at leaflets. I was surprised I was seldom challenged. This could have been because I wore a staff badge and most of the busy practitioners (many of whom have more pressing immediate concerns) seemed disinterested in questioning who I was.

As with all ethnographic studies, there comes a point when the data is saturated and the researcher is less able to reflect on what is going on. As the Preceptees were socialising, so was I. During the last few observations they approached me less for conversations. As Becker (1998:210) points out, the ethnographer is at "the mercy of the moment" and relies on waiting for things to happen that

are theoretically interesting. When my data was saturated, and I became unable to reflect as well as before, I withdrew from observations. In a final point, I recognise that interviews are an active, social process, and are not neutral interactions (Holstein and Gubrium, 1985). I therefore reflected on how I might have influenced the data and the impact of my previous nursing career as part of the reflexive approach to this study.

## Ethics

The study was subject to the scrutiny of the NHS Research Ethics Committee and received a favourable opinion and approval based on the conditions of the protocol. I was mindful of the political nature of ethnographic research and the ethical dilemmas which I might need to negotiate throughout the fieldwork (de Laine, 2000). Such negotiations are a central part of immersion in a field as there are different relationships to maintain and different interests, hidden agendas and power relations to navigate (de Laine, 2000). Ethnography and observation methods carry their own ethical dilemmas and I realised the potential to inadvertently harm participants. My empathetic stance may have encouraged participants to say more than they had intended, and so I made them all made aware that anything they said to me could potentially be used as data, unless they requested otherwise. One of the key concerns of ethnographic research is confidentiality, particularly at the end of the study (Murphy and Dingwall 2001, in Atkinson *et al.*, 2001). I was mindful of some participants being able to identify themselves as there was only one person in their role. This was a particular concern as I was to some degree taking a critical

approach. This became a real issue before the end of a study when I collaborated on an academic poster and needed to discuss my early findings with the CE Team member responsible for delivering Preceptorship. Although she was initially perturbed by some of my findings and the disturbance in her existing 'world view' of the programme she had designed, she was keen to understand my construction about 'what was going on' and potentially act upon my findings.

The newly-qualified nurses may have felt obliged to take part in the study as my sessions with them, (e.g. the group interviews) were built into their Preceptorship study days. I emailed them an invitation letter (see Appendix 3) and participant information sheet (see Appendix 5) before they started the programme, which allowed an 'opt out' choice. Only one participant chose to opt out of the study. All participants gave written consent (see Appendix 4) to their participation. There is always the problem of "asymmetrical" relationships when participants have consented to a study (Murphy and Dingwall 2001, in Atkinson *et al*., 2001). On the day of the group interviews, I made sure that the CE nurse was not in the room and I also reiterated that they could withdraw from the study at any time. All of the nurses gave me permission to be at their study days. The feedback that I received was that they found the study interesting and that they wanted to help to make a difference to the experience of new nurses.

## Conclusion

This chapter has discussed the methodological approach I took to answer my research question which seeks to identify the practices of professional 'becoming' in the context of an organisation's attempt to introduce Preceptorship. I have shown how ethnography, although a challenging method was chosen as the most appropriate approach to studying the practices of the Preceptorship programme. I described the research setting, explaining the particular challenges that Oldshire faced and hence why this Trust made such an interesting case. I explained the sampling strategy and showed how I collected the data in every-day situations as well as outlining some of the challenges I faced in this troubled Trust. I explained the different ways I collected data and how this data was analysed to thematically group different practices of professional becoming. I have clarified my reflexive stance which was influenced by my previous occupation as a nurse and finally, discussed the important ethical considerations of the study and the processes I followed to make sure this study did not cause harm to staff or patients. The following chapter sets the context of this research and richly describes the setting, the history of the Preceptorship programme and introduces the key participants in this research.

# Chapter 5: The context of Preceptorship at Oldshire Trust

## Introduction

This chapter provides context to show how the Preceptorship programme was adopted, translated and organised across the three hospital sites in Oldshire. Although this account includes some data, the chapter is largely descriptive. This is important so the reader is able to understand organisational concerns and broader pressures during Preceptorship. To begin this account, I introduce Oldshire Trust and demonstrate how early immersion in the Preceptorship programme raised important issues for the context of 'professional becoming'. Next, I introduce the three organisational sites, Burydale, Riverton and Runnysea, paying attention to their geographical location, their facilities and general characteristics. I do this to demonstrate how the physical setting gives clues to different ways of organising, to draw attention to visual clues and to explore how people speak about each site. This is important because as I later show the practices of different settings can shape becoming. This rich description also enables the reader to understand some of the situations which both I and the newly-qualified nurses experienced as newcomers to the field. Following this description, I introduce the CE Team responsible for delivering Preceptorship. I explore the importance of its role in conveying the Trust's organisational priorities and expected practices. I present contextual findings which help understand the practices and logics of the CE Team, how it translated and adopted national Preceptorship guidelines, and the organisational imperatives that I found to structure the programme.

First, I introduce the Trust using an illustrative vignette that describes an urgent meeting I was invited to attend at Trust Headquarters. I include vignettes to take advantage of the richness of the data which helps to tell this 'story'. The vignettes are adapted from my field notes and are distinguishable from the main text through use of a different font. The vignettes are used to elaborate discussion and where possible I have supported them with other examples. Although I have not been able to provide in-depth data from other examples in all cases, where they are included they are rich examples of the phenomena.

Vignette 1 is interesting because it conveys the 'culture' shock that I experienced as a researcher and newcomer to the field and also demonstrates how I took an early reflexive approach to the study. The vignette also introduces a serious organisational issue that would have an immediate impact on the 'professional becoming' of some Preceptees.

**Vignette 1: The office door**

*The last time I had visited Burydale was over five months ago and as I returned to the site with my supervisor for a meeting, we became lost because the office door had been renamed, in fact, so had the team. It had changed from being a 'Professional Development' team to the 'Clinical Education' team. This was a surprise to me as during our last communications there had been no mention of such a change. As we began our meeting, Mia, who was responsible for delivering Preceptorship, informed us that there had been a*

*change of plan. As she and her line manager explained, the Preceptorship cohort I had been scheduled to study had been cancelled. As they understood it, the financial situation at the Trust was going from bad to worse, and as recruitment had been frozen there were not enough newly-qualified nurses to run the scheduled cohort in a cost efficient way. This surprised me because numbers on previous cohorts had not been an issue as far as I understood. I was told that as an alternative, I could study a later cohort of Preceptees but this course would be run from Runnysea, the most remote hospital in the county. I was immediately concerned as Runnysea was a two and a half hour drive from my home which could limit potential visits and data collection opportunities. I was also apprehensive as Runnysea had recently been in the news following a poor CQC inspection. I had read the news reports detailing the findings and how an unnamed Trust spokesperson had responded by apologising on behalf of Oldshire, stating that it was working to deal with all of the issues in co-operation with the CQC. The newspaper reports also indicated that, given the recent findings from the CQC, the decision had been made to move student nurses from the hospital.*

*Although I had not anticipated that my research site would change, in view of the recent media reports, the situation was not a total surprise. The real surprise I experienced however was the casual way in which I was told; there was no apology, it seemed matter of fact. I concluded that giving bad news was probably becoming common in this Trust during this current crisis.*

*Nevertheless to complete my fieldwork on time I agreed that I would study the Runnysea cohort.*

The above vignette is important to include because it reveals the background situation of the group of Preceptees I studied. This was important to understand when analysing Preceptee interactions with Preceptorship because it shaped their views and expectations of the programme and also their early experiences on the ward. As the Trust could not run a cohort when originally intended, the vignette highlights that those nurses who would have been eligible for Preceptorship experienced a delay in the allocation of a Preceptor-an experienced nurse working in the same clinical area as the newly qualified nurse-and also the opportunity to attend monthly study days. This shows how unstable conditions at the Trust not only affected the delivery of care but also the opportunities and scope of the Trust to support newly-qualified nurses.

This vignette is also important to include because it reveals how the unstable conditions in the Trust affected my research (which I fully recognise was less important than the capacity for the Trust to deliver safe patient care). As such, Trust's regulatory problems were necessarily at the forefront of my study which highlighted the need for reflexivity and my questioning of assumptions about practice. My lack of total surprise showed me that following the news report, I had already formed negative opinions about Runnysea and had begun to consider how public concerns about care might play a role in the 'professional becoming' of nurses at this site as this might become a potential source of identification. By the time I had begun my fieldwork, although

Runnysea remained my primary data collection site, fieldwork was carried out at three out of the seven hospitals managed by the Trust and this gave me a more balanced view. In the next section I describe in more detail each of the three hospitals to show how they were distinct from one another in terms of their culture, practices and image.

## The hospital settings

The three hospitals in which I carried out fieldwork were situated in towns approximately one hour's drive from each other within the county of Oldshire. Each town was quite different in terms of history, architecture, facilities, amenities and socio-economic factors. These appeared to be reflected in each hospital's appearance, and were immediately noticeable both to me as a new 'research instrument' (Hammersley and Atkinson, 1997), and an active participant of the observations.

*Burydale*

Burydale was a large district general hospital (DGH) and initially appeared to be modern in design, due to its new looking buildings and pleasant entrance. However, I soon discovered that this was at odds with the Trust's headquarters, which were located at the far end and in the oldest part of the hospital. This is interesting because what had once been the front door of a grand Victorian hospital was now the backdoor of the modern hospital. Not only was the façade a striking contrast with the rest of the hospital, the inside of the building also felt dated. This 'back -stage' setting of Trust HQ may have contributed to the sense of separation between the hospital management and the front-line staff.

This sense of separation was expressed as a common view during my fieldwork; e.g. that the Trust management was far removed from the 'real world' front-line staff experienced and was to blame for poor patient care. During a focus group, Felicity, one of the Preceptees who worked in the Accident and Emergency (A&E) department, described this disjuncture when talking about the pressures on Preceptees' (a newly-qualified nurse enrolled on a Preceptorship programme) new practice, particularly when they have to avoid breaching the four hour NHS waiting limit:

> *You've got your managers on your case all the time about breaching and all that. You don't just like have a ward sister, she never comes out of that office. We don't have a matron; we have the manager of the hospital, the head of nursing. And all of a sudden these bodies come in, they are like scrutinising you and you can see them thinking 'oh you're working like that' and 'that's what's taking time so work this way and it will be quicker' and then you've patients won't breach but then you're thinking 'well it's the doctors who need to be doing their job before we can do ours.*

The above statement shows how there was an apparent lack of regular contact between 'shop floor' nurses and senior management, who would occasionally arrive on the wards and appear surprised at what was happening. As far as Felicity was concerned, senior managers remained unaware of all the dynamics of everyday work which had an impact on good patient care. A lack of regular contact with senior management was also common for most of the CE Team

members, apart from Susan, the team leader, who had occasional meetings with Elizabeth, the Deputy Chief Nurse (DCN). Susan was thus seen as management by the CE Team whose interactions would be more polite when she was present.

The main CE Team office was situated in the basement of Burydale hospital, adjacent to the School of Nursing offices. It was very dated in appearance, dark with varnished wood doors and was thus a sharp contrast to the modern 'front stage' appearance of the main clinical areas, suggesting that Clinical Education (CE) was not a department that the hospital needed to 'showcase' to the public or regulators. The tucked-away office of the team therefore gave the impression that CE (or professional development) was not valued as a day-to-day priority for clinical workers as they could not easily access the office or the team's noticeboards.

As noted, Preceptorship at the Trust was delivered by Mia, who was a Band 5 nurse acting up as a Band 6, therefore holding additional responsibility. It was unclear to me why Mia was acting up rather than being hired on a permanent basis. Mia told me in an ethnographic conversation that she did not feel secure in her post, not only due to her lack of firm position but also due to future funding issues relating to the Preceptorship programme. This is noteworthy because Mia was under extra pressure to 'impression manage' in front of her seniors. Interestingly, during the eight months that I spent at the Trust, I did not see her interacting with senior management. I had expected to see some evidence of communication due to the interface of Preceptorship with Trust

policy. For example, on one occasion, I watched Mia sit at her desk writing a report on Preceptorship and asked her if she would communicate her findings directly to Elizabeth, the Deputy Chief Nurse (DCN). Mia explained she no longer tried to contact Elizabeth, and instead would ask Susan to pass on messages to her and ask questions on her behalf. Mia described Elizabeth as being "up there" in the hierarchy, raising her hands into the air to reinforce her statement. She explained how it was almost impossible to speak to Elizabeth, as a nurse several grades below her; "Don't be silly I'm only a Band 5" and, "Oh no, she doesn't talk to me, I'm not important enough". This illustrates how the strategies and practices of the CE Team were mediated by the physical separation and low visibility of the senior management in this hospital, which in turn positioned the CE Team as perceiving itself to be less important than senior management. Mia was therefore reliant on a chain of command to receive and send information, which showed the potential for messages to become lost in translation. This would later have an impact upon the Preceptorship course and is discussed in following chapters.

*Riverton*

Riverton Hospital was the smallest hospital I visited and situated on the edge of a traditional market town. Although Riverton provided general medicine, surgical and other specialities, including a midwife-led maternity unit, apart from a minor injuries unit it lacked A&E facilities. In terms of CE for nurses, there was little classroom activity at the site and nurses on Preceptorship programmes had to travel to Runnysea or Burydale to attend the taught element

of the programme. When I first drove into the hospital, I could immediately see its distinct appearance compared to the other two sites. The hospital buildings at Riverton were mostly single story, thus giving it a more 'cottage' feel. On entering the hospital, the corridors were smaller and quieter and the wards noticeably less modern than the ones at Burydale. Although it is accepted that all hospitals are quiet at night, when I visited Riverton one evening to shadow a Preceptee, the corridors of the hospital were almost deserted. There was also no evidence of security, which illustrates its deficit of facilities. There was a further important issue that plagued Riverton, as 20 years earlier it had suffered a notorious scandal where several patients had died. In the report on the scandal, the hospital had been described as lacking resources and was perceived as only just viable as a hospital. This event and subsequent withdrawal of certain services at Riverton appeared to leave a lasting legacy. Preceptees would refer to the scandal during ethnographic conversations, for example one day a Preceptee joked about how poor Riverton was in terms of its service, and stated, "this is the [refers to staff responsible for deaths ] hospital isn't it?". This is worth mentioning because this Preceptee would have been a small child when the events occurred showing that significant historical events such as this can continue to be a negative identifier for newly-qualified nurses across generations.

As there were a low number of vacancies at Burydale, several newly-qualified nurses who had trained there reluctantly took their first post at Riverton. They would often complain to me about the lack of facilities and equipment. For example, three nurses who worked on a surgical ward pointed to issues such as

the difference in the way that resuscitation equipment was stored at Riverton and that essential items such as suction tubing would often be missing. They would also criticise the poor paperwork systems and the non-standardised forms across the Trust, arguing that Burydale forms were more up-to-date and better for recording patient care. This is an important point which I return to in the following chapter. Yet despite the historical criticisms, there was nothing in CQC reports to suggest that there were any problems at Riverton, although it had not undergone a recent inspection. Nevertheless, Riverton was seen as the poor relation of Burydale, a description which becomes evident in further chapters.

*Runnysea*

Runnysea was a large DGH based in a town that faced social challenges from community tensions and was often featured in negative media reports. The main hospital building was built on an old Victorian estate and consisted of a 1970's imposing high rise structure and mismatched satellite buildings. Most of the wards were located in the tower block or surrounding buildings and catered for nearly all medical and surgical specialities. However, despite its size (it is the second largest in the Trust), Runnysea did not specialise in all clinical and medical areas. For example, Burydale provided the Trust's Special Care Baby Unit (SCBU) (for serious cases) and the regional stroke centre, meaning that there were often transfers between these hospitals. Unlike Riverton, Runnysea always appeared to be well-equipped although I would later discover that there were variations in processes, e.g. it also used different

patient care plans from Burydale. These variations and different ways of 'doing' would be an important factor in 'professional becoming' and is expanded upon in the following chapters.

Similarly to Burydale, the CE Team at Runnysea was based in an office some distance away from the main hospital, located on the ground floor of the original, run-down house that pre-dated the hospital and was situated on the edge of its grounds. Various practitioners and educators were located on the upper floor of this former grand building. Other teams which were based in the building on different floors were perceived by the CE Team to be unfriendly, for example, there were often disagreements between the upper and lower floor staff over parking and the use of the photocopier. These minor disputes appeared to reflect a lack of wider teamwork and indicate professional boundaries but also the disputes over decreasing facilities at the DGH (as money was concentrated around care pathways rather than staff benefits).

Mia spent most of her time at Runnysea with approximately one day a week working at Burydale, depending on the Preceptorship cohort. This meant that she had two permanent desks, although the one at Runnysea had more of her personal effects suggesting that she considered this to be her main base. I also noticed how Mia behaved differently at Runnysea compared to when I saw her working at Burydale. For example, at Runnysea, she would more often engage in conversations about non-related work issues with the other members of the team. This suggests that working in an isolated, run down building with poor

facilities led to decreased social contact with wider members of the Trust, and hence a different set of social norms had developed.

There had recently been a police investigation into care on one Runnysea ward, resulting in its temporary closure. This ward, situated on the top floor of the high rise building, was closed and had become a 'no-go' area for staff. In a recent report, the CQC had described how patients on this ward were left in a degrading state and indicated that the hospital must raise standards or face prosecution. The CQC report also identified moderate concerns over record-keeping, patient privacy, dignity and independence, safe-guarding, safe premises, staffing and supporting workers. Despite this damning inspection, the CQC had found that the administration of medicines was safe, and there had been an improvement since the 2010 inspection, where 'minor' concerns were identified. Nevertheless, in a second follow up inspection in 2011, medicines management was criticised for having no proper measures in place for obtaining, recording, handling, using and safely administrating medicines. The concern over medicines management would have a particular impact on the Preceptorship programme, which I describe in the following chapters.

Although the CQC has been much criticised for a lack of consistency, seen in the Royal College of Nursing (RCN) (2012) report *Putting the quality back into the Care Quality Commission*, there was much indignation and sensitivity expressed by some staff about its findings in this Trust. I would discover through anecdotal conversations with members of staff that they were extremely sensitive about the poor report and therefore were initially cautious

about my presence on the wards. Staff on the ward would often joke and say for example, "You're not really the CQC, are you?!" Although some nurses were defensive about the hospital ("it's not a horrible hospital, it's just the way it's run"), others appeared to recognise that there was more than a grain of truth in the reports but blamed management for problems. This would become further evident during group interviews and interviews not only with Preceptees but also more established members of staff. The CQC report was undoubtedly taken extremely seriously, as illustrated when the Trust issued an apology on its website.

## The CE Team

As previously noted, the Preceptorship programme was managed by the newly-named CE Team. Based at the main Trust site, the CE Team reported to the DCN (Elizabeth) and was managed by Susan, the Professional Development Lead. In addition to Mia, the other team members were two deputy managers (one for each large hospital site) and three other nurses who had responsibility for the development of trained nurses, assistant practitioners, healthcare assistants and nursing cadets. All members of the CE Team other than Mary, an administrator supporting the team were Registered General Nurses (RGN).

Mia explained that the CE team had undergone the name change from 'Professional Development team' to be more associated with clinical practice. Hence, she and her fellow Band 5 nurses had all been renamed "Practice Educators" within the CE Team. This was a decision that had been taken

during a recent meeting in light of the current events, to better signify that the team actually went out into practice. Mia reflected on the name change:

> *Well I have two thoughts about it really because I think that as far as nurses are concerned, and we are an all graduate entry in the profession, and yet we're going to have professional 'blah' whatever it is taken away from our description and be called practice 'something or the other, so it's a contradiction really. But I don't mind being practice. I don't mind, that's fine. I actually would rather see myself as a practice educator to be seen as somebody who puts their frock on and goes and works in practice. That's absolutely fine.*

Yet the team's intranet site remained 'Professional Development', its manager Susan was a 'Professional Development Lead' and members frequently referred back to their old name in conversations. The issue of whether the team was more professional or practice focused was therefore un-reconciled. Susan also agreed that there was some conflict in this area, and suggested that they had wrongly evolved in a direction that moved away from the department's origins in clinical training. On the other hand, she suggested that the organisation did not fully understand the role of professional development in honing the non-practical skills of newly-qualified nurses and in reinforcing the values of the collective profession:

> *"We have evolved from 'clinical training' to 'professional development' and the organisation doesn't really understand our role. And I think that is because at this moment we are finding our role. We have actually got, in terms of a strategy and structure, we have that but the key issues are what the staff are actually wanting on the wards… you are not just wanting people to go into a ward area and be sound very quickly without having professional judgement and understanding of accountability to go with it."*

Susan's statement reflects the confusion over the difference between clinical education and professional development and the team's purpose. This has implications for the identity of a team in flux and trying to position itself between the organisation, practice and the profession. Yet not all members of the team were responsible for registered nurses and thus there was a divide in the team's responsibilities. This change to 'practice' in its title therefore appears to be a strategy to convey a particular identity to the organisation's members and is a 'defensive' response to wider turbulent conditions when improving practice across occupations was a pressure in the light of recent scandals.

Since Mia had been promoted, deputy manager Peter no longer had direct responsibility for the Preceptorship programme. Despite not being directly involved, Peter still maintained an active interest in the development of the programme:

*"I have a vested interest in it because it's my department's name that sits on the Preceptorship programme web page essentially, so we've all got a responsibility to make sure that patients get fantastic care and this for me is a really great solution to make sure that happens."*

Although the CE Team may have had responsibility for different work streams and areas of professional and occupational interest, Peter's statement showed Preceptorship thus transcended the formal structure of the team and became a concern of a very small community of practice (Lave and Wenger, 1991; Wenger, 1998).

Susan, the manager was based across the county in the university facility at Runnysea and would occasionally visit the team in Burydale although not weekly. One deputy manager, Jenny, left soon after I arrived and another was on long-term sick and did not return until I was part way through the programme, and so the work of the team continued relatively unsupervised. When I was present, Susan paid visits to the team at Burydale and would tell me how she was extremely stressed with work pressures and that her relationship with the DCN was difficult. In light of these issues it was no surprise to me that 'top-down' team communication seemed to be lacking at times. For example, Mia told me that the junior members of the team had no idea why her predecessor had recently left. Susan had not discussed the circumstances with them, nor explained why she was not able to discuss the issue. The relationship between Susan and the rest of the team did not always

appear to be smooth. Thus the team lacked supportive resources, which was further compounded by Susan's physical location away from the rest of the team. Susan was the team's intermediary to management but her lack of communication often appeared to leave the CE Team ignorant about Trust management activities. Thus, due to the material conditions of the team, its junior members were positioned much lower in terms of status than Susan who worked at the interface with the Trust. In the following section I explain the objectives and purpose of the team and where Preceptorship was located in relation to members' other work.

*The purpose of the CE Team*

Wishing to understand the role of the team better, I asked Jenny, to articulate the team's objectives:

> *"Our departmental objectives are to support the clinical staff through their career pathway. So it [Preceptorship] fits perfectly, our career pathway for clinical front-facing staff within this organisation from bands one to eight, so it fits perfectly in the band five part and we've actually introduced it into Assistant Practitioners as well."*

Despite Jenny's statement the nursing Preceptorship programme was managed separately to that of the APs and indeed, from my observations, I was not aware of any large joint projects between staff groups. However, they often

moved between sites and I was not often present when the whole team were together.

During interviews, I was able to explore other concepts which might identify the team's common ground. For example Jenny and Susan both articulated the notion of 'career pathways', a concept that entered the discourse of nursing practice following the publication of *Modernising Nursing Careers* (2009) and the Willis Commission (2012), which suggested nurses could learn from the career pathways of medicine. Susan told me that she had spent much time organising a new 'career pathway structure' of which Preceptorship was seen as a logical component. The career pathway was a flowchart consisting of five domains of practice- knowledge and skills, management of resources, leadership, supervision, team working and clinical practice. The pathway also included criteria of evidenced based practice, ethical issues, critical thinking and reaching autonomy. The pathway framework was made up of levels of competency through which nurses could progress. The Preceptorship period was situated as the first level of competency which was followed by practitioner, specialist practitioner, advanced practitioner and consultant practitioner, each with their own defined skills under the aforementioned domains of practice. For example, it was expected that following the Preceptorship period the nurse would be able to:

- Make judgements based on knowledge of relevant social and ethical issues.

- Work within professional codes of practice, local policies and procedures and governance structures.
- Critically appraise the evidence base to answer questions and inform practice.
- Comply with legal, ethical and regulatory requirements and recognise ethical dilemmas and manage these with support and guidance.
- Demonstrate an ability to problem solve and evidence arguments and assumptions to reach sound judgements.

The career pathway document is interesting as it adopts the government's promise of autonomy for the newly-qualified nurse following Preceptorship (DH, 2010a). It also highlights the debates about when a nurse is fit to practice as it implicitly accepts that new nurses have not yet refined these competencies (and therefore highlights the tensions of being fully accountable upon qualifying). The competencies are also not specific to nursing as the document was also intended to apply to any qualified practitioner at this Trust. This again demonstrates that the expectations of the newly-qualified nurse remain subject to contradictions about what it means to become a professional because at the same time he or she is also a practitioner. On the one hand the nurse has qualified into a particular profession with promised autonomy, but on the other the nurse has become subject to influences of inter-professional standardisation of work. It will be shown how this plays out in 'pushes and pulls' on practices such as what nurses are and are not allowed to do. Finally the document shows how the language of policy is translated into local Trust documentation, and

that the dominant language such as ‘competency and ‘autonomy’ in such documentation goes unquestioned.

The work on the career pathways appeared to be a contentious topic for Susan who was deeply unhappy about how they had been received by the Trust. This was despite career pathways being established in medicine and appearing as a critical element of *Modernising Nursing Careers* (DH, 2005). An intermediate nurse consultant/organisational development expert had been brought in to work with the Trust in response to the CQC issues. Susan told me that this individual had not acknowledged the effort she had made on the career pathway framework and Susan felt her work had been disregarded, something that had made her very upset and angry. Despite a search, I could not find anything from either the Department of Health (DH) or National Health Service (NHS) websites that was as a detailed and explicit tool as the one Susan had developed, and I could therefore understand her frustration. This experience demonstrates how organisational instability and frequent changes in management can prevent a consistent approach to professional issues in nursing. Despite Susan trying to produce her version of a career, she experienced low autonomy because it conflicted with a management strategy she did not have full knowledge of.

To understand more about the identity of the CE Team, whether orientated towards practice, the profession or otherwise, I first looked at their website where its philosophy was articulated from a learning organisation perspective (Senge, 1990) and the website used words and phrases such as ‘cultural

change', 'innovation', 'professional' and 'multi-professional' working which echoes themes arising from DH, such as *Equity and Excellence* (DH, 2010b). The website described the team as having a coherent approach to development and sharing resources and knowledge both within the organisation and at a national level. Further, the website stated that learning was the individual's responsibility and that team would help employees identify their career objectives provided they aligned completely with the Trust's competency framework. In terms of nursing (who made up the majority of employees receiving clinical education) this demonstrates that the responsibility for learning lies clearly with the nurse, who is both a healthcare practitioner and a 'professional'. This reflects that nursing, although defined by its everyday practice, has historically been in the process of professionalising since the introduction of degrees and diplomas, which according to Allen (2001:10) was "an explicit strategy" of professionalisation.

The interplay of forms of media with local policy and practices would be of continuing interest as I observed the programme. In the following section, using data from ethnographic conversations, interviews and observations, I describe how the Trust's then current crisis shaped the introduction, translation and adoption of the Preceptorship programme.

## The CE Team and the CQC inspection

The latest CQC report was discussed in my presence. The CE Team blamed individuals such as certain ward leaders as an important factor in poor care, or

factors such as a lack of funding as causing staffing shortages. This attitude was apparent when I was invited to visit the wards with Susan and Jenny to do an audit of care plans following the latest inspection. Susan and Jenny donned their dark blue nursing uniforms for the first time in months as they told me that this added practitioner legitimacy to their effort to try and raise standards. As we walked around the hospital, they described certain wards in negative terms. For example, due to perceived poor leadership there were wards that were considered poor environments for Preceptees. The reasoning behind this negativity regarding practice on one particular ward was directly related to the ward leader who Susan and Jenny felt was an unpleasant character who would not be a good mentor for Preceptees who they saw as vulnerable. During this tour, I was dismayed to learn that newly-qualified nurses were referred to by the CE Team and some ward sisters as *"baby nurses"*. Indeed, one ward-based clinical educator described the newly-qualified nurses as *"a pain in the neck"*, *"cocky"* and a *"law unto themselves"*. As a former nurse, I found these descriptive labels offensive. However, as a researcher, it gave me a clue to the low socio-cultural positioning of Preceptees which drove me to further investigate this issue during my fieldwork.

During this visit I also learned more about the poor CQC inspection at Runnysea that had resulted in the temporary withdrawal of the entire student cohort due to serious concerns about the suitability of the hospital as a learning environment. The Patients Association called this a "damning condemnation of care". This was later described to me as a very dramatic experience by the affected Preceptees, as some had been asked to immediately leave the building

during a shift. None of them received an explanation and they could only speculate about what had happened. One nurse told to me that she was worried that she had personally done something wrong. For around fourteen nurses, the impact on their education was significant and led to a delay in them starting work as they had to gain more clinical experience. The examples of the team's name change, the low value placed by the Trust on their work, the added burden of poor care and turbulent shifting of organisational imperatives showed that the CE Team were having a crisis of identity. The following sections explore the adoption of Preceptorship, two further drives of the programme, retention and perceived risks of not implementing it and the problem of minimal guidelines.

## The adoption of Preceptorship at Oldshire

Mia told me that the Trust was an 'early adopter' of Preceptorship as it was introduced before the Preceptorship Framework (DH, 2010a). I learned through conversations with the CE Team that funding had been secured from the Strategic Health Authority in October 2009 after the need for Preceptorship had been recognised by the Trust's workforce development team. Hence, I sought to understand why Oldshire had become an early adopter of the programme and found two main reasons. First, in line with issues I described in Chapter 2, there was a concern about the retention of newly qualified nurses. Second, there were perceived risks of not introducing and maintaining Preceptorship as a threat to safety and quality of care, again reflecting the national movement towards a quality and safety agenda and later 'knock-on'

effects of the CQC inspections. These issues are important to understand as they reflect the deep concerns of key actors in the programme and hence the contextual conditions of the 'professional becoming' of nurses within this Trust. There were further operational difficulties as seen by a lack of evidence and guidelines which is explored in this chapter. The next section focuses on the possible impact of Preceptorship on the retention of newly-qualified nurses in the Trust.

*Retention of nurses*

During early strategic planning of the programme, the CE Team and Trust management had hoped that the Preceptorship programme would improve the retention of newly qualified nurses and improve absence levels. This was primarily because Preceptorship would mitigate the effects of the shock of new practice. Mia explained her evaluation of the impact of running a Preceptorship programme for the last year or so on retention:

> *"Preceptorship has made a difference, but where it's a supportive nurturing environment and you go on there and you think "oh this is a nice ward, I wouldn't mind working on there myself", they stay. On wards where you walk in and you think "oh my god it's like downtown Beirut here" they don't stay".*

Despite this statement, Mia and the CE Team were doubtful about achieving certainty for the future of the programme within the Trust due to funding and

related issues. For example, there was difficulty in evaluating and measuring the outcomes of the Preceptorship programme, and the CE Team did not have access to the most recent staff retention and absence statistics on newly qualified nurses in the Trust, as the statistician himself was on long-term absence. The lack of importance placed on the statistician's role by the Trust, demonstrated by the lack of absence cover, is an example of how some knowledge transmission within the Trust was contingent on its management structures to adequately support certain roles. The last time Mia had access to data was months earlier when she was informed that the Trust absence average for nurses was 5.5% annually and explained that she was informed that sickness absence of newly qualified nurses had decreased since the introduction of Preceptorship to the same as the national average which she felt had been very encouraging for her. Nevertheless, there was no hard data available at the time of this study.

Upon searching government national data, I was able to ascertain that this Trust had general absence rates of around 5.5% in October-December 2012. This was above the national average of 5% for the same period (Health and Social Care Information Centre, 2013). This type of data was not, however, useful to the CE Team as it did not distinguish between new nurses and those beyond the first year in practice. The programme was also too recent to infer long term effects on retention of staff. More interestingly, the situation of the absent statistician demonstrates the difficulty in trying to measure the outcomes in a Trust where the sickness of one member of staff leaves a neglected role that can affect departments such as the CE Team. This shows that despite the

implementation of a policy that would help solve the problem of retention in the Trust, the local practices of the organisation of data meant that the CE team were unable to assess the impact of Preceptorship on this issue.

*Safety and quality: perceived risks of not introducing Preceptorship*

Susan (Professional Development Lead) told me that she was under pressure from local and national priorities to improve the quality and safety of newly-qualified nurses as a main outcome of the Preceptorship programme. Although she hoped that Preceptorship would enhance professional autonomy, the programme had been initially aligned with the Trust's strategic needs. The Trust was therefore an early adopter of Preceptorship because of these local priorities. Indeed, the programme evolved at the same time as the introduction of performance dashboards and metrics designed to measure and improve quality of care. Susan stated that these priorities were designed to reduce errors, improve medicines management and recognise the deteriorating patient. According to Mia, the need for improved care planning and record keeping had also been identified following the 2011 CQC inspection. Later in 2011, a new Preceptorship review document was co-produced by Mia's predecessor and a university lecturer, as the CE Team wanted to lessen the impact of the paperwork for the nurses, by mutually developing it with the School of Nursing so that it would be familiar (from education) and therefore more accessible to the nurses. During this process, the programme was explicitly aligned to organisational goals as shown in the following statement[1]:

[1] Statement not referenced to maintain anonymity

> *"The Trust recognises the importance of training and development in helping staff to meet the needs of the patients, carers and members of the public, and is committed to supporting all staff in the development of the knowledge, skills and abilities to deliver high quality health services (2011). The aim of Preceptorship within (the Trust) is to enhance competence and confidence as autonomous professionals. The training and development strategy (2011) shows that [the Trust] puts education; training and evidence-based practice at the heart of patient care, and is striving to be a nationally recognised model employer".*

The pressure that Susan sensed she was under to conform to this was apparent. When Mia had produced a Preceptorship review, Susan asked her to change her draft document as it was not 'organisational' enough. According to Mia, this was because the managers did not want to consider professional issues, but instead needed the document to be completely aligned with the Trust's organisational outcomes. In view of her tenuous and low position, it was therefore difficult for Mia to do anything but follow instructions on this matter.

Although Elizabeth (the DCN) stated she did not have particular concerns about the safety and quality issues of newly-qualified nurses, these very issues appeared to drive the Preceptorship programme. Recognising the 'deteriorating patient' had been expressed as a concern by the Research and Development Nurse who had invited me to study the programme. I was also told by Jenny that the Trust invested in the programme for safety reasons:

> *"I think that the organisation has invested in it from a patient safety point of view. We can't find out from the organisation: has the level of critical incidents decreased? Clinical incidents that have been done by a newly qualified… happened to a newly qualified nurse because you can't put it on the system whether you're newly qualified or not. So we don't know if clinical incidents have decreased. I would have hoped they would have done because awareness is out there more".*

Jenny's statement shows how some members of the team had a clear impression that newly qualified nurses were a risk to patient safety. I asked Elizabeth about this matter and she related concerns about nurses not recognising the deteriorating patient in the National Patient Safety Agency Annual Reports (Luttel *et al.*, 2007), a response to growing concerns over patient safety. According to the report the main causes of poor safety included: "not taking observations, not recognising early signs of deterioration, not communicating observations causing concern and not responding to these appropriately" (NPSA, 2007:5).

Elizabeth explained that this phenomenon had been a problem at the Trust for over twenty years. Despite 'recognising the deteriorating patient' being included in the Preceptorship programme, I could find no research evidence to suggest that newly-qualified nurses were a particular group of concern in this regard. During a subsequent interview, Elizabeth agreed that the issue of

recognising the deteriorating patient was not a particular problem associated with newly-qualified nurses at the Trust. Nevertheless, Elizabeth considered this topic was still a necessary part of the programme as it was not embedded enough into pre-registration education generally. Elizabeth also stated that this shortfall in skill was *"ultimately a product of a health care system"*, thus exposing another contradiction in the question of fitness for practice. Recognising the deteriorating patient may be something that can only come with practical experience. However, as Elizabeth and others suggested, it was also the 'system'- with all its turbulence and temporal pressures- that prevented staff from making the correct observations or gaining the right skills and knowledge through experience. Thus it appears that the Trust's issues of quality and safety were translated through the stories between practitioners and an interpretation of wider policy. I would discover that the issue of patient safety would have a major impact on the 'professional becoming' of Preceptees and I repeatedly return to this theme throughout the following chapters. Now that I have discussed the drivers for the introduction of Preceptorship, in the following sections of this chapter I discuss the main challenges that Mia and her team faced when implementing the new programme, the first of which was the lack of guidelines and research supporting it.

*Minimal guidelines on implementation*

The Preceptorship Framework (DH, 2010a) is very broad and does not give any specific advice on exactly how to implement the programme, it allows Trusts to decide this themselves. The CE Team acknowledged the lack of

evidence about the best way to deliver Preceptorship and explained they had little Trust guidance on how to organise and implement the programme. It had heard that a midwifery Preceptorship programme had been implemented at the Trust however there was little communication between the two departments on this matter. As Susan explained during an interview:

> *"Midwifery had been given this money and I had no idea about this the year before, but nothing had moved with it, and my remit was, "here is the money, here is the funding, go and do it". But there was no model to follow, there was no structured model nationally to follow, we had to make a local model based around things like the local drivers and the national drivers at the time. The beauty of the programme is it is so dynamic that every time the driver changes locally and nationally, we can make that programme fit, it is totally bespoke".*

Midwifery was not included in the scope of the CE Team's work and although they had recently developed a similar programme, there was an absence of collaboration between the two professions. This shows that to some extent professions at the Trust worked in different practice domains, and this might indicate the low influence that the overarching workforce development team still had upon wider professional development. Taking a systematic approach to workforce development is a recent innovation in the NHS, and Preceptorship is still absent from the Trusts' most recent workforce development policy. Yet, the experimental nature of the programme did not appear to concern Susan;

rather, she saw it as an opportunity for the team to have a say in the programme's content and to tailor it to local requirements.

The experimental nature of the programme did worry Mia however, who had invested much time to deliver a programme that she was suddenly solely responsible for. As I previously noted, Mia was also aware of the insecurity of her job acting up in the organisation. This was apparent when she justified her role:

> *"Well, the Trust wouldn't pay a Band 5 if they didn't think it was worth investing in and going to do some good and make a difference. Well no they wouldn't, especially not in this climate; they'd just look at it and say we're not doing that anymore. But they haven't, they have said yes. But we've got funded for another year, so they must think it's worthwhile but nobody ever says, from the high up people that I occasionally get to mingle with if I'm lucky [laughs]…"*

Mia had much at stake in the success of the Preceptorship programme, and as I show in Chapter 6 this would come to influence her management of problems associated with its implementation.

*Uncertainty over the optimum length of Preceptorship*

Mia explained that the programme had originally been designed as a twelve-month long period of training and support. However, the Trust's Executive Board decided that this period was too long and as a result it was, as Mia described, *"toned down to five months"*. However, the following year, Mia and her colleague Peter attended a Preceptorship conference and reported back to the Trust that most other Trusts were offering a twelve-month programme. Using this information, Mia's manager was able to persuade the DCN and the Trust executive board that a five-month Preceptorship period was inadequate. Mia explained that they still had to negotiate the length of Preceptorship:

> *"So we're back up to 8 months now, which is our sort of... the Trust say 5 months, we've said a year so we've met in the middle"*.

This shows the ambiguity surrounding the programme, as the length of Preceptorship was not rigorously supported by evidence concerning duration. It also shows the difficulty of applying a standardised approach to judge when a newly qualified nurse is no longer a novice practitioner. In this case, the decision was ultimately driven by economic considerations which may also reflect that at senior board level there may not have been any particular concerns about the safety of newly-qualified nurses, otherwise more money may have been invested into Preceptorship.

*The value placed on Preceptorship*

A significant challenge to implementing the programme was the attitudes of some members of staff. While observing Mia, it became increasingly apparent to me that there was a mismatch between the CE Team versus other groups of staff, such as ward managers, ward-based clinical educators and even some experienced nurses and Preceptors on the value of Preceptorship. A prevalent theme emerging from conversations with nurses with many years of experience was that 'we did not have it (Preceptorship) in my day'. For example, the ward leader on an oncology ward at Runnysea told me that newly qualified nurses were now *"mollycoddled"*, as did a theatre nurse (who also stated that "students these days are mollycoddled"). In contrast, there was professed support of Preceptorship by other ward leaders and Preceptors seen during ethnographic conversations and in interviews. This contrast in attitudes was evident on the surgical ward at Riverton, where the three Preceptees struggled to get time off 'front-line' duties to attend the courses or meet with their Preceptors. During an interview with their ward leader, I was told: *"Yeah, I think it's quite good that they get the structured Preceptorship thing"* but when asked what she understood Preceptorship to be she stated *"I would say it's a period of supervision and support … until they have gained their confidence and are up and running with the clinical skills"*. This statement and that of other ward leaders, shows that their understanding of Preceptorship was limited (i.e. restricted to clinical skills) and demonstrated a lack of connection to the wider aims of the Preceptorship Framework (DH, 2010a).

Preceptorship thus appeared to have become a 'tick box' exercise for senior management at the Trust. Far from people actively considering it worthwhile, Preceptorship had become an embedded, bureaucratic norm. Elizabeth told me that once it had been implemented, senior management considered the matter dealt with. The 'tick box' view was to surface repeatedly during my time in the field and there was often a difference between how people spoke about Preceptorship and what happened in practice. For example, Elizabeth was eager to promote Preceptorship and explained that she saw newly-qualified nurses as a rich resource and 'an opportunity' for organisations before Preceptees became "world weary". She explained:

> *"Because of my role, what I'm very keen to happen is for people to see that the organisation is committed to supporting newly-qualified [nurses] and certainly from a Oldshire aware [ness] perspective, we need to understand this concept of growing our own [talent] in terms of newly qualified staff, retaining them within our workforce because I think they are our future".*

Yet despite this statement, the Trust's commitment to Preceptorship appeared to be superficial, Elizabeth admitted that beyond interactions with the CE Team, she rarely heard Preceptorship discussed and admitted that she saw it as a professional issue, ideally embedded into pre-qualification education and not just in professional development. In this situation, professionalism was interestingly seen to be ideologically nested in educational practices and not in organisational ones, and I show in the following chapters, how professional

becoming was shaped by organisational practices. During my discussions and interviews, I explored how the programme was oriented during its implementation.

## The implementation of Preceptorship

Once the decision had been taken to introduce the Preceptorship programme, a number of choices were made about the programme's design and delivery. The programme was originally designed in 2009, but was further developed in 2011 so that the Preceptees would meet the ten core competencies. These were inspired by the five domains of practice seen in "*Equity and Excellence"* (DH, 2010), with the competencies benchmarked for assessment purposes. The programme was also claimed to be closely-aligned to the Preceptorship Framework (DH, 2010a) and a Trust 'Behaviour Framework'. The framework, a guide for all staff at the Trust, stated that:

> *Ensure the development of innovative leaders within healthcare, the Trust is focusing on effective behaviours to be used as a clinical performance tool ensuring that attitudes, values and behaviours are integral to competent clinical performance.*

Despite the presence of the Trust Behaviour Framework, it was noteworthy that Susan was adamant that the person who was leading the course should also be totally aligned with nationally recognised indicators that introduced ideas of 'professionalism', arguing:

*"So it is about engendering people, [and] professional etiquette because if you don't have a sense of self-awareness, a sense of integrity, a sense of professionalism, you can be the most clinically skilled and intellectually eloquent person in the world but if you actually don't understand the concepts of how to respond to people, talk to people, interface with them, consent with them, communicate with them, the rest is subsidiary. So you have got to have those elements working all the time. The professional etiquette, behaviours as a professional, clinical supervision which I think is quite devoid in this organisation… it has to be that support mechanism, alongside the elements of clinical skills, such as medicines management, (huge issue), infection control".*

The Oldshire 'Behaviour Framework' was designed to be a specific clinical performance management tool to "ensure the development of innovative leaders of healthcare" and was intended to be organised around work streams. However, not all people I spoke to were happy with the inclusion of the Behaviour Framework to structure learning as a main element in Preceptorship. The nursing lecturer Alice, who had helped to co-design the portfolio expressed doubts about the design and the inclusion of the Behaviour Framework, as she explained:

*"The behaviour framework, I think that it's interesting that the Trust has that Framework. I wasn't aware of it until it came into*

*this document so I guess my honest view is that when we are talking about nurses then they should be able to behave in those ways shouldn't they? So the fact they make such a play of it at this Trust, I can only assume that they have an issue with behaviour. That's the only thing I can think. So when we're talking about the government teaching us compassion, I just look and think how do you teach compassion and dignity?"*

I explored why Alice had not expressed this opinion at the time and heard from her that although she had been asked to design the portfolio, she had initially turned down the opportunity. Alice believed the person designing the portfolio should have been more clinically competent and in a position of greater authority than she. Nevertheless, Alice was persuaded to do it as a good career move. Once she had started, she quickly realised the main driver for Preceptorship was not smooth transition and support, but safety, and that it was the Trust which decided upon the issues to be addressed by the programme rather than professional drivers. Alice was therefore caught in a 'power trap', co-producing the portfolio was a good career move, yet she was ultimately ill equipped to influence the Trust on matters concerning the programme's content. The Trust's concern about safety was very evident in the portfolio's rationale for Preceptorship, which states it is:

*To assure yourself, the patient and the public that this organisation is committed to developing a patient safety culture.*

This statement implies that newly-qualified nurses in the Trust were considered to be a risk to safety and that the Preceptorship period was offered to the Preceptees as a system of exchange, whereby if they completed it, they would be legitimised as safe nurses.

Despite Susan's statement expressing a need for professionalism, the period I spent at the Trust showed that local drivers increasingly dominated the programme and its design. This demonstrates how wider forces of professionalism and local drivers were both operating and although not necessarily all were conflicted, organisational pressures were the stronger and hence why the programme was designed to be more 'organisational' in orientation. The following sections demonstrate this further by showing how the Preceptorship programme was designed. They also reveal the different components of the portfolio which were created from the translation described above.

## The organisation of the Preceptorship programme

The Preceptorship programme was delivered by Mia, who was responsible for signing off the Preceptees' portfolios to show they had completed the course, following which they were issued with a certificate. The Preceptorship programme comprised a series of structured learning opportunities. There were monthly study days which used a traditional pedagogic approach delivered by the CE Team and other invited speakers in the form of lectures. These took place in the lecture theatre at either Burydale or Runnysea but not at Riverton

because it lacked such facilities. The Preceptees were required to complete a structured portfolio based on reflective, experiential learning which I noted in Chapter 2 is a problematic concept based on the structural view of learning. Preceptees undertook e-learning modules outside of work time. The Preceptees were allocated a Preceptor to provide guidance and support on the ward. However, during my time at the Trust, Mia changed the structure of the course to 'front-load' the Preceptees with three consecutive study days in the first week to prioritise certain aspects of the course such as clinical skills. Mia explained:

> *"One of the evaluations was "please can we have some teaching about CD's[controlled drugs] so that we know what we are doing, blood sugars so what we are going to do?" We have a Trust Induction for two days and then we're going to have them for the next three days".*

The reason for the change was not only driven by evaluation, as Mia clarified:

> *"So before they're let loose in the Trust they're going to be taught about recognising the acutely ill patient and that is one of the things that our newly qualified nurses don't do, they're not very good at recognising when a patient goes off ".*

At first, Mia appeared uncertain about whether the problem of recognising the deteriorating patient was faced by this particular Trust or was a general issue

for the NHS, but decided that it was both a national and local issue, telling me the story about how this had been a problem on the closed-down ward at the Trust where the patient had died. This discussion again shows how Trust concerns about safety created pressure that the CE Team's more junior members felt were placed on them to correct historical mistakes even though there was no evidence to suggest the mistakes had been made by newly-qualified nurses. It appears that in this situation, the scandal at the Trust created myths about the Preceptees who became scapegoats for blame.

Yet Mia wanted to protect the Preceptees from taking on too much learning straight away and did not accept that it should be necessary for the Preceptees to learn extended skills immediately: *"They are obsessed by clinical skills, they want them and they want them now"*, although she acknowledged that learning some straight away would give them more confidence. This demonstrates an interesting tension in the timing of the teaching of more advanced skills during Preceptorship. The CE Team did not think that advanced skills were an important part of early qualified practice; but as Mia noted, today's newly qualified nurses appeared to perceive these skills as typifying modern nursing. Mia wanted to ease the pressure on Preceptees. However, as previously noted there were safety concerns and by delaying the teaching and signing off of more clinical skills, the CE Team could reduce the possibility for being blamed. On the other hand, the Preceptees were under immense pressure from their practice environments to upskill, and therefore this pressure was not so much about professionalism. Rather, Preceptees were concerned about meeting immediate needs of the practice environment.

In the following section, I briefly introduce and describe each of the components of the programme which are expanded in Chapters 6 and 7 when I show how these elements become part of (or are absent from) real-time practices of 'professional becoming'.

*Organisation and content of the Study Days*

The dates and details of the programme and study days were published in advance on the hospital intranet, and ward leaders were expected to release Preceptees from ward duties to attend each session. There was no additional staff cover for the ward and the study days were intended to be compulsory. I later discovered that some ward leaders did not always enforce this rule or would place nurses on night shifts around the date of the study day. Mia was very concerned about this problem, and explained:

> *"The Preceptorship programme is supposed to be compulsory and so there should be no excuse for not letting them come and actually generally speaking they[ward leaders] are very good but sometimes I get an email saying we are short staffed so we are not letting them come. But I have been told to let all sorts of high up people know so that they can investigate why that is the case because they are not supposed to do that".*

Often before Mia could report this to a higher authority, unbeknown to her the Preceptees would make strenuous efforts to attend which they described as a very stressful experience as they had to use negotiation skills. If this failed, they would sometimes attend study days in their own time. For example, on one occasion at a Runnysea study day, I noticed that a Preceptee looked very tired and she explained that she had worked through the night. The problem of attending study days was arguably a reflection of the staffing pressures which were evident during my time at the Trust, and later became a national priority following the Francis Report (2013). This was not a new phenomenon; a lack of 'back-fill' had been a consistent issue associated with the continuing professional development of nurses (Gould *et al*., 2007). Thus, the design of the programme could conflict with ward practices; negotiating these became a difficult experience for Preceptees affected.

The content of the study days included an introduction to the programme, followed by scheduled sessions on Safety Culture, Safeguarding and Medicines Management, Clinical Skills, a Portfolio tutorial, Nutrition, Tissue Viability and Pain, and End of Life Care and Communication. An original session on nutrition was subsequently replaced by 'Recognising the Deteriorating Patient' as this was considered to be a greater priority, given the CQC inspection. As discussed above, safety was at the forefront of the decision to implement the Preceptorship programme, and I explored this matter further with Mia, who explained how the content had been chosen:

*"Well, for this programme I wrote an outline of what I thought we ought to be covering on what is relevant within the Trust at the moment. So all of the things coming up in the Trust, whether it's IR1's[Incident Report] or if it is something the CQC have raised, or latest government white papers, all of those sorts of things. So that is my starting point and then I show it to Susan who has… and you need to see these things and then we try and put them together and… it is quite difficult but mainly prioritising what the government and Trust want and what is top of the agenda for the moment is the Trust really".*

Mia's explanation is interesting as it shows the degree to which the Preceptorship Framework (DH, 2010a) could be interpreted and adapted locally by drawing upon many available sources of codified knowledge. Mia's description reflects that there may be different priorities of government, regulatory bodies and the Trust, but ultimately, in times of crisis it is the Trust's particular concerns for their whole workforce that will be the priority for the programme. Although the Trust may have been laying the foundations for a more advanced level of learning, I could find no evidence that this was the case and as I show, even the affiliated University was powerless to offer alternatives. Indeed, this was viewed by one Trust member as an example of the 'hijacking' of the programme by the Trust. Towards the end of my fieldwork I was able to interview Peter, the Deputy Manager of the CE Team. He had never talked frankly with me before and had always seemed guarded and uncritical about the programme. During this interview, he made it clear

that the CE Team felt under pressure to use the Trust's general safety concerns as its starting point for the programme. Peter was also worried about the balance between the strategies of the organisation, education and the wider profession:

> *"The Trust will often want the mandatory stuff that the CQC require to go into the Preceptorship programme, so they will hijack programmes to put in what the latest campaign might be and, actually, those issues I think sometimes sit elsewhere, they're clearly required by the CQC, they're clearly required at a national level but they don't necessarily fit in with Preceptorship and I think sometimes the Trust's attitude is that they see a group of people in a room and see that as the place that is the easiest target to go and capture a whole group of people and teach them about something but actually, that isn't about the Preceptorship*."

Peter's use of 'campaign' is interesting as it reflects the crisis-led approach the Trust had for reforming care standards. It also reflects Peter's perception that the CE Team was seen by the Trust as an instrument for quick reform by targeting Preceptees.

*E-learning*

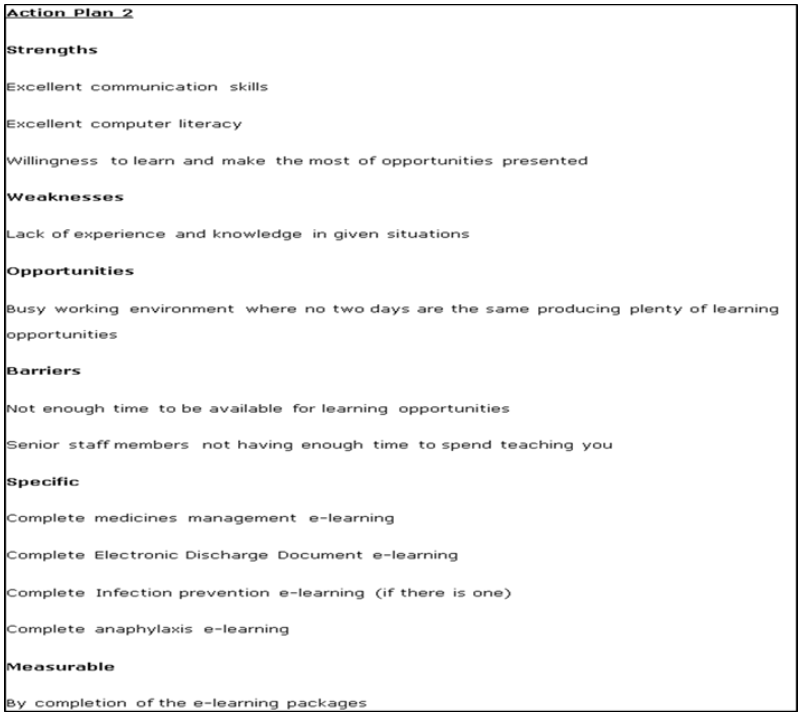
Nurses had to complete several e-learning modules using the National Learning Management System (NLMS) which was linked to their staff record. The

NLMS was a joint initiative between the Trust and the Department of Health. It provided access to national e-learning modules such as safeguarding and local modules which had been specifically tailored, such as medicines management. These modules were intended to complement the classroom sessions. They could be undertaken on the wards (if there was time) but not from home as they were delivered though the hospital intranet. The use of the NLMS in Preceptorship was interesting because it was used by the Trust's HRM systems to monitor staff. The NLMS was therefore compliance focused and potentially created a mechanism for performance management through the Preceptorship programme. This contradicts the Preceptorship Framework's (DH, 2010a) intentions i.e. that Preceptorship is not a performance management approach. Nurses were allocated time on study days to complete this training but were always given the choice to do it another time'. For example, on Cohort 1's second study day, Mia told them they could do it at their convenience telling them, "I'm treating you like adults". Therefore the uptake was piece-meal in terms of time to completion.

E-learning was a familiar concept for Preceptees as they had had to use the NLMS System for their general induction and progression on the ward. I was unable to witness the Preceptees using this system, because they would often do it on night-duty. They also had to complete e-learning modules prior to certain study days such as medicines management. This link to generic learning systems and therefore HRM structures was important as it shows how the boundaries between performance management and induction can often become blurred. This demonstrates the hybrid nature of induction, as noted by Gherardi

and Perrotta (2010) who describe the tension between peers, professionals and the organisation at such time. Some Preceptees would refer to e-learning in their portfolio as part of their action plans. For example, it was identified as a specific and measurable task that they could easily refer to. An example of a Preceptee action plan is shown below in the lighter coloured text.

**Figure 1: A Portfolio Action Plan**



Action Plan 2

**Strengths**

Excellent communication skills

Excellent computer literacy

Willingness to learn and make the most of opportunities presented

**Weaknesses**

Lack of experience and knowledge in given situations

**Opportunities**

Busy working environment where no two days are the same producing plenty of learning opportunities

**Barriers**

Not enough time to be available for learning opportunities

Senior staff members not having enough time to spend teaching you

**Specific**

Complete medicines management e-learning

Complete Electronic Discharge Document e-learning

Complete Infection prevention e-learning (if there is one)

Complete anaphylaxis e-learning

**Measurable**

By completion of the e-learning packages

The above action plan shows how e-learning modules were an easy option to use when trying to evidence Preceptees' perceived knowledge gaps and actions to be taken, as it required minimum input from them to pass. The document shown above demonstrates that this Preceptee considered that a major barrier to learning the skills was the absence of practical support, and I discuss the practices of seeking resources in the following two chapters.

*The Portfolio*

The Preceptees were also expected to complete a portfolio throughout their Preceptorship period. The portfolio was also centred on the Trust's previously mentioned Behaviour Framework and a Core Competencies document, plus it incorporated many aspects of the Preceptorship Framework (2010a). The programme's success was linked to the Preceptees achieving self-awareness, though how this would be measured was unclear. A copy of the blank portfolio was located on the intranet and in its introduction there was a statement from the Trust which pledged that it would:

> *Ensure that all newly registered nurses have equitable access to Preceptorship and, as appropriate, access to an identified, suitably prepared Preceptor; ensure that Preceptorship is adequately resourced; ensure that a system is in place for appraising the Preceptees' performance through the (Trust) Behaviour Framework or other structure to support appraisal; and evaluate the process and outcomes of Preceptorship.*

On deeper analysis, this statement reflected the commitment by the Trust for Preceptorship, a nationally-led initiative whilst clearly linking the performance of the Preceptee with a behaviour framework that was unique to the Trust and its appraisal systems. This shows that when programmes are locally translated, the boundaries with other systems such as appraisal can become blurred. The document also introduced the importance of role-modelling, explicitly stating that the programme was to assure the patient, the public and the nurses of a

'patient safety culture'. This implied that newly-qualified nurses are 'unsafe' and reinforces the notion that creating a safety culture was a particular issue for this Trust. Although the Portfolio was downloaded and kept by the Preceptee, it was designed to be used in partnership with their designated Preceptor and contained a list of key attributes that each should possess. For example, the first attribute that was listed was that the Preceptor should be an effective role model, demonstrating professional values, attitudes and behaviours. I return to the issue of role-modelling in Chapters 6 and 7 when I give examples of role-modelling (and anti-role modelling) in practice.

Role-modelling was complicated because, as I noted in Chapter 3, at the time of writing this thesis it was recognised nationally that nursing values, attitudes and behaviours needed to be defined and articulated clearly to nurses and the public (Cummings and Bennett, 2012). Other attributes required in the Preceptorship Framework (DH, 2010a) are also commonly found in generic mentoring and coaching programmes, and include active listening, giving constructive feedback, good time management and leadership. Although these attributes are not specific to nursing it could be argued that they should be essential attributes for a contemporary nurse. Most nurses today have to role model and mentor, even if informally and unconsciously, and this takes place in a rapidly changing knowledge environment in which these skills could be seen as necessary for knowledge transmission. These attributes are supplied only as a list in the Preceptorship Framework (DH, 2010a), which does not give any examples of what they might look like as behaviours. There was little guidance for Preceptors in the Portfolio and it can therefore be suggested that

the Preceptor and Preceptee were tasked with meeting an opaque agenda that had not been articulated explicitly but was tied to outcomes imposed through the C E Team.

The portfolio was thus driven by national and local needs, and the Trust produced a tailored model of Preceptorship which held specific values. These values could be described as part of the rhetoric of professional development as the CE Team sought to mesh the values of the Preceptees with those of the profession through the use of reflective practice which positions the aforementioned competencies as professional requirements (Edwards and Nicholl, 2005). However, I argue throughout this thesis that the influences of the organisation were a stronger force in the classroom.

*Preceptors*

Preceptees were allocated a Preceptor by their ward leader or clinical educator, not the CE Team. All Preceptors were required to have completed their mentoring training, a portfolio of qualifications in mentorship, and to demonstrate an in-depth understanding of the concept of clinical supervision. A relationship between the newly qualified nurse and a much more experienced nurse is central to the concept of Preceptorship (DH, 2010a). I assumed that Preceptors would be carefully chosen based on their characteristics. For example, the Preceptorship Framework (DH, 2010:17) lists many attributes of an ideal Preceptor. These include being an effective role model; demonstrating professional attitudes, values and behaviours; demonstrating a clear

understanding of the regulatory impact of care that they deliver; and the ability to pass on this knowledge. In the case of nursing, the quality of the relationship has been considered to be an important factor for perceived positive experiences and successful outcomes of Preceptorship programmes (Robinson and Griffiths, 2009).

However, at Oldshire, nursing management did not have tight control over the selection process of Preceptors, and, on the contrary, were only able to state the attributes required of a Preceptor on its website and in the Portfolio. Mia explained to me that the allocation of Preceptors was *"nothing to do with me"* and that she would not routinely have contact with the Preceptors or identify them for some time after the Preceptees commenced the programme.

Instead, it was the ward leaders or clinical educators who had control over the allocation of Preceptors and I discovered that it was difficult, as it would depend upon who was available to undertake the role. Sandra, a ward leader on an acute cardio-respiratory ward, explained the allocation pressures and told me how she had recently allocated a Preceptor following a discussion with her junior charge nurse:

> *"I said "Who do you reckon would be good for her? We have got this one, we have got that one, we haven't got anybody at the moment". Then we look at the off duty as well because I think those first few weeks, it is no good having somebody who is on holiday or on nights, they[Preceptees] will need somebody who is here who*

*can start them off the right way and will be able to pick them up. So there is [sic] the two factors really. It is who is free that would be good for that person, because different people work different ways".*

Sandra articulated some of the qualities that she thought Preceptors needed to have:

*"They need to be supportive; they need to have the experience to share their skills with the Preceptee. They need to be able to prioritise and show how to organise and prioritise. They need to have the clinical skills to recognise first of all when a patient is unwell so that they can explain what is happening but also the clinical skills to be able to teach the Preceptor as they are going along. They need to have the, what is the word, patience; they need to have the patience with them as well which is sometimes difficult, sometimes hard".*

Sandra's statement is interesting because it could be argued that all of these qualities are essential for a more experienced nurse. Even nurses who are not mentors or Preceptors will generally have learners around them at some point, whether those learners are students, newly qualified nurses or newcomers to their clinical areas. Yet despite knowing the qualities needed, the previous statement shows that matching Preceptors and Preceptees was often a pragmatic choice.

Although becoming a Preceptor was expected of experienced nurses, it was not compulsory and, as one Preceptor Joanna, articulated, was not something that should be forced on staff:

> *"I think if it's something that's forced upon qualified staff, certainly a member of staff who's… who says 'I don't want to do it, I'm not interested', then I don't think they're going to put in what they should and it's not just the ward that it affects, it's the person that they're acting Preceptor for, it's the person that will not benefit"*.

Joanna explained that she knew nurses who refused to be a Preceptor as they did not feel that they had the right qualities and were concerned about time pressures. The NMC Code (2008:5) states that nurses should be "willing to share your skills and experience for the benefit of your colleagues". However, formalising this relationship may exclude some nurses who do not feel trained or supported to take on this role but who help newly qualified nurses in other ways. As the CE Team did not always know who had been identified as a Preceptor, this made it impossible for me to contact Preceptors prior to entering the field, and this hindered my progress in approaching them.

When Mia did talk to Preceptors, it tended to be when she was contacted about a specific concern. For example, one day at Runnysea, a Preceptor emailed Mia to say she was concerned that her Preceptee was not reaching the desired

competency level quickly enough, and was becoming frustrated. The CE Team did not keep a database of Preceptors and their qualifications which again I found was surprising given the potential influence of the role. Therefore there was limited certainty about the suitability of the Preceptors and further, if qualifying as a mentor would provide them with the right skills. As I noted, mentoring in nursing, is used specifically in relation to pre-registration education. The Royal College of Nursing Toolkit (2009:5) describes mentors as "positive role models" and in the NMC's (2008) Framework to support learning and assessment in practice, there are clear competencies that mentors must achieve principally beyond basic registration requirements. It states:

> *Mentors and practice teachers acting as role models will be able to demonstrate clinical decision-making abilities, enabling students to gain a holistic view of professional roles* (NMC, 2008:19).

With only the above guidelines and little information from the Trust, I questioned how Preceptors would negotiate the complexity of applying the same principles of student mentoring to qualified nurses.

The Preceptors I came into contact with had varying years of clinical experience, ranging from two years since qualification to over thirty. In the first year of the programme there had been Preceptor training days but according to Mia, were not well attended and had consequently been stopped. Only a minority of Preceptors that I interviewed had done the day's training on Preceptorship. As Peter explained:

*"I'm not sure that the role of the Preceptor is adequately used or promoted or worked on because actually, we haven't got the resources to put into putting on or compelling staff to go to large scale Preceptor workshops but I think there's a lot of work to be done around educating Preceptors about what it's all about because they're invited to workshops but actually they don't turn up".*

The problem was defined by Peter as a leadership issue, a lack of 'buy-in' by the ward leaders and a lack of resources. As Peter noted,

*"It doesn't actually follow through that in practice the matron ward leaders will support those people really actively supporting the staff, which is always difficult when you've got a Trust where we're losing staff, and we've got tight budgets etc. that time together is more difficult to manage".*

The perceived apathy of ward leaders was seen as having been a major hurdle since the implementation of Preceptorship by the CE Team. Indeed, this problem was so deep-seated that the CE Team explained this issue to me in a very resigned manner and this problem appeared to have become a taken-for-granted aspect of the programme's translation. This occurred despite the portfolio statement on the role of the practice development nurses which promised that they would "nurture effective relationships with managers and

staff to ensure ownership and implementation of the Preceptorship Framework". This lack of influence highlights the social chasm between the clinical staff and the CE Team.

The joint working between Preceptors and Preceptees was considered to be vital for knowledge transfer and Susan explained its importance:

> *"The role of the Preceptor is vital. If you don't get a Preceptor who is structured and will work with that Preceptee for at least forty to fifty percent of the time, you are not going to get a portfolio development or career development that is successful or effective".*

Susan's statement is noteworthy due to its focus on the draft 'Career Pathway Framework previously discussed rather than on a patient focus. In the interview, Susan appeared to understand the overarching aims of Preceptorship as written in the Preceptorship Framework (DH, 2010a) and had a long-term view of the benefits of one-to-one learning on the wards. Yet one-to-one support is a well-documented problem with the Preceptee/Preceptor relationship (e.g. Robinson and Griffiths, 2009). Mia explained how this was often problematic at Oldshire:

> *"We have had newly qualified nurses who have had issues on the ward and have come to me and I have said 'Well I think you need to go and talk to people, it is fine to talk to me about it but you need to try and sort it out first' and they have come back to me and it*

*hasn't worked and I have gone to a ward area and not said 'what are you doing', but perhaps we can have a little chat and 'these people haven't been given a Preceptor and they have been here 3 month' and we have sorted it out".*

Mia's statement raises some important issues. First, it shows the constant battle that the CE Team had in trying to implement effective Preceptorship which could be due to the lack of buy-in described above. Second, the lack of Preceptoring was often blamed by those I spoke with, on the computerised roster, though this was only used on certain wards. I explored this in group interviews and as two Preceptee noted:

*"Well I thought we were going to work lots of shifts with them, but I haven't had that many"*

*"Because it's all down to the computer isn't it? It does it all".*

Some Preceptees acknowledged that ward staff did try to roster them with their Preceptors. A Preceptee who had two Preceptors explained that the clinical educator who rostered the shifts tried to help her: *"he does try to put them [with me], yeah he does try"*. Preceptees accepted that it was not the fault of the Preceptors, instead blamed the system, either in IT issues or time constraints and difficulty in co-ordinating staff schedules. Yet Preceptees were not always passive and once they realised that the opportunities for face-to-face learning were limited, would try to overcome this problem and request shifts.

*"I've probably worked with her four times maybe since I've started, she's on the early, I'm on the late, you know things like that and you think... 'why can't you know that she's my Preceptor, so why can't you just put me on with her?' But I've copied pretty much all of her shifts for May and hopefully- I said to her I've done this, you know I am not stalking you, I've done this because I want to work with you and I need to because we need to go through whatever's in the portfolio thing".*

Whilst most Preceptees accepted the situation and, as I later show, actively sought help from anyone, there was a suspicion that there was a deeper problem. For example, a Preceptee on the Critical Decisions Unit (CDU) was convinced that this lack of co-ordinations was deliberate, because support was seen as 'mollycoddling'.

Peter wondered if there was another problem that might explain the lack of co-ordination:

*"I just don't see it as being that difficult to manage to get two people to work in a room or on a ward together or to be able to access each other, I really don't understand what the big issues tend to be, because it's not a cost issue because actually it's just a rostering issue potentially. However, it might be that the Preceptors are, I don't know, maybe a little bit anxious about being Preceptors".*

This complexity was recognised and working with a Preceptor was seen as something that should be more regulated, as Mia stated:

> "*I do think, what I would like to see is that its somehow mandatory that you work with your Preceptor at least once a month, and by that I don't even mean that you work together in the same bay, I just mean you're on the same shift so that you can talk to each other in break time or after the shift or something so at least you'd think you were getting somebody to talk to".*

When I asked Mia if she was doing anything to rectify this situation she told me that she tried to boost Preceptors' support work on the wards by working with Preceptees herself when possible. This demonstrated her perceived inability to influence the rosters. Ultimately Mia recognised that she had little capacity to easily change ward working practices and that she could only try to make the Preceptees safe though classroom teaching. As she explained, it was only people above her grade who had any interface with the workforce development team, or the Deputy and Chief Nurse. Thus, the problems of implementation of Preceptorship appeared to be multi-faceted and often political.

## Conclusion

In this chapter, I have explored Preceptorship through the study of 'what', 'where' 'when' and 'who' (Antonacopoulou, 2009) in the context of Oldshire.

I began by exploring the Trust and showed how each hospital was distinct in characteristics and atmosphere. This is important because it gives clues to the specific contexts in which the practices of Preceptorship take place, and as I later show, how they vary. I have introduced the CE Team, and the translation, organisation and intentions in its delivery of the Preceptorship programme. This analysis has shown a troubled NHS Trust with a CE Team that was placed in an uncomfortable position, with professional, public and organisational forces pressures influencing their work.

The early impression I had of the CE Team was that it was confused about its identity as either practice or professionally-focused and felt the need to legitimise itself in different ways to management, to nurses on the wards and the wider profession. This had an impact on the way that the programme was translated. Although as Edwards and Nicholl (2005) note, professional educators are increasingly positioned to be flexible and innovative in the light of service changes, the CE Team was heavily-influenced by very specific Trust imperatives on safety and quality. The junior members of the team had lower levels of resources compared to those in senior management positions and less able to effect change. They were pre-disposed to be resigned to the difficulties in managing Preceptors to undertake the Preceptorship programme due to their sense of weaker power, and the lack of 'buy-in' by senior leaders. This highlights the complexity of working in a team at the nexus of different interests and the difficulty of promoting the programme throughout the Trust. This also highlights how clinical staff were under-resourced and prioritised ward staffing over the clinical education of more junior staff. This lack of

understanding and ‘buy-in’ from people in leadership roles within the Trust added pressure to organising the programme.

The implementation difficulties showed a problem with trying to standardise a Preceptorship programme among these different pressures. The Preceptorship programme was translated amidst local and national economic and political conditions, resulting in a programme that, as Peter noted, was felt by the CE Team to be “hijacked” by the Trust’s immediate and cultural concerns, rather than broader professional issues and values. In this Trust, the content of the Preceptorship programme thus appeared to arise from the influence of Trust policy outputs, coupled with a fear of regulators, which influenced the translation of the programme. As Fenwick (2010) and Billett (2004) note, although there will be a professional mandate, there are different approaches in organisations as particular discourses determine the agenda for learning.

The CE Team was aware of the difficulties of Preceptorship ‘buy-in’ and acknowledged that some aspects of the programme did not work well. Although it was open to making small adjustments there was little evidence that it questioned whether knowledge would smoothly transfer during Preceptorship. Although the value of learning-in practice was highlighted, the emphasis on reflective practice and the lack of acknowledgement of individual needs or existing knowledge is later shown to contribute to some of the more negative emotional experiences of ‘professional becoming’. As Dejours (2009: 37) notes:

> *The conditions created in the new, re-structured work organisation places workers in an extremely painful psychological situation, one which throws them out of kilter with values of high-quality work, their sense of responsibility, and professional ethics.*

The following two chapters present my findings. These are themed as significant practices that were evident along the journey of the newly-qualified nurses from joining the Preceptorship programme to leaving it eight months later.

# Chapter 6:

# The beginning: ‘professional becoming’ on Preceptorship study days

## Introduction

In this findings chapter I examine how the Preceptorship programme was organised and enacted in everyday practice. I give particular consideration to the relational practices of educators with Preceptees, but also pay attention to Preceptees’ interactions with each other. Through bringing to light these practices, the chapter explores how ‘professional becoming’ of newly qualified nurses within an organisational context unfolds over time, with early events laying the foundations for subsequent situations or interactions. Through these interactive practices, particular organisational expectations and assumptions about professional nursing are promoted, but are also significantly aligned with broader organisational demands and priorities. The chapter shows how within, and outside of, the formal learning encounters in Preceptorship new nurses interact among themselves and with others such as educators to find additional or alternative understandings and meaning about their work.

The main themes of this chapter centre on how the programme was introduced to the Preceptees, the creation of cohorts, the fostering of learning styles, and the way nurses ‘learned the ropes’ in the classroom. The data is drawn from observations, group and individual interviews. I present these empirical findings in a broad time-line, focusing on particular interactive moments and

commenting on where these practices continued during the programme. I begin with a vignette which provides a summary of the first day on the programme. I explain why this vignette is important and from this analysis develop themes that typify the early period of the Preceptorship programme but which are also relevant throughout the programme.

## Vignette 2: It's Like Free Counselling

*Mia asked the Preceptees "How's it going?" and following a pause, a Preceptee replied "Alright…hectic". Mia introduced herself as Programme Leader and briefly outlined the day, calling them "You clever lot" for completing their training. She asked the Preceptees to perform a warm-up exercise where (in silence) they had to get up and order themselves in a line according to descending birth dates. Some Preceptees rolled their eyes and looked unimpressed, while others tried to complete the task. After the exercise, Mia asked them what they thought of the Preceptorship programme. A solitary reply was a (slightly) sarcastic "Good aim". Upon further questioning, most Preceptees looked 'blank' and their lack of response suggested they did not understand what Preceptorship entailed.*

*A discussion followed and a Preceptee told Mia "All of my training has gone out of the window" whilst another said she cried on her first shift. Mia asked them if they were getting support. There were a few nods. One Preceptee said "Some days are ok, good, others, forget it!" Mia reminded them that although*

*they never stop learning, the transition period was "Huge" and they needed to find people to talk to. Some said they had not yet been allocated a Preceptor on the ward; others said they had formed a good relationship already.*

*Quickly cutting short further discussion, Mia began explaining Preceptorship in more detail. Few Preceptees seemed aware of the recent government White Paper, Equity and Excellence (2010), when it was referred to. The Preceptees described how nearly all of them had been experiencing difficulty accessing the hospital intranet and had not been able to find out any information on the programme or print off their Portfolios.*

*For the next two hours, the nurses were shown a PowerPoint presentation that explained the sixty five page long Preceptorship Portfolio they were obliged to complete. Some expressed unhappiness about this by complaining that they also had to complete local ward induction packs. Mia appeared sympathetic but explained there was no negotiation on this matter (the Portfolio was a requisite document).*

*The Preceptees appeared more cheerful when Mia ran through the programme outline explaining that Preceptorship is like 'free counselling'. She reminded them that they should be familiar with reflective writing as they used this during their education, although they would now use a different model to guide their writing. She explained that the new model was designed to work on the basis that nurses can become self-aware, critically reflexive and develop a new perspective on their practices. Finally, Mia explained that the*

*Portfolio was mapped to the "6 month gateway" - that is the end of their ward induction period - when they could expect a pay rise subject to performance assessment.*

*Each Preceptee then completed a Strengths, Weaknesses, Opportunities and Barriers (SWOB) analysis where they identified issues such as not being able to do IV's, staffing levels and inability to delegate. Mia did not spend much time discussing these concerns and quickly moved onto a discussion about how to use the Portfolio. The Preceptees did not ask many questions; instead it appeared as if they were trying to digest the information presented to them. When Mia asked them (in a strict voice) if they had written their action plans only one Preceptee was able to refer back to her Portfolio. The other nurses could only look at the examples on the PowerPoint slides as Mia explained what the action plans were. At the end of the morning, Mia told them about the positive response to the programme that the CE Team had received from other cohorts.*

The above vignette outlines the initial encounter between the Preceptorship programme and the Preceptees. By including this vignette I wanted to reveal the highly structured and organisationally-orientated nature of Preceptorship in the classroom and the consequent limited participation of Preceptees. As I was already aware of the difficult conditions that Trust was experiencing in terms of short staffing and regulatory problems (described in Chapter 5), it was surprising that there were not more opportunities for the Preceptees to discuss issues and ask questions. Through observing the use of classroom space and

the nature of Mia's interactions with the Preceptees, it struck me how much of the session was delivered in a pedagogic style that was similar to traditional university lectures. This appeared to be at odds with the flexible aspirations of the Preceptorship Framework (DH, 2010). As such, the content and delivery of this first session (and as it transpired, of future sessions) appeared to be driven by the organisation in a paternalistic fashion. In other words, the organisation knew best about what Preceptees needed to learn. Further, it was apparent that the CE Team felt it necessary to strongly justify how they would deliver the programme they had designed. This vignette is important because it shows how the CE Team 'set the tone' for the rest of the programme in terms of how they positioned themselves as 'knowing' and the Preceptees as needing to learn one best way of practicing in the organisation. This helps to demonstrate the broader issue which is how an NHS organisation used Preceptorship to align newly-qualified nurses to organisational requirements.

The vignette thus reveals the nature of the interactive practices which would become central to Preceptorship within the organisation. Significantly, these practices exposed contradictions in the way the policy was implemented e.g. showing the tensions between formal and more organic ward-based learning. The following section builds on the vignette by focusing specifically on how the programme was promoted, the initial reactions of the Preceptees and the management of their expectations by the CE Team.

## Introducing Preceptorship

*Promoting the programme*

Vignette 2 shows how the CE Team spent a significant amount of time (a whole morning) on the first day of the programme explaining their version of Preceptorship. This revealed tensions between organisational and professional pressures on the Preceptorship programme, for example, when justifying the programme.

In Vignette 2, I noted how Preceptorship was introduced with the aid of a lengthy PowerPoint presentation in which a range of national policies and professional codes were cited. These included *The Code -Standards of Conduct, Performance and Ethics for Nurses and Midwives* (NMC, 2008), *The Preceptorship Framework*, (Department of Health 2010a) and other evidence, e.g. the white paper *Equity and Excellence* (Department of Health, 2010b). The Trust's 'Behaviour Framework' was also referenced and Preceptees were reminded that an important aim of the programme was to "*ensure leadership development*". However, Mia made no specific connections in the presentation between the Preceptorship and Trust Behaviour frameworks, which gave the impression of a disjointed process. Interestingly, a nurse lecturer who had helped design the programme later explained that she did not see the connection and that they were under pressure to include it: *"the fact that they make such a play on it at this Trust, I can only assume there's been an issue with behaviour"*. Vignette 2 also notes that the Preceptees were quiet and did not ask questions which suggested indifference either with the content or

delivery of the programme. This indifference to the long introduction was evident in group interviews later that day when for example, a Preceptee remarked, *"why do we need a whole day on that?"* Mia also noticed their quietness because she jokingly asked them, "*Are you with me? Because if not, I will make you go outside and do star jumps*". I also noted the Preceptees' apparent indifference on other study days in the programme such as during a session on dignity which I describe later in this chapter. However, they appeared to be more enthusiastic (noted by their smiles) during more practical sessions such those which involved learning clinical skills. This suggests a lack of relevance of aspects of the programme to their everyday learning needs.

Once the Preceptorship programme had been explained, the Portfolio was introduced (described in Chapter 5) and three main benefits were explained. First, Preceptees were assured they would be allocated a Preceptor who would sign off their competencies and help them complete the Portfolio. Second, a connection with the Trust's appraisal process was promoted, e.g. it was explicitly stated by Mia that "*Preceptorship will lead into the Appraisal and Personal Development",* and she also explained that the Portfolio could be used as evidence for the six-month pay 'gateway' (a performance related pay increase). This surprised me because in the literature, Preceptorship is not described as a form of performance management. Third, Mia explained that Preceptees could evaluate the programme to help future cohorts. I thought this also surprising given the lack of apparent benefit to Preceptees. Finally, Preceptorship was promoted by citing the *Boorman Report* (2009), which

centres on well-being at work, and by explaining that the programme would offer *"free counselling".*

Following the Portfolio's introduction, I noticed that the Preceptees appeared unhappy (seen by their frowning facial expressions and hearing exclamations such as *"More written work"*). This suggests that the Preceptees may not have expected Preceptorship to require evidence of competencies. Discontent was also articulated on the following month's study day when, upon arrival in the classroom, Preceptees complained that the Portfolio was a burden on their time. On this occasion, Mia reminded them that all qualified nurses were expected to complete a Portfolio as part of their Post Registration Education and Practice (PREP). Their lack of verbal objection at this stage suggested that they were better persuaded by this justification on the grounds of professionalism rather than the performance management related arguments made the previous week.

The group interviews later that day revealed a lack of understanding about what would happen on the programme, with Preceptees remarking: "*I didn't really realise there was a day each month that we'd be coming*" and "*I didn't know it was for eight months*". Furthermore, some Preceptees had also heard poor reports about the programme: "*I have heard quite negative things about it from newly-qualified nurses on my ward"*. During the breaks and visits to the café, I learned from ethnographic conversations that they did not have high expectations of it making a difference to their learning because of the busy nature of ward work. We also discussed this topic during the first day group

interviews and one Preceptee argued that, "*In an ideal world, the Preceptorship programme would be fantastic"* and another agreed: *"It's the time aspect"* that rendered it questionable. As noted, in Vignette 2, Preceptorship was 'sold' as "free counselling" and generally Preceptees hoped that it would provide support. However, they remained confused about how the programme would unfold. Preceptees did agree that the programme would be useful for, as one Preceptee described in a group interview on the first study day a "*Catalogued*" approach to gaining extended skills which were an urgent priority. In other words, they saw it as addressing a 'list' of necessary clinical skills.

The above examples of how the programme was promoted are noteworthy because first, they highlight the CE Team's need to persuade the Preceptees of the value of Preceptorship and the Trust's particular version of the programme. In other words, 'buy-in' was not automatic; this may have been in part due to student nurses not perceiving Preceptorship as a priority during their education. As a nurse lecturer explained:

> *"I think there is a limit to how much you can prepare the students [about Preceptorship] because a lot of that depends on them recognising the value of what they're coming to."*

This may indicate that nurses will not see the value of such a programme until facing the reality of their new role. However, the data also indicated that many of the Preceptees entered the programme without strong support from the ward

which may also contribute to a lack of buy-in. The group interviews also revealed that approximately one third of Preceptees had not yet been allocated a Preceptor and were therefore left without a specific 'go to' person who may have been well placed to persuade them of the value of being a Preceptee. As this was a new programme there was also poor understanding among some ward leaders (described in Chapter 5) which contributed to lack of access to resources, e.g. the lack of access to the intranet to view the Preceptorship web page. On the other hand, some of those Preceptees who had been allocated experienced Preceptors had more information. Donna, a Preceptee from theatres explained in a group interview that she and her Preceptor had discussed the Portfolio: "*My Preceptor made sure she sat down with me and talked through and made a plan and an action plan*". This experience was seen by some Preceptees as the 'gold standard', as Donna argued: *"But that should be across the board, shouldn't it? Every ward should be doing that, standard thing*." Nevertheless, as this was not usually the case, the data suggests how important the introductory day was for gaining 'buy-in' from the majority of Preceptees who encountered inequitable access to Preceptorship. However, despite the 'hard sell' the Preceptees remained concerned about the limitations of a professional development programme (the ideal) that appeared to be uncoupled from early work as they experienced it (the real).

The CE Team attempted to gain fidelity to the Trust's programme and Portfolio by invoking policy frameworks, professional codes and the pledging of certain benefits. This is significant because there were professional and organisational tensions evident in this process. By drawing on national policy and codes, the

CE Team presented the professional justification for Preceptorship. Yet an organisational framework was also used which focused on locally-driven behaviours and associated competencies which required large amounts of evidence before Preceptees were signed off. This is interesting because it shows how both the organisation and the profession were interchangeably drawn upon to promote of Preceptorship.

The amount of time spent promoting the programme may have reflected a lack of confidence on the part of the CE Team due to the newness of the programme and, in particular, their experience (from running previous cohorts) that a lengthy Portfolio would be unpopular. This helps explain why the initial promotion was not completely successful. As Preceptees did not appear fully persuaded of this process, professional responsibilities were again cited, showing how the CE Team used professionalism as a powerful argument. It could be argued that this is an example of professionalism "from above" (Evetts, 2003:407), where, as noted in Chapter 2, organisations use professionalism as a discourse to meet organisational needs.

The next section explains the Preceptees early reactions to their new roles. These reactions are important to explore because they revealed aspects of their 'professional becoming' which were largely unexplored during the taught sessions.

## Early reactions to ward working

The study days provided little opportunity for Preceptees to express their early experiences of work and their reactions to Preceptorship. However, to explore this further, in the group interviews on the first day I asked the Preceptees in group interviews to describe their initial experiences. The conversations centred on the pressures on their becoming and the nurses described their awareness of the telephone constantly ringing, their feet that felt as if they were 'on fire', their lack of time to have a drink, the rapid pace of work (90mph), the feeling of their heads buzzing and not being able being to have a drink, sit down or take a toilet break. They also described the emotions they felt such as 'fear', 'anxiety', 'shock', and feeling 'overwhelmed'. However the Preceptees also described how the epaulets (the part of the uniform identifying them as qualified nurses) gave them a sense of their professional pride and excitement.

The data from these first day group interviews revealed important themes. The main themes which arose from these conversations were as follows- low status (in the hierarchy), unfamiliar work settings and lack of contact with Preceptors. I explore these more fully now and support with data from ethnographic conversations and observations where available.

*Early reactions: Low Status*

In the group interviews Preceptees expressed feeling low down in the hierarchy, e.g. *"Where do you start off in that line of people?... low"* and perceived themselves as being rated below HCA's, as Clara stated:

> *"You feel like your opinion is never valued… I know I have only been a nurse for 5 minutes but probably caring [as an HCA] for eight years and you do feel hen-pecked by other carers, [It's]patronising.*"

The sense of low status also arose from Preceptees' view of perceived public opinions of nursing since the CQC report of Runnysea hospital. These views were manifest in discussions about their uniforms. In an early group interview one Preceptee described her uniform as a *"badge of shame"* and was embarrassed to pinpoint exactly where she worked instead telling people: *"I am a nurse at a local hospital".* In the interview two Preceptees also discussed a sense of deflation:

> *Preceptee 1: "I don't know about other people but I'm just feeling really deflated with all the press and all the negative comments that you get about the hospital."*

> *Preceptee 2: "You go on Facebook and they go, "Runnysea hospital is fucking shit, all the nurses are crap", I think actually no they're not, you've had one bad experience."*

The above examples show that faced with challenges to their sense of professionalism when working in a new organisational role, newly-qualified nurses 'anchor their identity' (Nicolini and Roe, 2014) by referring to symbolic representations of the professional nurse, e.g. the uniform and the epaulets, as a singular identity. However, when a hospital's reputation suffers, this interrupts their identification processes and leads to a disassociation with the uniform (and hospital). The examples cited also show the low self-positioning newly-qualified nurses accord themselves in the hierarchy when they join a new community of practice (Lave and Wenger, 1991). This is significant during Preceptorship because the feeling of low status was a source of emotional disturbance that was hidden from the CE Team and yet which arguably should be a concern for those claiming to provide pastoral support.

*Early Reactions: Unfamiliar settings*

Working in unfamiliar sites was problematic, as a Preceptee observed:

> *"It's out of your comfort zone isn't it? I trained at Burydale. Even if you ended up on a ward you didn't particularly know, they're set out the same. How it ran, things like that. You go to a different experience [at Runnysea hospital]."*

This highlights how newly-qualified nurses could be surprised at a new hospitals practice and question what was previously taken-for-granted. Some

differences on wards were so subtle they could not be articulated clearly, as another Preceptee observed:

> *"There was something about it that was different. I've never been able to put my finger on it."*

Preceptees who moved from Burydale were particularly aware of different customs and practices. For example, Clara commented on the sight of Runnysea staff travelling to work and smoking in their uniform (which was strictly against the Trust's policy) remarking,

> *"It's a different culture isn't it? At Burydale, you would not be caught dead doing that. It's really strange how people here do it. I saw a healthcare [worker] stood outside, he had no coat on or anything, he stood outside having a fag, I was like "what?"*

Clara was surprised at what she saw as a more unprofessional approach to behaviour when wearing the uniform which again shows the perceived differences in custom and practice at hospital sites within Oldshire. This awareness of different habits was also evident when during an early observation I accompanied her on her own cigarette break to the designated shelter outside and noticed how she made sure she wore her coat to cover her uniform. Clara was quick to point out how the other staff we could see who were also smoking had not done the same.

Preceptees saw Runnysea as a place of poor practice and Riverton as a backwater, a 'cottage hospital' where people did not want to listen to new ideas. During a group interview 3 months into the programme, two Preceptees raised this issue as a persistent problem:

> *Preceptee 1: "I said "in Burydale we do this", [and they said] "Oh yeah well you're in Riverton now."*

> *Preceptee 2 "How many times do we hear ourselves, "in Burydale we do this" but we've got to stop saying that."*

> *Preceptee 1: It's really poor; they're [more senior staff] not willing to listen*

The recognition of the sharp contrast in different hospital's customs and practices is significant during Preceptorship. Although Preceptees recognised negative aspects of their new hospitals practices, there appeared to be no way to feed this back to the CE Team.

It was also common for Preceptees to be working on unfamiliar wards. In accordance with Trust recruitment processes, Preceptees were unable to choose specific wards or departments. As a university lecturer also noted during an interview, *"They feel a little pressured to get a job, any job, as opposed to where their heart really wants to be"*, and hence Preceptees were often

unfamiliar with their new environments. This was often problematic, as two Preceptees described during the first group interviews:

> *Preceptee 1:"In a new department, I don't know the routine. Each staff member has a different way of doing things and every time I am told to do something, I am told to do it another way, which makes things confusing."*

> *Preceptee 2: "You go to another ward and you are just completely lost, I mean it should not be really like that, you should be able to [practice] anywhere*".

Mike, a Preceptee who worked in the operating theatres also explained:

> *"I'm in a completely new department. None of my training applies…So I've got to learn a whole new way of working. Its learning my trays, learning what instruments [to use], what you're handing over, even down to hand [ing] it in a different way."*

The initial confusion Preceptees experienced was often described in sensory terms, of not seeing, hearing or comprehending. For example, Donna, a Preceptee who was working in theatre recovery described communication difficulties because everyone appeared the same when wearing masks and gowns: "*I feel blind, just feel blind, I can't understand anything*". Preceptees

also complained about not understanding the language that their colleagues used: "*It's like gobbledygook"*.

The immediate period after supernumerary time (when Preceptees are not counted in the designated staffing numbers), was also challenging as described by a Preceptee, Hannah:

> *"When I first started on CCU they didn't give me patients as such, I was sort of with other nurses. But then as soon as I started having my own bays, they are classified as your own patients and you think "If I don't do anything for them, who is going to…and it hits you…"*

This above comment again shows the shock of professional responsibility in the newly-qualified situation which relates to the "environment reality shock" (Kramer *et al*., 2011:1) described in Chapter 2, in which joining the complex context of the environment can cause emotional disturbance.

Preceptees that worked in the hospital where they had trained generally reported a more positive experience as Felicity who worked in A&E stated:

> *"I just got a job where I was an HCA so I have been in the department for eight years, so I'm kind of easy. I know the department and I know how it works*".

The above examples give clues to why working in unfamiliar settings can be problematic -because of the difficulty in accessing esoteric knowledge. It was not just the routines and ways of working which were problematic but the understanding of how to use 'tools of the trade' which highlights the material nature of learning (Schatzki, 2001). These examples also illustrate the diverse experiences of newly-qualified nurses. This is significant during Preceptorship because these experiences create different needs in terms of pace and content of learning. This is important when considering if and how aspects of Preceptorship can feasibly mitigate this experience. It appears that in very difficult conditions it may be unrealistic for a Preceptorship programme to manage turmoil for Preceptees working in an unfamiliar setting.

*Early reactions: Experiences of working with Preceptors*

Whilst Preceptees looked forward to working with Preceptors, their early experiences of this varied widely. Their problems centred on time pressures, different understandings of Preceptorship, nature of the ward speciality, anti-role models and role boundary issues.

On Day 1 of the programme, I learned that some Preceptees had met their Preceptors. However, other Preceptors were often unavailable or unapproachable. As a Preceptee noted during the first group interviews, "*I haven't been told if I've got a Preceptor. I've been there for 3 weeks, so I just go to the ward sister.*" This did not seem to concern her as the sister was considered approachable. During early observations I noted that other

Preceptees would be more hesitant than others in asking for help and I discuss these circumstances in the following chapter. Although other Preceptees reported a good, developing relationship with Preceptors, there were problems in accessing them due to different shifts, working in distant ward bays and conflicting co-ordination roles. During the course of a first group interview, a Preceptee explained this lack of access:

> *"All I'd want is an hour per month, to sit down and just go through everything. For them [Preceptors] to show me what packs I should be doing at what time. Things like that. I wasn't told anything. I couldn't even get on a computer. You're not shown. You just turn up on the ward. I've got no email, no computer, no nothing."*

This demonstrates that many Preceptees expected that a Preceptor would be available to help them access 'tools of the trade'. This is noteworthy because such help could be viewed as constituting general induction requirements which are traditionally the responsibility of ward leaders. These notions of Preceptorship can seemingly blur the boundaries between ward-based learning and professional development creating uncertainty around responsibilities.

Significantly, access to Preceptors could be complicated by differing views on responsibility for learning. During a group interview in the middle of the programme, Kim a Preceptee on CDU explained:

*"Mine's [Preceptor] fantastic but like I said, I was told on my first shift [by the ward leader], you're now a qualified nurse. [Preceptor] is not your mentor and you work your own shifts, you are not allocated days with your Preceptors".*

The ward leader's comment to Kim was important because it sent the message that professional nurses should be self-reliant and they should manage their own Preceptorship. This was similar to the proactivity Mia tried to convey as noted earlier in the chapter. However, it appeared to take time for Preceptees to grasp this idea. This shows how they still retained a student 'mind-set' and why the Preceptorship programme tried to encourage newly-qualified nurses to adopt a more proactive approach.

The relationships between Preceptors and Preceptees appeared more active in higher intensity wards such as the Emergency Department (ED), Theatres Coronary Care Unit (CCU) and the Special Care Baby Unit (SCBU). As one of the children's nurses explained during the first group interview, "*I think I am quite lucky as a child branch student…because I think they wrap you up in cotton wool a little bit*". This support was viewed positively during early group interviews however later in this chapter I discuss how too much support could stifle autonomous working.

This suggests that wards delivering more critical care regarded Preceptorship as a safety resource and recognised they also needed to protect Preceptees from the emotional side of high risk work. This is interesting given the situation

above where Preceptees on other wards needed to be more pro-active in seeking help, which demonstrates the differences in specialities.

Preceptors and other qualified nurses were sometimes seen as *anti*-role models. This was discussed by Preceptees in the early group interviews:

> *Preceptee 1: "They need to be compassionate, they need evidence-based practice"*

> *Preceptee 2: "There's no back up from them, they're not bothered, there's no support from them whatsoever".*

Gemma, a Preceptee on a cardio-respiratory ward expressed similar sentiments in a group interview:

> *"I've got one junior Sister who is actually my Preceptor and she will love to make me feel stupid, not just me, everyone. If I say something she'll be …really aggressive, bad, you know will belittle me"*

In these cases, *anti*-role models were seen as unprofessional. Conversely, in the early group interviews Preceptees referred to better support given by HCA's, "*I've found it's been more healthcares*[2] *than nurses*". HCA's were deemed to be approachable and experienced, "*I often say to one of our healthcares, she's*

[2] HCA's were known as 'Healthcares' in this Trust

*been there 20 years and I often say to her, what do you think?",* although Preceptees said they were careful who they asked ("*You are very wary of which ones you ask*"). Junior doctors were also regarded as approachable; "*The junior doctors, bless them, they are in a similar position to what we are*". However, this again varied between wards. This is significant because it shows how professional knowledge can be accessed through other occupations. Here, Preceptees sought help from medical staff and HCA's to develop their professional knowledge, not only from officially allocated Preceptors.

Interestingly it was the group interviews, rather than official time during the Preceptorship study days that revealed this mixed picture of Preceptor activity. By centring on Preceptees early reactions to their 'professional becoming', the group interviews revealed a lack of consistent support, as previously evidenced (Robinson and Griffiths; 2009; Whitehead *et al.,* 2013). The above examples are important because they show how Preceptorship was also mediated by ward context. Furthermore they show the presence of anti-role models, alternative role models and other staff acting as unofficial Preceptors (as a source of identification) which decentres the role of the Preceptor.

The above data on early reactions to Preceptorship and ward working have highlighted Preceptees' immediate need for information, help to navigate ward induction processes, 'tools of the trade' and learning advanced skills. Further, Preceptees were still trying to find people who would help them access the context-specific knowledge and resources which would help them to move from a peripheral positon in the community (Lave and Wenger, 2001) to a

more central one. These concerns were hardly evident during the structured classroom sessions because the Preceptees were denied a voice and these issues could thus be described as 'the elephant in the room', an element of their 'professional becoming' that was not addressed through the programme.

This final section on the practices of introducing Preceptorship, studies how Preceptees' expectations were managed by the CE Team and other educators.

*Managing Expectations*

During the programme, I observed that an aspect of delivering Preceptorship was managing the Preceptees expectations. I give two examples of this in relation to the Portfolio and extended skills. First, I show how the CE Team managed expectations concerning the Portfolio.

The Preceptees had certain expectations from Preceptorship. For example, Preceptees initially expected to be helped by the allocation of specific ward time, in particular with Preceptors. However, by the second study day, Preceptees had experienced barriers to using the Portfolio because of busy shifts and lack of time with Preceptors to witness their practice: *"I've done loads but no-one has seen me".* Following complaints about lack of access to Preceptors, Preceptees were informed by Mia that anyone could sign off the individual competences in the Portfolio (their Preceptor had to sign for completion) and were told, *"You are all adults"*.

As previously noted, Preceptees also complained about the duplication of the Portfolio with other ward induction documents. Mia advised Cohort 2 that they would not be chased for the Portfolio; she stated *"It's not my responsibility"* but that completing the Portfolio was Trust policy. Again, she moved the agenda on and discussion was curtailed. This reinforced the notion that completing the Portfolio was a professional expectation and shows the efforts that the CE Team had to make in order to manage Preceptees' expectations.

The above examples show the tension between the needs of the Trust to codify and evidence knowledge and the practicalities of managing the Portfolio amid competing organisational expectations. Although Preceptorship centres on the Preceptor-Preceptee relationship, the programme was sold on the basis of Preceptor support for evidencing Preceptee competencies. However, as the programme unfolded, the CE Team needed a more pragmatic approach to helping Preceptees' achieve this aim. This exposed an underlying contradiction. On the one hand, the programme was implemented in the classroom as a traditional pedagogy that promised to deliver professional knowledge supported by the Portfolio. On the other hand, the programme expected Preceptees to take responsibility for learning professionalism in an organisational setting mediated by local practices which were out of the CE Team's control. Further, the Portfolio duplicated other induction processes, highlighting that Preceptorship does not occur in isolation from other socialisation tactics (Van Maanen and Schein, 1979). Both professional and organisational processes attempted to align newcomers' interests and although

these did not necessarily conflict, the duplication increased pressures on Preceptees which had to be managed by the CE Team or Preceptors.

The second example of managing expectations relates to the issue of extended skills. As a Preceptee argued during the first day focus group, *"It's ok to talk about feelings, but we need practical support"*. Preceptees wanted to upskill, e.g. *"Knowing exactly how to take bloods".* Not having such skills appeared frustrating: *"I need clinical skills; it's doing my head in"*. As one Preceptee stated:

> *"We get huffed and puffed because we can't do IV's….they are like, you can see it, I'm working with you again, I have to do all the IV's"*

This issue appeared to impact on Preceptees' sense of professionalism. One stated for example, *"Well I'm meant to be a staff nurse, but I feel like a student because I can't actually do it".* However, Mia reinforced the CE Team's position: *"You don't need to do additional skills yet",* to which Preceptees responded e.g., *"But we want to do things, we don't want to be a burden"* and *"I feel like a spare part."* Cohort 1 did not learn skills such as taking blood, and performing Echocardiograms (ECG) until halfway through the programme. Because of the pressure from Preceptees and ward staff, the CE Team changed the skills training to the first week of Cohort 2's programme. This shows how practice evolves when there is a critical mass of pressure on a CE Team's agenda. Nevertheless Mia remained firm about the position of the CE Team on

delaying the teaching of intravenous (IV) drugs: *"We want you to be safe, look after patients and stay with us"* and instead reiterated what Preceptorship would do in terms of building other skills first. This was an important moment in the programme. When Preceptee and CE Team agendas clashed, the Preceptees were positioned as being potentially unsafe by the CE Team discourse.

The above examples show the different drivers behind CE Team and Preceptee agendas. The CE Teams' agenda appeared to be influenced by wider organisational concerns of quality control (including safety) and the need to standardise practice. Conversely, the Preceptee agenda for learning was driven by pressures arising from the immediate needs of their wards and from themselves as a form of professional peer pressure. Extended skills, e.g. giving IV's, was believed to be an important part of the professional role of a qualified nurse. The examples suggest that in order to deliver an organisational agenda, a CE Team may have to circumvent pressures on the Preceptees by managing their expectations about what Preceptorship would offer. This shows how early 'professional becoming' can be a site for conflict as professional responsibility is defined and redefined by different groups. Differences existed not only between the CE Team and Preceptees but between and within learning cohorts. The next section describes how learning cohorts were created and sustained throughout the programme.

## Creating learning cohorts

During observations I noticed how Preceptees were encouraged to develop a sense of shared learning need. This may have been because they were a diverse group of learners who had varying student experiences and faced different work-life balance challenges during their 'becoming'. Initial observations and group interviews revealed their diversity. For example, the Preceptees varied in age, ranging from their twenties to fifties, and were predominantly female (the second cohort included two male nurses). Preceptees were mainly of Caucasian origin though there were ethnic minorities in each cohort. For example, Navneet had qualified in India the previous year and was asked to join the Preceptorship programme due to perceived differences between Indian and UK nursing practice. Navneet was not obliged to participate in Preceptorship, and indeed, she stopped attending halfway through the cohort which could indicate either that she experienced aspects of the programme as irrelevant or because it was not compulsory for the ward to send her. Preceptees were also not all members of the local community (due to lack of positions at Burydale) and needed to travel longer distances to Runnysea. As such, during the early group interviews Preceptees experienced a range of family circumstances and work-life balance issues. For example, a Preceptee with young children noted:

> *"I feel guilty for my patients that I can't give them the best care and guilty for my family. I don't spend time with my family and I am tired, and yes, it's a pain".*

Another Preceptee stated:

> "*It feels slightly different to when I was a student, and obviously I've got a little boy at home, I was working part time… I just feel like I haven't got enough time now."*

I later witnessed the difficulty Preceptees with young children had in achieving work-life balance on the ward one day when a Preceptee on a general medical ward asked the junior sister if she could change her shift to see her son in a school play. The sister declined her request and later told me that she thought this was a cheeky request and that newly qualified nurses "take the piss". It was clear that the Preceptee had expectations that her new role would be more family friendly than it was in reality.

On the other hand, being older was also considered to be problematic, as a Preceptee, Margaret explained during an early group interview:

> "*Part of my problem is because I'm older, people assume that because I've got these epaulets on that I've been a nurse a long time…and I've had them come to me and ask me something and I've been like a startled rabbit."*

In addition to their different demographics, Preceptees also had diverse early ward experiences in terms of supernumerary time. This appeared to affect individual confidence levels. These were described in the early group

interviews. For example, some Preceptees stated they felt established on the ward, e.g. *"I think I've settled in terms of the basic routine of the day"*. However, other Preceptees talked about being 'thrown in at the deep end': "*It was nerve racking, really nerve racking; I had a couple of days where I broke down in tears*". In an extreme example, a Preceptee spoke about 14 patients she cared for on her first day:

> *"It was on a night shift and there was me and one other qualified nurse and so we had 14 patients each and I honestly hands down did not know what any of these procedures they'd had done were."*

This appears to demonstrate surprise and a negative emotional response when Preceptees were given early responsibility, further complicated by working in an unfamiliar setting. The Preceptees felt let down when placed in such circumstances, and these experiences set them apart from Preceptees who were settling in well on familiar wards. It is noteworthy that Preceptees were aware of such differences during their first study day. Donna described this to the group:

> *"I think today, I don't know about everyone else while we sat talking, we were all different, weren't we? ...and it felt like a million miles away since we'd all been sat there, I felt like we'd all changed. I felt like we were all really different."*

The above examples again show the degree and sense of diversity amongst Preceptees. This indicates a goal of professional socialisation and induction is typically to align new comers or novices with the shared practices, customs and identities of the wider collective or community. To some extent this involves accepting certain differences, but in others it can involve seeking to make members more homogenous. For the Preceptorship programme, the extent of differences between the newly-qualified nurses was significant because they had designed a pedagogic, structured style of teaching in the classroom using a 'one size fits all' approach. At the same time, the CE Team had little control over what could be a more tailored approach on the wards, and were constrained by a lack of available Preceptors and a lack of 'buy-in' from managers as discussed in the previous chapter. The next section shows how the programme tried to resolve these tensions.

*Dealing with diversity: aligning Preceptees*

The Preceptorship programme appeared to manage diversity by trying to align the Preceptees' interests and identities. This appeared to happen in three ways, through formal teaching, class rules and homogenisation.

The first way Preceptees were aligned was through styles of teaching. Some parts of study days required active participation, for example the clinical skills sessions were entirely practical and were evaluated as the most popular session by Preceptees, despite concerns about transferability. This was noted on an evaluation form:

*"I enjoyed the clinical skills day but don't feel I transferred it into practice due to [lack of] support and opportunity".*

However much of the programme was delivered using a formal teaching approach, aided by the traditional layout of the main lecture theatre, e.g. rows of chairs facing the projector screen and lectern. There was nothing in the practices of the Preceptees to suggest that this formal mode of delivering Preceptorship was unfamiliar. Indeed, Preceptees had used these rooms for lectures during their previous education. There was occasional group work, e.g. during parts of Acute Illness Management (AIM) and Medicines Management. However, the majority of the days followed the same pattern whereby speakers would give lectures using PowerPoint presentations from the front of the room. I noticed how the Preceptees were given minimal opportunities to participate and would not often attempt to ask questions. As noted, Mia would ask Preceptees to be quiet if they began chatting because of limited time to discuss matters on the agenda.

Towards the end of the programme, Peter of the CE Team reflected on its' pedagogic design. As he revealed:

*"I think we still have big issues with people [sic] that haven't been educated on how to teach or to deliver lectures doing what they think is the right thing, coming and delivering PowerPoint*

*presentations, reading the slides and thinking they have taught a class and actually whilst some people, why some of the Preceptees might enjoy that, for me I think that it's really limiting on the way that they learn."*

Peter talked about the need to design a studio workshop as a more successful and technological learning environment. Peters' quote shows that although ideas for transforming the pedagogic teaching were present in the team, there was no attempt to implement serious change. This could have been indicative of the early iteration of the programme and how accommodating the immediate needs of the Trust constrained the style of programme delivery.

The formality of the classroom was significant in setting the scene for Preceptorship. Historical influences from former education appeared to pre-dispose the Preceptees to sit quietly and listen. Formal teaching appeared to be what Preceptees expected from a post-qualification training programme as they had not experienced any other form of education style and as noted in the first group interviews, most described feeling like students again and could not yet speak with authority. This shows how following the usual social conventions of the classroom are enduring practices which can reinforce the pedagogical relationship with speakers and disempowers the Preceptees. This was important because limited participation further emphasised the specific focus of the curriculum which, as noted in the previous chapter, was orientated towards Oldshire issues of quality and safety.

A second way that Preceptees were aligned was through the use of rules which positioned the Preceptees as a body of learners. For example, an unwritten rule became to not interrupt the flow of the day by raising issues divergent from the lesson plan. This was demonstrated when Mia asked Preceptees to 'Shhh' when they began chatting about other aspects of work or private life. This restricted participation was also evident when Preceptees undertook a group exercise during a Medicines Management study day. When they were due to feedback to the whole cohort, instead of allowing this, the pharmacist moved on to the next item on his lesson plan. When I asked Mia about this during an ethnographic conversation she explained "*He forgot to listen, he's done this before*". I do not suggest that these were deliberate tactics, but rather, this demonstrates that educators felt tied to a formal agenda and were seemingly unable to create a more flexible approach that allowed for increased learner participation.

A second classroom rule was no eating and drinking. During later study days I observed how the CE team would quickly point out if anyone broke this rule even to the point of admonishing Preceptees who were drinking plain water. Mia explained this was not her rule but that of a 'fiery' administrator who the CE Team was afraid of upsetting. Mia explained to the group that she had once been verbally disciplined about this by the administrator in front of previous Preceptees, which had nearly made her cry. Her telling this story is also an example of *pathos*, a component of rhetoric, in which storytelling and passion were used to appeal to Preceptees' emotions in order to gain their compliance (Edwards and Nicholl, 2006).

A third example of aligning Preceptees was through what I call 'emotive talk', a form of managing identity. For example, on the first study day Mia emphasised the emotional support that would be gained from undergoing the programme e.g. when the programme was justified as a type of 'pastoral tool' (as quoted earlier). She further reinforced this by telling an emotive story about how she had cried on her first shift as a newly-qualified nurse. She reminded the Preceptees that "*you all have each other*". This showed insight into working at the Trust that was not always apparent in the classroom. It may also show a lack of confidence in being able to buy-in support for a fairly new and experimental process and therefore felt the need to play on the pastoral aspect which was more apparent. The style of talk used by Mia to appeal to the Preceptees' emotions secured their attention as they were looking for support during this difficult early period of 'professional becoming'.

In another example of such 'emotive talk', the Preceptees were told by the pharmacist on a Medicines Management day, *"You're our hope"* and *"imagine if you make a mistake and the Care Quality Commission gets involved"*. The pharmacist continued by telling a story about a patient's death from a medicine error (again another example of *pathos*; Edwards and Nicholl, 2006). This emotive talk appeared to serve to align the interests of Preceptees in meeting Trust needs to improve safety. These highly emotive words and stories are similar to "emotion talk" (Holland and Leander, 2004:128; Satterfield, 2007) which is a way to shape moral identity and socially position people as a form of liberation from oppression. Emotive talk was used to drive home messages

to Preceptees and positioned them as unknowing and even unsafe, which could be seen as shaping identity to encourage them to form a community of practice and align their interests.

The above examples of formal teaching, class rules and emotive talk have shown how the early delivery of programme encouraged Preceptees to be attentive to the Trust agenda and created a sense of belonging and need. The approach served to encourage the group to adopt a standardised identity of Preceptee and comply with the Trust's expectations of them, yet this prevented them from openly sharing experiences which could have made a valuable contribution to the Preceptorship programme. This might also have shaped the agenda to meet the learning priorities of Preceptees. The following section studies the different learning styles that were promoted throughout the programme, beginning with documentation. I then move to the issue of learning through reflection.

## Learning styles

The Preceptorship programme continued with a series of sessions such as medicines management, AIM, patient safety and dignity and clinical skills. The training was delivered in part by e-learning which was always done in my absence because Preceptees often achieved this on night duty when they had better access to computers. However, learning ward-based competencies was structured by the Portfolio of which reflective practice was seen as an important mode of learning to be documented. The following section explores

the importance of documentation for different groups (e.g. CE Team and Preceptees).

*Importance of documentation*

Documenting Preceptorship appeared to be an important priority for the CE Team and Trust, but was less so for the Preceptees. As previously noted, many Preceptees resisted completing the Portfolio and were mindful of competing processes. They were concerned about time to complete the Portfolio, e.g. during a group interview in the middle stage of the programme, Kim, a Preceptee from CDU, *"It's just not practical"*; "*And then they expect you to write more. I'll be doing in my sleep".* These comments show how work-life balance conflicted with the way in which the CE Team chose to communicate and assess professional learning. The resistance was also related to Preceptees desire to move from a peripheral position on the ward team, as one suggested:

> *"I think it's even more paperwork. We've been doing it for the last three years, and now they want us to do more, it just takes more [time], and when are you going to get that time on the ward?"*

Documenting the Portfolio was associated with pre-qualification education. As a Preceptee stated early in the programme, *"It's like being a student again".* This is interesting because, as noted, it appears Preceptees needed to be persuaded that documenting practice was a professional activity. This shows

that Trusts that structure Preceptorship with organisational Portfolios need to do more to persuade Preceptees of its professional value.

Some Preceptees were more easily persuaded and considered the Portfolio as a mode of engagement for Preceptors that had a more focused approach to specialist learning. Hannah, a Preceptee on CCU also remarked during an early group interview:

> *" thought at the end, that's it but then I was speaking to a Preceptor and she was really keen to help everyone with this learning and everything, it will make me learn about cardiac conditions, whereas I wouldn't have to if I didn't do the Preceptor bit."*

Another Preceptee appreciated the enduring nature of the Portfolio to capture practice:

> *"[It's] obviously a Portfolio but it's like a catalogue of stuff that you've got and you don't want to lose".*

However, as noted, competing time pressures from ward induction packs (ward specific written work) appeared to be one of the most problematic aspects of using the Portfolio. Mia was aware of the situation, as she highlighted in the case of theatres:

*"…they have a massive theatre pack that they have to work their way through and it covers…absolutely everything and so the girls from theatre are saying to me "I don't want to have to do that", and I'm saying "Well don't then" but somehow the evidence you need for your Preceptorship Portfolio just needs to be slotted into the ward one."*

The above quote reflects the tensions when trying to meet local and professional requirements to codify new learning. During an interview towards the end of the programme Mia revealed the pressure she felt to deliver to the Trust:

*"It's very stressful…what I am trying to get them to do is do a Portfolio that will benefit them, get them through all of the things the Trust want because you have to jump through hoops for the Trust, but it means they can learn something as well and develop, it isn't just a millstone around their necks."*

Mia's statement acknowledges Trust pressures on using the Portfolio (which appeared to be greater than wider professional pressures) but also shows her frustration with what she understood was an unprofessional attitude of Preceptees. Mia often spoke about Trust pressures during ethnographic conversations in her office at Runnysea and once described a CE team meeting where Trust failings were discussed. She would also refer to emails from management although she was unwilling to let me see them directly as she was

worried about their sensitive nature and so my data is not supported by further evidence on this matter. This demonstrates the blurring of professionalism and organisational pressures when trying to structure the 'becoming' of newly-qualified nurses during Preceptorship.

The above examples show that despite the barriers to and resistance in using the Portfolio, it was seen as a logical tool by the CE Team that could codify standardised knowledge and competencies influenced by the profession that were also tailored to organisational needs. Competencies in this respect were seen as rational and easily defined, an 'entity approach' critiqued by authors suggest competency is a practical achievement and highly interpretive (Sandberg and Pinnington, 2009). This 'entity approach' appears to be consistent with the tendency of organisations to promote a bureaucratic form of learning via HRM or professional development systems, particularly in the current climate of quality and safety concerns (Currie *et al.*, 2008). Although Preceptees completed Portfolios during studentship, once they were in the workplace with professional responsibilities and experiencing additional pressure from HRM they were reluctant to complete another one. However, this appeared to be viewed by the CE Team as lack of cooperation.

The practices of completing a Portfolio showed that an important aspect was its' 'signing off'. The Portfolio was also a record that documented a nurse as being competent. Preceptees began to realise that ward leaders would expect it to be completed and 'signed off' before they could be awarded the next pay scale. As such, the connection of the Portfolio to performance management

systems leads to the possibility that the Portfolio could become a potential site for surveillance, rather like the disciplinary power of Bentham's Panoptican (Semple, 1993). The Panoptican is a type of prison, circular in shape, that showed that the design of surveillance could be hidden so that detainees never know when they were being watched and thus 'obedience' was gained by authorities (Clegg *et al.*, 2006). The Preceptees were thus under constant pressure to perform as their competencies would be need to be signed off by a more senior nurse. The Portfolio was therefore an important route to compliance with Trust priorities.

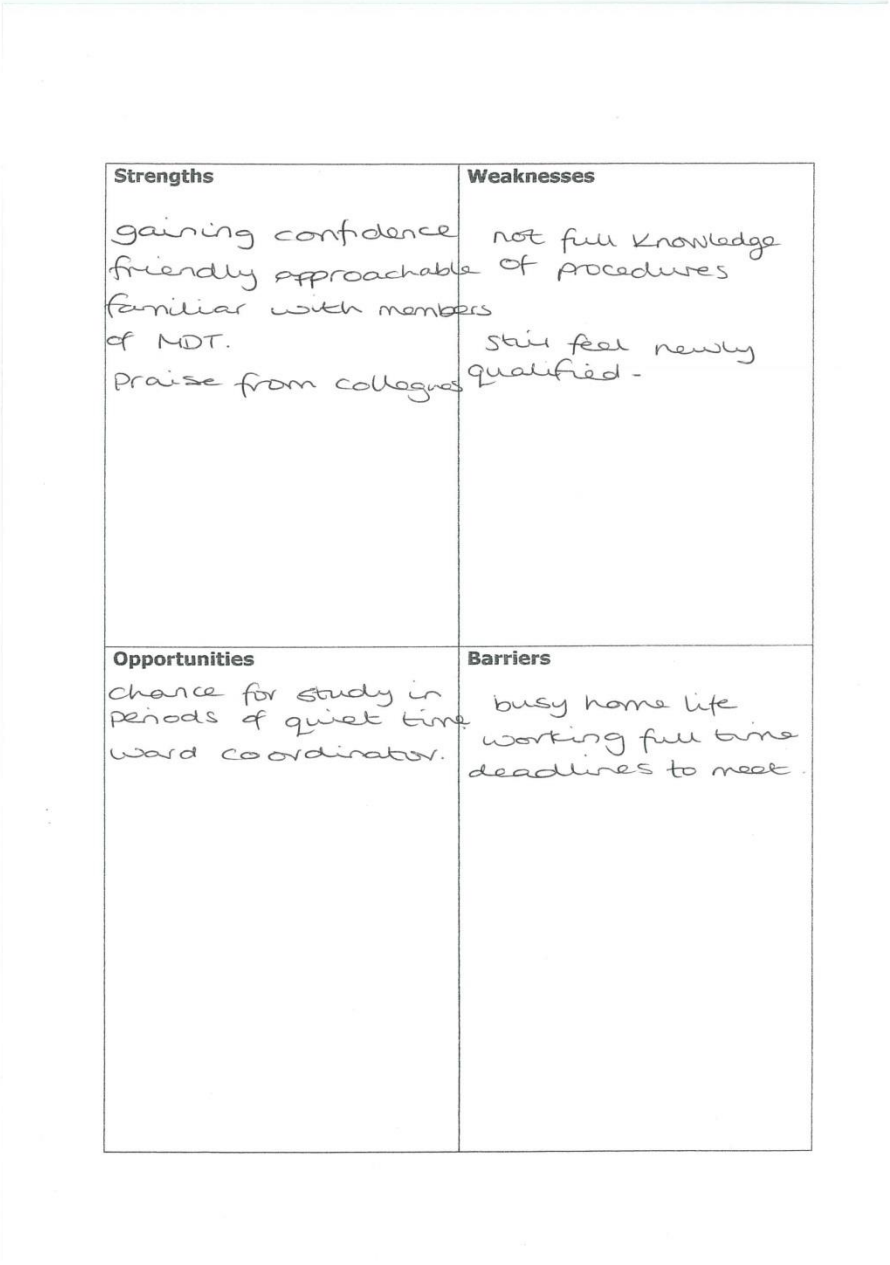
While the Trust exerted power and influence over the Preceptees' obligation to complete the Portfolio by linking it to performance management, another feature of the Portfolio was capturing Preceptees reflections. The following section focuses on the importance of reflection in this process.

*The importance of reflection*

Reflective practice was seen as an important aspect of the Preceptorship programme as a method of work-based learning. The programme offered Preceptees different routes to evidence their competencies through reflective practice such as reflective writing and monthly Strengths, Weaknesses, Opportunities and Barriers (SWOB)[3] exercises. An example of a typical Portfolio SWOB is shown on the following page:

[3] SWOB is often used as a tool for reflective practice

Figure 2 SWOB Exercise



| Strengths | Weaknesses |
| --- | --- |
| gaining confidence<br>friendly approachable<br>familiar with members of MDT.<br>Praise from colleagues | not full knowledge of procedures<br>Still feel newly qualified - |
| **Opportunities** | **Barriers** |
| chance for study in periods of quiet time.<br>ward coordinator. | busy home life<br>working full time<br>deadlines to meet. |

The above image is interesting because this suggests that the Preceptees saw the ward co-ordinator (rather than a Preceptor) as a learning resource. It is also noteworthy because it is very brief and therefore one could argue, perfunctory. Although the CE Team did not express any concerns about reflective practice, a lecturer who helped design the programme stated:

*"They should be reflecting in practice, but then afterwards they sort of go, 'I've got that action plan to fill in'...and maybe they don't always reflect afterwards."*

By week 5 Mia identified the need for her to expedite the Portfolio-filling process, explaining the problem to me during an interview:

*"I have seen fantastic Portfolios and I've seen some really crappy ones as well. It just depends. It depends what's expected of them in their ward area, how much support they get... whether anyone's interested... If nobody's going to look at it, why would you bother?"*

The completion of the Portfolio was thus seen to be highly contextualised i.e. enacted on the wards and out of the practice reach of the CE team.

In addition to time pressures and lack of ward interest, another reason for not completing the Portfolio were difficulties engaging in post-activity reflective practice. This was mentioned by the Preceptees during group interviews and to Mia during individual consultations. For example, in a group interview at the end of the programme, a Preceptee explained the difficulty, even when using frameworks,

*"It's absolutely fine and all lovely when you say it, yes, you're going to do this and it'll help you reflect on it, but to be quite honest, when I finish my shift, I want to go home, have a cup of tea, watch the telly and go to bed."*

In a personal consultation, Kerry explained to Mia that she still needed to master reflective writing in order to make further progress:

*Kerry: "It's just like banging my head against a brick wall because I've done it all before, I know how to reflect."*
*Mia: "But you need to write it down."*
*Kerry: "I know I do but I just find that I reflect anyway, when I go home I reflect…"*

Kerry was suggesting that she reflected during practice and reflecting later was difficult to write down in words, similar to the argument made by Schon (1983) and described in Chapter 2. I return to this consultation in Vignette 3.

The reflective pieces of writing that I observed during these meetings (and sometimes on the ward) were often prescriptive and lacked conceptual debate and critical thinking. Rather, they would be descriptive accounts that detailed the basic activity that the Preceptee undertook. This can be seen in a piece of a Preceptees' reflective writing about nutrition:

*"For any patients who have allergies to food…these would be identified on admission by going through the initial assessment. If any specific requirements are identified I ensure the patient is aware of the alternative menu."*

Another Preceptee had only brought notes on a scrap of paper from which she would have to use as a basis for evidence to complete parts of her portfolio. Although I was unable to see her completed portfolio, it is likely that the lack of depth in her notes would have been problematic for post-hoc deep reflective writing. Preceptees and Preceptors admitted that these (often brief) accounts were not always read properly before being signed off by Preceptors although this varied depending on Preceptee and ward context. I expand upon this in the following chapter when I discuss this in the light of ward observations of Portfolio activity.

The above examples offer a critique of reflective practice as a taken-for-granted mode of work-place learning that has been long questioned by authors who argue that such an approach to learning is "reflection as recipe". That is to say it is an approach to learning driven by managerialism demands for evidence that tries to capture and codify professionalism as individual traits (Bradbury et al. 2010:3). In the context of Preceptorship this is significant because reflective activity centres on the Portfolio which is heavily influenced by the organisation and as such, is more difficult for Preceptees to 'own'. Reflective practice thus moves from a personal process of individual

development to an organisational procedure and the certification of competencies for the services of management to monitor professional performance. The following section continues to describe the Preceptee journey, focusing on the middle and later parts of the programme.

## 'Learning the ropes'

In this section I draw out two main themes which emerged from my observations; promoting organisational priorities and constructing safety before I end with examples of peer support.

*Promoting Organisational priorities*

Throughout the study days, I noticed how different educators continued to attempt to align the Preceptees with the Trusts agenda through their practices in the classroom. For example, on an AIM study day, the trainer, Gary, began the session by stating that "*Newly-qualified nurses who have qualified in the last 15 years are not doing their observations properly*". When Gary asked a Preceptee to demonstrate doing a blood pressure to the group, he stopped her doing it just after she began. This appeared to be because he anticipated that she was about to perform it correctly and he wanted her to do it incorrectly so that he could demonstrate this incorrect technique to the group. Hence, Gary picked another Preceptee who he hoped would demonstrate the 'wrong way' of doing it. Soon after she started, he asked the Preceptees if they "*all agreed that none of you can do blood pressure properly*". The Preceptees nodded hesitantly and Gary stated he would report the poor skills of newly-qualified nurses to the Trust. This may show that Gary came into the classroom with the intent to

align newly-qualified nurses to the Trust agenda and take action if they did not display the right skill. This may have been to protect himself in times of uncertainty. When I interviewed Gary later however, he revealed his doubts about his approach to teaching Preceptees:

> *"I think the backlash from litigation and complaints and reports that have come out about the lack of patient care, which have highlighted particular issues with nursing staff and lack of training that have forced the agenda. But I do feel that the organisation will use that and tick the boxes and say yes, we are meeting the national agenda…..so if the proverbial does hit the fan, we can turn round and say 'Well we've done our bit and it's down to the individual- they were a bad penny".*

This above quote shows that although Gary had concerns, he acknowledged the pressure from the Trust to include particular agenda items on the programme and saw this as an example of 'box-ticking'. This ignoring of individual skills and experience shows a standardised approach in which newly-qualified nurses were positioned as 'unsafe'. Therefore this encourages the Preceptees' alignment with the Trust by worrying them with professional and legal issues. This also demonstrated the managerial approach to competencies described earlier.

A second example of promoting organisational priorities was seen during a study day on safety and dignity. Brian, Oldshire's head of safety and quality

talked to Preceptees about system errors, showing them a video that reconstructed a fatal incident in an operating theatre. He discussed issues of poor culture and the problem of *"The way we do things around here"*. When he also spoke about medication errors, the nurses appeared horrified and told him how they always worked 'by the book'. This was interesting because Brian later told me in an interview that he did not have any immediate concerns about the Preceptees (unlike Gary):

> *"I don't think I have enough evidence you know to comment on newly-qualified nurses as a defined group. I've got evidence that is very useful to you about performance of the nursing teams, not particular wards but I can't separate out newly-qualified nurses."*

Rather, Brian told me he understood the safety problem at the Trust to be cultural, which was leading to systems failures in areas such as recruitment, hierarchies within the professional groups, and a lack of non-technical and 'softer' skills.

A final example of Preceptorship promoting organisational priorities was seen during a session on patient dignity, when Kevin, a Trust Dignity nurse, used an hour long PowerPoint Presentation to discuss dignity in the context of Oldshire. During his presentation, Kevin tried to use black humour. Observing the Preceptees facial expressions; I inferred most did not find it funny. At one point Kevin asked how many of them thought they were a 'can do' sort of person. After most nodded, Kevin joked sarcastically, *"Well I'll give you 5*

*years…"*. I overheard Preceptees whispering their annoyance about this comment.

During the second half of the session the Preceptees were asked to wear pink hospital gowns to help them to 'experience' being a frail patient. Although some of the Preceptees were giggling, others appeared annoyed at having to do this. Nonetheless, they all put on pink gowns and Kevin told them stories about safeguarding incidents. I also heard other mutterings during the session, e.g. "*why do we have to do this for the second time*?" (It later emerged in a conversation I had with Preceptees that the session on dignity was repeated directly from an earlier nursing education module). When Kevin left, the Preceptees indignantly discussed a joke he had made, it was felt that it was in bad taste. Adele, who worked on the SCBU was annoyed by the content of the session and later told me *"I feel like reporting him"* (for telling the joke). This incident shows how the session on dignity paradoxically caused indignity amongst Preceptees who felt positioned as students and did not consider that Kevin behaved professionally. The content of the session related to an issue (dignity) the CQC had identified as being a problem in the Trust. However the Preceptees felt strongly that they did not have any problems with maintaining dignity. Nonetheless, nothing was said directly to Kevin by Preceptees which demonstrates the power relationship between educator and learner in the formal classroom setting.

The above examples indicate how, in times of turbulence at the Trust, guest educators felt under pressure to deliver training on topics that had been

highlighted by the Trust and CQC reports despite there being no evidence to show that newly-qualified nurses were the main source of these apparent problems.

*Re-constructing safety and quality*

Running parallel to the educators' agenda, Preceptees reconstructed their own versions of quality and safety. I give two examples of this. The first arose from the teaching of safe medicines management where, as I previously noted, it was stated by educators that Preceptees were unsafe. These concerns appeared to be partly accepted by Preceptees. For example, a very recently-qualified Preceptee admitted she had not done a medicines round for 15 months prior to qualifying, and another stated:

> *"My last drugs round would have been[some time ago], because my home base was actually outpatients, [my experience] is quite limited with regards to medicines management and things like that, but yes I should be checking and double checking, I think that is a responsibility in itself to make sure you are not making a mistake"*

Nevertheless, in later group interviews there were complaints about the session. Two group interview quotations from Preceptees show this:

> *Preceptee 1:"We had that pharmacy woman and man come and tell us about medicines management, but we'd all been doing it for seven months!"*

*Preceptee 2: "It was too late …"*

Preceptees also considered that not being able to do IV's created safety issues, rather than it being unsafe to learn to do them, as a Preceptee argued:

> *"It is really dangerous…Especially for me who can't do IV's at the moment. So this trained nurse is doing the medications and then the IV's, I'll go and help her mix them , or I'm doing the medications and have taken over from her whilst she does the IV's, it's just ridiculous".*

The second example I show arose from the AIM course. In group interviews Preceptees were quick to point out how they *"always work by the book"* and were heavily critical of many of the more experienced staff's practices on doing basic observations. As three Preceptees noted:

> *Preceptee 1: "Even though they have had all the teaching, they are still not doing it how it should be… if somebody's blood pressure is below 100 you've got to do a manual blood pressure"*

> *Preceptee 2: "But then it's like the nurse in charge… where they should be kicking arses"*

> *Preceptee 3"Yeah yeah they are starting to…"*

*Preceptee 2:"Because it's being picked up on audits now"*

The above conversation shows that the Preceptees appeared to be paying 'lip service' in their compliance with the CE Team's agenda. The Preceptees were aware of being positioned as unsafe, however claimed that they worked *"by the book" unlike some of the more* experienced ward members, as a Preceptee stated, *"I'm very thorough".* This shows that Preceptees had a strong sense of professional identity and placed a symbolic boundary between themselves and more senior staff who were regarded as 'the other'. As two Preceptees noted during an end of the programme group interview:

> *Preceptee 1: "I find in this hospital you're risking your registration…the hospital is a mess, it's a shambles and it doesn't seem to be getting any better".*
>
> *Preceptee 2: "It's going to take something really major. Some poor patient is going to die a horrific death or something because there wasn't [sic] enough staff".*

Preceptees therefore appeared to reconstruct safety in terms of their thoroughness and working 'by the book'. Further, on medicines management days, the Preceptees used the time to discuss and share aspects of practice that were not directly associated with the agenda for example where medicines should be stored and where forms should be kept. The medicine chart activity (where they had to spot deliberate mistakes) appeared to trigger discussions

around what was best practice and why practice might vary on different wards, in other words they were sharing knowledge based on practical experience rather than theoretical knowledge.

Throughout the programme, the group interviews I ran continued to be dominated by stories and discussions around customs and practices at Runnysea or Riverton hospitals, and particularly about safety issues Preceptees perceived were beyond their control. For example, at the end of the programme, a Preceptee told the group:

> *"The state this hospital was in, say my boyfriend got ill… and they were shoving people through beds and he got ill, I would get him in the care [centre] and I would take him to…. Or somewhere like that… I'm not saying the nurses are bad here. I don't think that their nursing is safe anymore. They have got so many jobs to do. Things get forgotten. I'll be the first to admit I forget to do things sometimes."*

This statement shows that even at the end of the Preceptorship period the Preceptees were aware of safety issues and did not identify with experienced nurses who they perceived as unsafe. This implies that Preceptees did not identify with typical local customs and practices, even if they appeared to be compliant at work. The impact of this issue is explored in the following chapter when I focus on ward practices.

Preceptees were specific about safety concerns, particularly about processes such as handover of patients and medicine rounds. For example, Sally and her colleagues noticed issues with the way that handover was conducted on a ward at Riverton and how care plans were completed. During a focus group Sally remarked:

> *"We all trained at Burydale and we've gone to other hospitals and there's a big difference. But if it's the same Trust then it should be the same policies [at each site] but there's a huge difference. And they are just not implementing… they aren't listening to our ideas and we've got the most up to date training. We could go in there and you'd think they would be grateful". (Sally described how she was told by a member of staff "Oh yeah but you're at Riverton now").*

It appeared to be the Preceptees who worked on large general wards who voiced the most concerns about local practices, prompting comparisons in the group interviews of their different levels of support. A Preceptee working on the Recovery unit noted "*Do you know what, listening to you lot, I'm so pleased I didn't go on a ward, so pleased*". Angela who worked on SCBU also agreed: "*I think that children's nursing and adult's nursing are like...Whoa, so far apart."*

During group interviews the Preceptees discussed how they tried to change practices. One nurse told how she was able to get a new dressing introduced.

Similarly by working together, three Preceptees on a surgical ward were able to change the handover procedure. However, this seemed to be less common; as many Preceptees felt powerless to change processes. Although they had ideas for improvement, on some wards it was apparent that those ideas were not always valued. During the final group interviews some Preceptees described how they had stopped suggesting change, as one Preceptee described, *"I just come to work for the money now"* and another stated, *"I don't think they would listen"*. This shows that there may be a critical period of time in which a Preceptorship programme could benefit from two way feedback, i.e. before Preceptees become disempowered by the context in which they worked. As previously noted, in order to be signed off from Preceptorship, Preceptees are required to complete the Portfolio. The final section of this chapter considers how the CE Team extended efforts to encourage Preceptees to do so, paying attention to tension between working on wards and classroom experience. This builds on what I have already discussed regarding the perceived lack of time to complete the Portfolio.

## Managing tensions between classroom and ward

In this section I show how tensions between classroom and ward working were managed by both the Preceptees and CE Team. This is important to note because the management of tensions appeared to resolve some of the difficulties which were encountered because of competing interests, time pressures and adhering to the structured programme. I also observed how managing these tensions allowed the programme to conclude to everyone's

mutual satisfaction. The first themes I discuss are peer support and how Preceptees made use of time away from the formal classroom setting in order to gain support. I then describe how the CE Team allocated time to listen to Preceptees, both in a special one-to-one Portfolio clinic and on the final study day.

*Peer support in the café and group interviews*

It became apparent that although the study days were important for peer support it was the time away from the formal classroom sessions that were particularly valuable for Preceptees. For example, the Preceptees would go to the Runnysea staff café for coffee and lunch. During this time they generally stayed in their friendship groups and their talk was rarely about what they had just been learning in the classroom. Sometimes the conversation centred on home life but they would often tell ward stories which shows how this informal time was used for peer support. For example, one day, in the third month of their Preceptorship programme, some of the Preceptees appeared quite down and unhappy and seemed unable to relate the programme to the wider nursing profession. As a Preceptee remarked, "*It's just a means to an end, as long as they keep paying me, I'll stay*". A Preceptee, Adele who worked on SCBU told the group a story about when she had recently had to take charge of a baby on Continuous Positive Airway Pressure (CPAP). The ward was short staffed due to the admission of a higher dependency baby. Adele told how she was "pushed" to take this baby by the nurse in charge. Adele was upset saying "*No-one would come in and relieve us, not even a ward sister. What kind of an*

*example is that*?". Story-telling in the café was therefore important to the Preceptees as a source of understanding each other's different experiences and the wider context. As a Preceptee from CCU told me during one coffee break, that the Preceptorship programme "*had not been any good*" due to the course content but said she did enjoy seeing the other Preceptees.

Shared stories were important during professional 'becoming' of the Preceptees because they afford them the opportunity to recreate Preceptorship on their own terms, in their own groups and without the bounded formality of the classroom. They are also important because they provide an opportunity for knowledge sharing and sense-making.

The second place that Preceptees found peer support was during the group interviews where they became aware of their diverse perspectives on becoming. For example, Preceptees who worked on specialised units such as the SCBU were generally happy with their job: *"I think I'm just a bit lucky where I work, because it's just really nice"* and *"I am lucky….because I do get support".* Yet Preceptees who worked on busy general wards felt disappointed as one described, *"I'm enjoying it…….I've been here 6 months but I don't think it's everything that I thought it would be".*

This shows how Oldshire's regulatory problems and short staffing impacted onto Preceptees sense of self and professionalism. It could be argued that the reflection of the Preceptees tended towards that of "comrades in adversity", a phenomenon noted when groups of NHS practitioners took part in group

reflection (Nicolini *et al.*, 2004:16). However, there was little doubt that the Preceptees, particularly those on large general wards were experiencing intense hardship. The data from these group interviews again revealed 'the elephant in the room' and showed that many issues remained unspoken in the formal classroom.

*Completing the Portfolio*

Tensions remained in the programme because completing the Portfolio continued to remain problematic for the reasons described throughout this chapter, e.g. lack of time and support from Preceptors. This was an issue that needed to be resolved so that Preceptees could pass through the aforementioned pay gateway and the CE Team could meet Trust requirements concerning programme delivery. Mia expressed her frustrations to the Preceptees on the fifth study day, telling them that they were professionals now and that working from home on their Portfolios was what would be expected throughout their new career. However, after sixth months, Mia realised that she would have to take urgent action to help the Preceptees complete the Portfolio on time and she cancelled the penultimate study day, replacing it with a 'drop-in' clinic so the Preceptees could discuss their Portfolios and receive guidance. The meetings were held in Mia's office, where I saw that many of the nurses had filled in very little of the Portfolio. The Preceptees, who had understood the benefits of the Portfolio and made a concerted attempt to complete it, still reported that they lacked the time needed to do so. The reasons they gave for this included, needing to concentrate on the ward developmental packs, that the

reflective framework was not fit for purpose, and that some had still not met their Preceptors and remained confused about what to do.

Preceptees also took the chance of the one-to-one meeting to bring up individual concerns about their practice. These concerns included issues such as not being able to perform electrocardiograms (ECG's) or take bloods from a patient. These concerns were also related to anxiety about appraisals and passing through the six month pay gateway to receive a salary increase which again shows the blurred boundary between Preceptorship and performance management. One Preceptee raised concerns about another Preceptee on the CDU, saying that people were starting to talk about her slow development. Mia briefly addressed these concerns and encouraged the Preceptees to be pro-active. However she focused on the completion of the Portfolio rather than these other concerns. An example of a consultation is shown in the short vignette below.

**Vignette 3: Kerry's consultation**

*In a consultation meeting a Preceptee Kerry, explained to Mia how she had just had an appraisal and that the ward Sister told her she had time management problems and had recently been unable to meet with her Preceptor. Kerry sat wringing her hands and told Mia how she was learning to improve the speed of her medicine rounds. The meeting became confessional as Kerry continued to behave in the meeting as if she was under scrutiny.*

*Mia steered the conversation to the Portfolio and the issue that Kerry had done very little of it. Kerry complained about the difficulty in reflecting and not having time with her Preceptor but conceded that she had no choice but to finish her Portfolio as soon as possible. She told Mia wanted to get it done and put it all behind her and move forwards.*

This short vignette was included because it typified many of the consultation meetings that I observed where the emphasis was on completing the portfolio and this n codified knowledge rather than addressing the actual concerns of the Preceptees that centred on fitting in to ward routines and how to access knowledge in the absence of Preceptors. The episode described above is interesting because although Kerry explained to Mia that she did not get any time with her Preceptor, this issue was side-tracked in preference for focus on the Portfolio as completion was the central issue for the CE Team. This was evident during other consultations. For example, as Alison explained to Mia:

> *Alison: "It's not that I'm worried I can't do it, it's just when you have done a 10 day stretch you're knackered, it's the last thing you want to do on your day off"*
> *Mia: [silent, is writing]*
> *Alison: "but yeah I'm going to go to the computer today because we've got this day to do some"*
> *Mia: [silent, is writing]*

This short vignette was included because it typified many of the consultation meetings that I observed where the emphasis was on completing the portfolio and codified knowledge rather than addressing the actual concerns of the Preceptees that centred on fitting in to ward routines and how to access knowledge in the absence of Preceptors. The episode described above is interesting because although Kerry explained to Mia that she did not get any time with her Preceptor, this issue was side-tracked in preference for focus on the Portfolio as completion was the central issue for the CE Team.

The vignette is also important because it includes data that shows 'silence'. Mia's silence may have reflected how powerless she was to change this situation, but this also demonstrates the strategies that educators have to use when faced with 'wicked' problems. In this situation, Mia cannot solve the problem and silence is her only option, similar to research that argues that silence is a strategy to deal with complexity used by contemporary leaders (Grint, 2010). The following theme shows how, once they were satisfied that the Portfolios were being completed there was an opportunity to build in some flexibility on the programme content.

*The end of the programme: reflecting on practice*

On the last day of the programme, Mia decided to include a session that was not previously time-tabled to encourage Preceptees to reflect on ward practices and formulate an innovative idea to make an improvement. This task was unsupported by any learning frameworks or tools and it appeared to be difficult

for the Preceptees to think of an innovation when placed ‘on the spot’. For example, one group articulated the idea of trying to have the names of staff on duty placed on the patients’ TV screens so they knew who was looking after them that day. Another group had an idea of promoting a new type of dressing which a Preceptee had recently managed to introduce on her ward.

This was the first time that the Preceptees had been able to express their ideas within a specific timeframe scheduled on the programme. However, ideas such as the TV screen did not appear to build on the tensions and discussions for change that had taken place during reflection in group interviews when ideas were not as ‘forced’. For example in a focus group discussions of poor practice prompted a Preceptee to suggest:

> *“[There are] Two trained [nurses] and one healthcare right? One trained [nurse] goes round and does medication for all 28 patients and does the IV’s. And the other trained helps the healthcare bed down everybody which I think you should have two and two, split the ward, two lots of medication and one lot of settling. And when you’ve done your medication four of you together do the settling.”*

The formal generation of ideas may have been difficult to accomplish without improvement methods that would have helped them understand their context (Roe *et al.*, 2014). It appeared that again, many of the concerns of Preceptees

were discussed outside of the classroom and opportunities were missed that might have helped them improve care.

On the final day, the Preceptees were formally asked to evaluate the programme including what a Preceptorship programme should include. In articulating their feedback on evaluation forms overwhelmingly the Preceptees mentioned enjoying the clinical skills session. However, the limitations of learning them in a classroom were noted. As a Preceptee wrote:

> *"I feel that the practice on cannulation and venepuncture and pumps was very useful but I have not started my cannulation or venepuncture in practice and I feel it would be more beneficial if I had started my packs."*

The limitation of the classroom learning experienced was also noted when another Preceptee suggested that she wanted *"more practical sessions [relevant to individual settings] and more setting specific days"*. The feedback also included the point that the components of the course were not always relevant, especially for children nurses. The talks on safety were hardly mentioned other than in oblique comments such as: "*some of the sessions were a little dragged out, particularly where we had guest speakers*".

Two major themes that did arise from the feedback were peer support and time. Peer support was seen as very important, for example being with other Preceptees who they could seek advice from. Interestingly, some Preceptees wrote that my group interviews were beneficial in this respect, which reflects the lack of time Preceptees had to have such conversations in their otherwise busy schedules. This is interesting because although Preceptees had different developmental needs, emotional support and clinical skills appeared to be where their interests had aligned. The second theme arising from feedback was time, and the need to allow space in the programme for writing in the Portfolio, going through scenarios and for advice on how to overcome issues of safety on their wards.

## Conclusion

The beginning of this chapter showed how Preceptorship was introduced and promoted to Preceptees and the strategies though which the CE Team attempted to gain fidelity to the taught aspect of the programme. There appeared to be a strong need to persuade the Preceptees of the value of the Portfolio. Tensions were evident in the work of promoting the programme which revealed the way the profession and organisation were invoked during this time. The heavy 'selling' of the programme could have indicated a lack of confidence by the CE Team because the programme was still relatively new. However, I also showed that the taught aspect of Preceptorship was not automatically 'bought into' by Preceptees because they may not have grasped

the significance of Preceptorship during education and also saw the programme as removed from the realities of ward work.

The issues Preceptees described in group interviews and café conversations were 'the elephant in the room' and were not discussed during the formal part of the programme. Nevertheless they were significant because they showed pressures on their 'professional becoming' and gave clues to the need to navigate these tensions on the ward.

Preceptees' expectations were managed in the light of these pressures from the Trust (e.g. quality control), the ward (e.g. competing time pressures), themselves (e.g. diverse needs) and wider pressures (e.g. professional expectations). This highlights how professional development is a site for conflicting expectations. I showed how learning cohorts were created by the CE Team through trying to align interests and there were different learning styles evident in the programme. The Preceptees 'learned the ropes' in the classroom amidst the promotion of organisational priorities and in doing so, reconstructed the safety agenda.

I have thus explored 'professional becoming' of newly-qualified nurses during Preceptorship in the classroom by focusing on four dimensions of practice; people, place, time and materials. The people involved were the CE Team, other special guest educators and Preceptees. I described the places of Preceptorship, which were chiefly the formal classroom but also the café and the CE office. I explored the temporal pressures facing Preceptees based on

conversations in group interviews. These were time limitations on the wards, not accessing Preceptors, difficulty in completing the Portfolios which included the CE Team's expectations that Preceptees would complete the Portfolio on time. Finally, I introduced the material dimension through highlighting the significance of the Portfolio (the physical representation of Preceptorship) in shaping the programme. Ultimately, the educators focused their attention and teaching practices towards a 'tick-box' and verifiable type of Programme. Preceptees' attention was therefore directed towards being signed off rather than always a genuine form of learning.

The data suggests that a major theme was how Preceptees were positioned in the social order. Throughout the study days, the Preceptees were positioned as new and unsafe. This, along with the perceptions of public judgement on the profession, acted as powerful sources of identification. This is apparent both in classroom practices and in the completion of the material representation of Preceptorship (the Portfolio), which originated from Trust concerns about quality and safety. This data also revealed a range of Preceptee issues around safety and quality in everyday work that became 'the elephant in the room'. Preceptees only partially accepted being seen as unsafe because they believed that they worked 'by the book', but on the surface they appeared to accept the view seen in Trust discourse. The Preceptees were powerless because they needed to have their Preceptorship period 'signed off' in order to become a legitimate member of the community. However, interestingly, data from group interviews and ethnographic conversations shows that they appeared to create an alternative mode of Preceptorship in practice that was unseen by educators.

This centred on reconstructing safety and quality and was also a mode of peer support and a way to work towards their desired professional identity.

I have shown how the style of delivery of the programme continued as a pedagogic teaching, similar to further education. Analogous to Gherardi and Perrotta's (2010) concept of socialisation as 'induction and seduction' that I discussed in Chapter 2, the programme showed less professional seduction and more organisational induction. 'Professional becoming' was mediated by the discursive practices of Preceptorship, which appeared to be induction processes attached to local concerns. Preceptorship also appears to be an example of what Vince (2002:222) names "the politics of imagined stability" whereby the organisation is presented to Preceptees as a coherent stable entity in order to reinforce emotional responses to effect change. Through the vehicle of Preceptorship, the Trust thus attempts to maintain coherence in current unstable political and economic times of the NHS. The above issues are important because Preceptees encounter different challenges during their professional 'becoming' and, as I show in the following chapter, may have to submit to these new ways of working in order to become a legitimate member of the ward.

# Chapter 7

## Introduction

In the previous chapter I studied how newly-qualified nurses interacted with the formal Preceptorship curriculum in the classroom. In this chapter I show the Preceptees' journey as they negotiated learning in every-day ward practice through interaction with other actors and 'tools of the trade'. It therefore contrasts the prescribed learning of Preceptees with their learning experiences on the wards to provide a rich understanding of "professional becoming". In particular I explore the relational practices of Preceptees with Preceptors but also include Preceptees' interactions with ward staff such as doctors, Health Care Assistants (HCA's), and with each other. Through examining these practices, I explore how Preceptees negotiate learning amidst personal needs, ward requirements and Preceptorship programme priorities. The chapter therefore builds on an earlier discussion of how organisational and professional knowledge is acquired through formal Preceptorship activity and focusing on the importance of everyday interactions. Again, I present these empirical findings using vignettes to introduce themes which arose on the Preceptorship journey. I note when practices were evident throughout or where they changed over time. I also show moments when Preceptees were positioned on the periphery of the ward community ('positioning episodes'). I begin with a vignette that summarises Clara's shift at Runnysea hospital.

## Navigating Uncertainty

### Vignette 4: The Stupid Game

*Clara was allocated eight patients (though often allocated twelve) and was hard to observe as she rushed around. The ward appeared busy and buzzers and phones were constantly ringing. I noted that Clara only sat down once to make a phone call. Although she was supported by an HCA, they did not interact frequently. The HCA completed tasks such as bed making and washing whilst Clara undertook work such as dressings, medicine rounds, admissions and discharges.*

*It was apparent that Clara, a newcomer to Runnysea hospital, was still getting used to the ward layout. For example, she often came out of a bay and turned the wrong way. Clara said "I still don't know which way to go" and explained the reason was 'old habits' as the hand scrubs were located on the opposite side of the bay than Burydale. Disorientation was also apparent when I accompanied Clara to the pharmacy and we became lost, which made the collection more stressful for Clara.*

*Clara undertook a medicine round but was often interrupted, e.g. by a bed manager and doctors, despite this being against hospital policy. Clara grumbled "I'm always in the wrong place at the wrong time". During the medicine round she made an error by giving a patient oral paracetamol instead of intravenously. Although both routes were prescribed, the patients*

*had only received it intravenously to date. This mistake became apparent when the patients' relative complained to the ward sister who reprimanded Clara.*

*Clara was not allowed to give intravenous (IV) medicines as she had been qualified for the less than the required four months. Nonetheless, at the end of the round she meticulously labelled certain medicine charts with "Needs IV" which she hoped would make identification easier for the sister.*

*When Clara returned to her bay, the HCA interrupted her conversation with a patient by answering Clara's questions because he thought he knew the information. His manner was very 'offhand' which could have been interpreted as interfering. Clara later asserted herself by doing impromptu bedside teaching and was thus able to demonstrate her knowledge.*

*Clara told me how guilty she felt about her inexperience as she believed it had an impact on patient care:*

> *"You are unable to do things for your patients because you are can't ignore the phones ringing, the buzzers and relatives patiently waiting to speak to you, whereas others appear to do this with ease".*

*Clara likened her new role to fighting against "[bad] habits" and hoped people would follow her example. On this shift Clara told me she was keeping "well away" from a bank nurse, "I don't want to witness anything". This was because she considered the bank nurses' practice to be unsatisfactory. Clara also avoided the staff nurse-in-charge who appeared stressed and with whom Clara did not want to bother with issues. She stated only feeling allied with other ward Preceptees and that her priority was to avoid 'trouble', make it through each day and prove her worth to the ward sisters.*

*Later, one of her patients fell and Clara had to learn how to fill in an electronic 'IR1' (incident form). She waited for an available computer but was then unable to obtain one-to-one guidance as others were busy. She persevered and eventually worked out how to fill the form in.*

*At the end of the shift, Clara went to the staff room where a sister told her "You are a good girl" (because she didn't leave dirty pots in the staff room). Clara pointedly replied that she had not had time for a break. Without acknowledging this, the sister replied, "See you tomorrow, back to playing this stupid game".*

Vignette 4 is included because it typifies the complexity of Preceptees working on the 'frontline' and shows how they simultaneously and consciously navigate the ward layout, resources, routines and relationships. For example, the vignette is intended to convey the time-related pressures on nursing work

which have particular implications for newly-qualified nurses as they have to learn how to work at speed and according to ward routines. The vignette also shows how newly-qualified nurses will try to compensate for their lack of skills, seen for example when Clara labels the medicines to save time lost through the need for extra work to the more senior nurse. The episode described in the vignette is also striking because it shows that newly-qualified nurses are acutely aware of who might be an 'anti-role model' and will judge who to learn from and when to avoid copying certain practices.

The following section builds on Vignette 4 and draws out important themes that highlight the importance of certain practices in understanding 'professional becoming'. First, I explore working how Preceptees used strategies to gain knowledge whilst working without Preceptors. I explore how they navigated the ward environment and routines and describe how Preceptees responded to challenges by 'avoiding trouble', or in other cases, tentatively trying to change practices they considered to be unsafe.

*Working without Preceptors*

In Vignette 4, Clara's Preceptor was not working with her as was often the case and Clara told me that she blamed the way that the e-rostering system was used. Clara felt that the system outputs were accepted and used without considering the importance of rostering Preceptors and Preceptee on the same shift. This reflected the views of other Preceptees who reported that their

relationships with Preceptors were also restricted by rostering issues. The amount of time spent working with Preceptors varied from every week to hardly ever. One Preceptor, for example, admitted she did not see her Preceptee for *"months"*. Preceptors were aware of the disappointment this caused, as Liz, a Preceptor on the respiratory ward at Runnysea explained:

> *"It's marrying the idea to the reality and so we let them down… it's not a failure on either side… it's a fact that in reality a ward cannot [support Preceptees as they expect]"*

Preceptors appeared to accept this situation as normal. As discussed in Chapter 5, there was a sense that some Preceptors were unconcerned because they considered that newly-qualified nurses were now "molly-coddled". However, most Preceptors I interviewed did not worry because they assumed that others would step into the role in their absence. A theatre recovery Sister explained:

> *"You know they don't have to work with their Preceptor all the time….work with whoever is on really, which is good and I say to the students [Preceptees], it's not good to work with one person all the time"*

Nevertheless, it was problematic to Preceptees who saw lost opportunities for gaining knowledge because their Preceptors would offer individualised attention,

> *"there was a day when she {Preceptor] was going to come in…spend a bit of time going through everything…and it just never materialised and there is not enough time"*.

Preceptees who did not enjoy regular contact with Preceptors often felt socially isolated from the established staff group. This was seen in Clara's lack of interaction with other qualified nurses and in her comment that she only felt allied with other Preceptees. This is significant because it indicated a situation of 'non-Preceptorship' which was not accounted for in the management of the programme. Although all newly-qualified nurses start work on the periphery of the community (Lave and Wenger, 1991), the sense of isolation therefore appeared to vary depending on wider ward support. Preceptees' strategies when working without Preceptors is explored in the following section.

*Strategies for learning in the absence of Preceptors*

In the absence of direct Preceptor support from their own Preceptor, as noted in Chapter 6 and discussed by the Preceptor above, Preceptees would consider approaching others. Some wards were seen as highly supportive as a Preceptee noted *"I can literally go to anyone…I don't feel on my own"* whilst on other wards approaching others could pose a dilemma. For example, a Preceptee complained, *"They've got their little cliques and you do feel, who do I ask now?".* One strategy employed to overcome the gap in support was seen when Preceptees working on the same ward would often seek out each other to discuss aspects of practice they were unsure about. For example at Riverton, I

saw a Preceptee ask another for advice about injecting a bony gentleman. On another occasion I overheard two Preceptees on SCBU having a (whispered) conversation about one of them misunderstanding a drug protocol. This Preceptee told the other she had been told off and her peer exclaimed *"I thought that was what you were supposed to do!"* They then rationalised why the misunderstanding had taken place and were satisfied. This appeared to be an informal mode of peer support and learning on the wards and was employed when there was no-one on the shift to whom they could comfortably discuss their dilemma without risk of losing face about their lack of knowledge.

If urgent information was required, they selectively approached HCA's. For example, Cathy at Riverton explained that she would avoid some HCA's because "*they are up themselves*".

Tensions often existed between Preceptees and lower banded staff such as HCA's and nursery nurses. For example Angela on SCBU explained:

> *"They are top of Band 4 pretty much and one of them she's fine but you know she pretty much thinks we are about the same… and I don't have a problem with [it]…but you are a healthcare and I am a nurse…it really grinds on me but then at the end of the shift when she then says to me can you sign my paperwork, I kind of think "There we go, back in your [my] place".*

Observations thus showed that during early 'professional becoming', Preceptees would approach anyone if absolutely necessary but were sensitive to their inter-professional boundaries. Sally explained how she found one HCA to be helpful because, "She [the HCA] does 'nursey' jobs without taking away my role". 'Saving face' therefore appeared to be important in this process as their professional identification remained fragile.

## Navigating the wards

*Navigating the ward layout and locating 'tools of the trade'*

Vignette 4 reveals disorientation experienced when beginning work in an unfamiliar environment. This was observed in Clara's movements as she navigated her way around the ward, its storage facilities and other hospital departments. This helps to explain the confusion described in group interviews e.g. when a Preceptee explained: *"It's like a whole new world out there."*

Preceptees not only had to navigate wards but also discover *what* was needed and *where* resources were located, i.e. to find the basics required for the job as noted in my field notes from SCBU: *"the Preceptee is constantly trying to find things"*. Much of this uncertainty revolved around identifying and locating the correct paperwork which could be ward specific in terms of design, use and storage. Forms were often kept in identical looking drawers with small labels and Preceptees complained that there appeared to be no common sense order.

However, even before they searched for forms, Preceptees had to become aware that certain forms existed and were a requirement. For example, one day, an HCA informed a Preceptee, Sally that a diabetic chart was missing but Sally did not understand what she was referring to. The HCA said *"let me show you"* and brought her an example, explaining what it was used for. This was interesting because it was the HCA rather than the qualified nurse who had noticed the missing chart. Further, Sally did not understand what chart should have been in place until the HCA raised the issue. Hence, it appears that before Sally could locate the form and make sense of it, she needed to understand the process it represented.

Similarly, one day Cathy attempted to discharge a patient for the first time and could not identify the correct paperwork needed. At that moment there was no-one available to help her, which frustrated her, *"I don't understand the [discharge] forms, there are so many".* The nuances of the discharge process were unclear to her, i.e. there were different types of discharge process depending on the circumstances of the patient. Hence, the information on the forms did not make sense and locating the correct one was problematic. Once Cathy had located the right form through a process of elimination she began to understand what she did not know about discharge. This shows how a simple task of locating a form was a learning moment, albeit a frustrating one.

In addition to locating paper forms, using electronic documentation was challenging because this was contingent on gaining access to the hospital

intranet. For example, as described in Vignette 4 following the fall Clara needed to use the hospital reporting system. She waited until a computer was free but did not have the necessary 'Smartcard' to access the system. After borrowing one, she then had to work out how to use an online form alone. Hence, access to technology and associated embedded knowledge was a barrier to learning. This was a difficult experience for her and she appeared visibly upset, seen by tears in her eyes.

In another example, Sally needed to undertake a risk assessment for the first time because she was caring for a confused lady who was wandering about. She did not accomplish this on her shift as she needed to access a ward computer which was being used by other staff. Sally was hesitant in asking if she could use it and consequently had to hand over the task to the next shift. Although the ward was busy, negotiating access may have been difficult due to Sally's lack of confidence in approaching more senior workers. In this situation she faced barriers to learning because of competition to resources and her hesitancy due to perceived hierarchies. I return to the issue of Preceptees' hesitancy later in the chapter.

The situations I have described were seemingly mundane yet significant in terms of 'professional becoming'. Preceptees could not move from peripheral practice (Lave and Wenger, 1991) until they had learned to navigate the wards and locate resources (in other words, the *where* of professional knowledge). Arguably, all newcomers, whether newly-qualified or not, have to become

orientated however, this is problematic for Preceptees for three reasons. First, confusion appeared to impact upon their developing professional identity as described in group interviews e.g. feeling like *"Homer Simson"* (i.e. rushing around like a fool). The incident with the diabetic charts also shows how professional identity was at stake; HCA's can give advice but it is important they do not 'tread on toes'. Second, gaining access to the basic resources had to be negotiated in competition with other ward staff. Third, locating resources exposes Preceptees' to what they did not know. I term this learning 'white knowledge'. Similar to 'white noise', the information on aspects of professional practice is there but not fully processed. For example, navigating organisational documents on the computer exposed Clara's lack of understanding of the process and responsibilities of managing incidents. The form contained embedded knowledge such as managing risk. Hence, Clara was able to realise both her professional responsibility and organisational requirements.

These are hybrid practices of 'becoming' because they show how learning professional requirements such as practicing accountability was heavily mediated by and subject to local relational practices. Significantly, these practices also highlight the impracticality of a single Preceptor to alleviate such tensions. This has implications for managing expectations during professional development where collaborative learning is assumed to be tension-free but takes place in situations of unequal resources and power.

I have begun to discuss the significance of locating and navigating resources and I expand upon this in the following section.

*Learning to use material resources*

Preceptees often complained they felt like students again, as remarked in group interviews. This shows that they contrasted their past with their present experience, and linked this to their aspirational identity of 'professional nurse'. To exemplify this, there appeared to be a connection with these sentiments and the use of basic ward equipment which could vary between clinical settings. One example was the use of ward whiteboards. These contained written information about admitted patients, including coded information in the form of coloured and patterned magnets to indicate, for example, when a patient needed a thrombosis assessment. It became apparent that wards would use magnets in slightly differently ways to reflect their local coding arrangements and care management. One day on the Coronary Care Unit (CCU) I saw Hannah 'fiddling' with the magnets and looking uncertain. When I asked her if she understood their use, she said *"Some of them but the ward leader here uses them to mean different things than on other wards"*.

In a further example, Preceptees arriving on the Clinical Decisions Unit (CDU) had to learn a new process for monitoring patients as there was an electronic whiteboard that was updated regularly by the co-ordinator. CDU also had a unique system which used additional whiteboards outside each bay.

Unlike other whiteboards which would be largely completed by the shift co-ordinator, each nurse in charge of the bay were expected to update them in real-time. Yet as a Preceptee Kim explained to me on her shift during the middle of the programme, it was difficult to know exactly how to use them as their use by experienced staff was sporadic and haphazard which reflected the challenges of learning to use material resources. Kim's Preceptor rarely worked with her and Kim told me she had tried to obtain advice on this matter but other staff were "too busy to explain".

Such examples reveal the importance of objects in newly-qualified learning as they contain local contextualised knowledge. Preceptees had to access this local knowledge in order to 'act with authority'. This also shows the importance of understanding symbols, language and related customs if Preceptees are to move from the periphery of the ward community. As Nicolini (2012:112) notes, "objects are inherently fragmented" and "hold together different orientations, interests and interpretations that are inherently contradictory". Thus whiteboards, for example, can represent knowledge and power as they are a resource that can be controlled by senior staff. Newly-qualified practitioners can find it difficult to understand some processes without accessing and learning how to use such material resources. Yet this is often not recognised in formal development and learning programmes such as Preceptorship which as seen at this Trust as being focused on tangible skills and competencies. The following section expands this understanding of how Preceptees accessed knowledge through understanding language.

*Learning the language of the locale*

In Chapter 6 I observed how the use of abbreviations could confuse Preceptees, and local language was seen as *"gobbledy gook"*. On a surgical ward I observed a doctor ask a Preceptee for an Arterial Blood Gas (ABG) bottle. He used the abbreviated form *"ABG"* which the Preceptee did not understand. The doctor had to explain the abbreviation, describe the bottle and also explain why it was required, e.g. to measure a patients' levels of lactate. Only then was the Preceptee able to understand what task the doctor was undertaking and from his description, locate the appropriate bottle. In a further example another Preceptee showed me how she coped with all the abbreviations by keeping a list in her pocket:

> *"I've got somebody to print me out four pages of abbreviations. I have it in my pocket now. And on handover when they do medical history and what the reason they've come in, it's all abbreviated. I get my little bit of paper out and write in it."*

These examples show how learning abbreviations is an important part of 'professional becoming'. Learning abbreviations allows Preceptees to access knowledge and affords them insight into practices of the local context, ('how we do things here'). Newly-qualified nurses have some understanding of abbreviations from their education but there are knowledge gaps. These are

often exposed when starting on a ward on which they have little experience. Hence, this knowledge is both professional and organisational in nature. This is important because learning this 'hybrid' language is a hurdle that must be overcome during "professional becoming". As Robinson (1989) suggests, newly-qualified nurses must learn how a professional nurse speaks. This learning is recursive, as seen in the case of the ABG bottle, where the need to understand abbreviations exposes 'white knowledge' and triggered deeper learning into medical processes. Yet this learning of the basic language of the community was not acknowledged in the local Preceptorship model which it was more developing specific competencies and less about building a tacit knowledge base.

*Navigating routines and ways of working*

Preceptees had to learn *what* was 'going on' around them in terms of ward routines and habits before they could learn *how* to practice. These routines were not immediately apparent which could lead to uncomfortable and sometimes distressing situations. In Chapter 6, for example, I showed how *not* understanding ward routines was described by Preceptees in terms of sensory confusion. Although this was acutely apparent in the initial few weeks of Preceptorship, I noted that this confusion continued into the Preceptorship period. I visited a Preceptee Verity on CCU four months into the programme and she explained she was still getting used to the routine. This was interesting because to some extent, Preceptees' shifts were structured by everyday routines which would have been familiar from student placements. These might include

patient handovers, doctors' rounds, mealtimes and medicines rounds. However, Preceptees were aware of subtle variations in seemingly ubiquitous practices. For example, one shift on a Runnysea medical ward began at midday (which appeared to be a more unusual shift at the hospital). The purpose of the midday shift was for the rostered member of staff to undertake a medicines round for the whole ward. Preceptees based on the ward disliked working this shift because it would take four hours to administer the medicines. They perceived this to be unsafe practice, for example because it delayed patients being given antibiotics which should be spaced evenly. They also complained to me that they, rather than more experienced nurses, would be allocated this shift which shows that they perceived that this was a task related to their low status at work. Their involvement on this round was also felt to exacerbate the situation because they were slower at administering medicines. Long medicine rounds were also discussed in group interviews where a Preceptee remarked: *"I feel like an air stewardess pushing my drugs trolley around"*. In other words, this was not an activity that they associated with their own profession.

When expressing these concerns to senior members of staff, Preceptees told me they had *"not been listened to"*. This shows how Preceptees have to participate in established organisational practices which can conflict with their wider, more professional expectations of nursing work. Accepting this lack of choice in ways of working was something Preceptees had to come to terms with during socialisation and in this particular organisation, I was struck how some wards did not appear to be open to changes suggested by Preceptees. This demonstrates the socialisation tactics employed by organisations (Van Maanen

and Schein 1979) described in Chapter 2. In this chapter, I later describe the tactics Preceptees used when Professional values rather than organisational imperatives shaped their practice.

In a second example, Preceptees on a Riverton surgical ward told me they were frustrated by whole ward medicine rounds when working on the night shift when there were only 2 qualified nurses on duty. On the night shift I observed a Preceptee, Sarah being asked to commence this task but she suggested to the other nurse that they could swap halfway through. The nurse declined, stating she had things to sort out as she was in-charge; however Sarah was unconvinced by this reason and later grumbled to me about the practice of whole ward medicine rounds and the lack of medicines trolleys which she felt was not ideal. I observed Sarah do the medicines round and was struck by the number of interruptions. She often needed to lock up the trolley to attend to patient's immediate needs. Splitting the task made sense to Sarah and for apparently valid reasons. However, she may have lacked insight into why the staff nurse declined to split the medicines round because she did not yet understand the additional responsibilities of being in-charge on a night shift where there were fewer staff. There may have been potential for Sarah to share her concerns and suggest improvements; but she lacked an authoritative voice. Her relationship with her Preceptor was poor (Sarah actively avoided her) so there was little possibility of Preceptorship providing an opportunity to make practice improvements.

Medicines management was often a site of conflict when Preceptees were adapting to ward routines. This was evident on CCU, where Sara described how an HCA questioned her medicine round timing; *"Have you not started our tablets yet?"* Sara explained she was finishing paperwork but the HCA pointed out that another Band 5 had started hers, exclaiming *"Oh you write too much you newly-qualified nurses!"* Sara appeared upset by this remark, telling me *"I write as much as I need to cover my back, I've got a registration to keep… I don't see why any healthcare feels the need to come and tell me my job".* This was an episode that appeared to threaten Sara's developing professional identity and positioned her on the periphery of the ward community.

Preceptees had to learn general ward routines but also different conventions of day and night. I observed a Sally on her night shift at Riverton and she explained that she only learned that the restocking of the 'BM box' (a box containing the equipment to test blood sugars) was done at night when she tried to do it in the day-time and was reprimanded by a sister. In a focus group, Sally later described the difficulty in navigating unwritten rules:

> *"That's how it is, it's 'my way or no way', or it's not even as strict as that, and you're just like, oh God. It's the simple things like the 'BM box'. Why doesn't she [the sister] put it in a rule?"*

This demonstrates that Preceptees wanted explicit information to help them navigate the context and were frustrated when work was not standardised and transparent. This again shows that Preceptees often have to accept the 'way we do things here', similar to the whole medicine rounds that they did not endorse.

The data has shown (and confirmed in group interviews) that Preceptees turn to the nearest available member of staff for urgent information, yet they could be tentative in seeking help if the matter was non-urgent. They also avoided directly tackling other issues that caused them concern. It appeared that they wished to keep a low profile which I describe as the practices of 'avoiding trouble'.

## Avoiding Trouble

There were many moments when I observed Preceptees appearing to avoid trouble and be less of a burden to others. I concluded through my extensive observations that this was important in their "professional becoming' because it could help Preceptees avoid taking part in more complex interactions and activities because firstly they needed to prioritise navigating the basic system. In other words, there was only so such that they could learn at a time (described in Chapter 5) when they felt overloaded with demands. I give three examples of ways of 'avoiding trouble'.

*Negating criticism*

I showed in Chapter 6 that Preceptees discussed the tensions they experienced because they were not yet allowed to administer IV medicines. Interviews and conversations with Preceptors also supported their claims. For example, a sister on a Runnysea medical ward asked me to speak to the CE Team as she had previously been unsuccessful in her request for the four month delay in IV training to be shortened. During an interview, a Preceptor on a respiratory ward explained the impact of the delay:

> *" The other day there was [sic] fourteen IV drugs that had a massive impact on the other qualified nurse's time and I had to help her [the Preceptee] with her time management"*

Significantly, I observed Preceptees taking measures to negate perceived criticism of their lack of competency to avoid trouble. In Vignette 4, for example, I noted how Clara meticulously labelled the medicine charts and placed them in the treatment room so that another Band 5 could easily identify the IV medicines to be administered. This was a common practice, for example at Riverton I noted how Cathy did the same and informed a more experienced Band 5 that the charts were on the desk, apologised and said she that she had put a note with them to make it easier. It is noteworthy that Cathy later suggested this would not have been necessary at Burydale, where nurses were more approachable. It struck me that Preceptees who practiced this labelling

strategy seemed to want to be seen in a more positive light and not being a nuisance. Although they did not explicitly say this, this could reflect the attitude noted earlier where some staff had told me Preceptees were "pain in the neck". Hence, this labelling appeared to be a strategy to avoid trouble and shows how Preceptees can be politically astute. Also of significance is that, as noted in Chapter 6, Preceptees were concerned about the safety issues of their *not* being able to administer IV medicines. Therefore labelling the drugs charts also appeared to be a strategy to improve safety.

*Hesitancy*

I often observed Preceptees in the early Preceptorship period appearing hesitant when wishing to speak to more senior staff such as ward leaders and matrons. For example, on a surgical ward at Runnysea a Preceptee tried to talk to a matron who was sat at the nurses' station, chatting with a sister about non-work issues. The Preceptee hovered for several minutes before she was acknowledged. After answering the Preceptees question on clinical evidence, the matron implicitly dismissed her by turning away, thereby excluding her from further conversation. Although one could argue that the matron was busy, her body language not only dismissed the Preceptee but inferred that she was unimportant. This also showed that newly-qualified professionals are uncertain about the rules including those of an informal nature. The convention of students may have been not to interrupt the professional, but this was a new situation where a professional tried to gain attention from a more senior professional and what to do was unclear. Hesitancy was also noted earlier in

this chapter when I described how Preceptees would go to each other for advice where possible rather than being seen to ask unnecessary questions. It was also interesting that a ward leader on CCU noted how a Preceptee would "get completely freaked out if I go to speak to her". These examples reflect the feeling of low positon in the hierarchy described by Preceptees in group interviews. This hesitancy and lack of confidence in communicating with more senior staff would lessen as they increased their repertoire of skills. I discuss this again later in the chapter.

*Leading by example*

Preceptees would also avoid trouble by indirectly tackling what Clara explained as *"other people's bad habits"* through leading by example. For instance, I observed a Preceptee at Riverton locking away tablets as the patient was away from her bed. The Preceptee explained, *"I won't leave them on the table"*, emphasising the *"I"* to suggest that other qualified nurses on the ward would do this unsafe practice. A second example involved two Preceptees on SCBU, Adele and Angela. Standing at the main desk I observed Adele quietly telling Angela that the drug preparation procedure she (Angela) was following was against Trust protocol. Adele discreetly showed Angela some written guidelines and remarked that even the midwife who was working alongside them probably did not realise what the correct protocol was. Angela whispered her gratitude to be told how to mix the drugs 'by the book' and I saw them give furtive glances to the midwife but they did not say anything to her. Rather, Angela followed the correct protocol. This was interesting because they did not

question the midwife, rather co-constructed their version of correct practice, also preferring to lead by example.

However in other situations, Preceptees felt powerless to lead by example, e.g. on a night shift Sarah Preceptee confided that she could not make sense of the night time routine. The evening staff would check the incontinence pads and do the 'toileting' just before they left and the night staff would do this again just after they arrived. As Sarah explained *"I don't know why, that's what it's like here"*. When asked if she had tried to change the routine she said *"No"* shrugging her shoulders. It appeared therefore that perceptions of relationships with senior nurses may have led to a situation where the Preceptee would rather avoid trouble. Indeed, in a last day group interview, Angela on SCBU described how a sister told her that "You're newly-qualified lovey and no-one will listen to you". Angela later talked to the sister about this, and was told "Well if you have anything just say it". However Angela described how lack of time made it difficult to discuss her ideas properly. In the same group interview, Preceptees agreed that changes were in the hands of management and not something they could easily influence.

In a strategy to overcome hierarchal barriers to change, some Preceptees confronted situations they wanted to change by *working together*. For example, as noted in Chapter 6, three Preceptees on the Riverton surgical ward were able to change the way handover was accomplished. Prior to their intervention, the co-ordinator would hand over from sheets that the nurses would fill in on the

computer. The Preceptees decided to approach the ward leader together and argued that vital information was missing citing Burydale's individual handover to the ward leader who agreed to try it out on the Riverton surgical ward. Nevertheless, some weeks later, handover reverted to the old style at the board. This and the earlier observation made shows that Preceptees would seek out each other and suggests that solidarity and a sense of shared identity is important as a resource for learning during 'professional becoming'.

*Double checking*

The final theme in the first section of this chapter concerns a strategy to cope with confusion and uncertainty whilst also avoiding trouble - to double or even triple check much of what they were trying to accomplish.

Formal and informal checking was obvious in Preceptees' practices. As described, Adele and Angela double-checked the correct way of giving the medicine because they wanted to 'work by the book'. In another example, Donna, who worked in recovery, told me how she was recently sent to cover a shift in intensive care; *"I was trying to plug everything in, and I was triple-checking it before I plugged everything in, my head was spinning*". Checking was what one Preceptee called her *"nervous disposition*"; she would check everything numerous times. On SCBU I saw Adele double-check with a Sister when she should do the 'cares' (the routine nappy change and checks) and when she should give medicines. Even though much work in SCBU was routine, Adele would constantly double-check and take opportunities to fit double-checking into conversations with more senior nurses. However, Adele

told me how she would never take people's word and always double checked with patients' charts as colleagues would forget to tell her things.

In highly supportive small wards where Preceptors and Sisters (or Charge nurses) were often available to ask questions, double-checking could also lead to reduced autonomy. For example, Adele was working with her Preceptor Julie and needed advice on feeding a baby. When Adele could not aspirate fluid to routinely check if the naso-gastric tube was in the stomach or lungs she approached Julie who decided to put the feed down the tube herself. This is an example of how double-checking can relate to the difficult decisions Preceptors have to make during Preceptorship. Although Julie wanted to 'protect' both baby and Adele, her actions also positioned Adele as having low autonomy, which appears at odds with Preceptorship policy which seeks to increase autonomous working (DH, 2010a). Conversely, when double-checking, Preceptees became aware that experienced nurses do not always work by the book. Preceptors were also aware of this and were mindful of how this would appear to Preceptees. As Gail, a Preceptor, later explained, she was always careful not to appear sloppy in front of Preceptees: *"When you're busy you might not cut corners as such but do it a quicker way, still do it safely but do it a quicker way, not that you would show it"*. Gail's statement shows that there were local customs which could vary from Preceptees previously held assumptions which surprised them during "professional becoming". This topic arose in group interviews as a moral concern of Preceptees:

*Preceptee 1:"You are sort of like saying to them 'well about calculating the drip' and it's like 'oh well I don't know the calculation; you just do it like this'. And then, I know I've seen [guidelines] you just think you know if you haven't got time to go back to double check and it has gone through too quickly"*

*Preceptee 2:"You'd think experienced nurses can put the fluids up without counting and then can get it more accurate than anyone who sits and counts it because they just know don't they just by looking at it but until you do know you just have to[refer to guidelines]"*

Double-checking was thus a material practice, as Preceptees often double-checked against guidelines and protocols, again reverting to this rather than experience when facing uncertainty. New practitioners will not always know the difference between cutting corners and unsafe practice until this is highlighted during specific moments of work. For example, Angela knew one way to prepare a drug, but Adele highlighted that this was local custom and practice rather than from an official protocol.

The above themes highlight that Preceptees negotiate routines and conventions which are taken-for-granted by other ward members but create uncertainty in learning because of subtle variations in practice. Although wards produced 'packs' which held specific information about patient conditions and related

competencies, these did not meet all of the Preceptees' needs. In the context of Preceptorship and its aim to relieve shock (Kramer, 1974), it is difficult for a single Preceptor to mitigate the existence of esoteric knowledge and Preceptees may have had unrealistic expectations in this respect. The observations and focus group data also revealed that Preceptees were faced with situations where they considered other people's practice to be of poorer quality but as newcomers, they often felt powerless to tackle it directly. Rather, they would try to lead by example. In other situations, there appeared to be no choice but to continue established ward routines or try to change them with peer support. This shows that Preceptees had a strong moral sense of professional practice but agency could be constrained by ward hierarchies.

The following section shows how Preceptees moved on from overcoming some of the basic challenges towards realising forms of knowing they associated with professional requirements for a nurse. This was in part, accomplished through relations with Preceptors.

## Negotiating Learning

In this section of the chapter I explore how Preceptees negotiated their learning which was accomplished through firstly 'seizing opportunities'. I also highlight learning through two different forms of Preceptorship -indirect and direct.

*Seizing opportunities*

In Chapter 6, I noted how Preceptees urgently wanted to learn advanced skills and it was apparent that they had varying opportunities to do so on the wards. Cohort 1 Preceptees were initially unable to try to gain experience of certain clinical skills because they had to wait until completion of the clinical skills training day. This was a situation that went unquestioned by some Preceptees. For example, on a night shift at Riverton, I watched Sarah work in a bay with an HCA. At one point in the evening, the HCA was undertaking blood glucose tests whilst Sarah was changing incontinence pads, which were arguably tasks each other should have been doing. This did not appear to concern Sarah who appeared comfortable undertaking basic tasks. This is an example of Legitimate Peripheral Participation (Lave and Wenger, 1991), where those on the periphery are not necessarily disempowered but biding their time and slowly gaining knowledge.

Later, Preceptees became more proactive and learned how to seize opportunities to advance their skills. For example, during an observation three months into the programme, it became apparent that Clara still needed to obtain her 'Smart Card' due to lack of time to leave the ward and visit the issuing office. Clara pointed out to me that the ward sisters were "*Gossiping at the nurses' station*" and told them (rather than asked them) that she was going to collect her Smart Card. I was surprised at how confident and proactive she appeared. This was an important moment in her "professional becoming"; Clara used a particular situation to her advantage so that she could obtain a

'tool of the trade'. The Smart Card would allow her access to further training and e-learning and was thus essential. Smart Cards can thus be viewed as an essential material artefact of Preceptees' 'professional becoming'. This incident also again demonstrated the political-astuteness of Preceptees.

Preceptees often had to persevere to learn a skill. For example, on an early shift at Riverton early in the programme Sally told me she wanted to learn bladder scanning asked her Preceptor Anne to show her what to do. I watched as Anne carefully demonstrated the procedure using a 'show and tell' style afterwards agreeing that Sally could do the next scan. In the meantime however, an HCA unaware of the arrangement completed it. Sally's facial expression appeared to show she was upset and disappointed by this. Afterwards Sally spoke to me about how frustrated she was feeling as she could not perform basic skills, even those she had learnt as a student such as blood monitoring tests. This had made her particularly anxious to learn how to do the bladder scan. It struck me how the demonstration of this non-invasive procedure could have been enhanced had Sally been allowed to participate rather than only observe. This shows how opportunities to learn often need to be proactively negotiated and explicit language used. In this case asking to be observed, rather than shown might have helped Sally seize the opportunity to learn. In this case, insufficient communication and not maximizing the time available delayed learning and maintained Sally's peripheral position.

In another example, Cathy explained how adversity had made her proactive and she had begun to join consultant ward rounds, explaining emphatically: *"I **will** ask, I **will** learn from them"*. To demonstrate her point she showed me a medicine chart on which Nifedipine had been crossed out. She explained she had learned its side effects from a consultant and that:

> *"This lady was displaying those symptoms so I suggested to the ward sister that it might be the Nifedipine. The ward sister laughed and told me that was ridiculous, but the doctor overheard and backed me up when he realised I was right".*

This story revealed how adversity could trigger proactivity and inter-professional learning. This is important because this shows how 'professional becoming' is reflexive practice where situational awareness and relationships leads to intuitive notions of what professional practice entails (Schon, 1983). The next section explores how Preceptor activity on the wards was able to support this learning.

## The formal transmission of knowledge during Preceptorship

Although Preceptors could be elusive, when rotas were favourable I was able to observe some of their in-depth interactions with Preceptees and noticed there were different forms of Preceptorship activity. Some interactions appeared to be more intentional and direct, whilst others were more opportunistic and

dependent upon favourable ward conditions. Before I give examples, I show a Vignette from which I draw out themes.

**Vignette 5: The Blood Test**

*Adele who worked on SCBU had been qualified for four months. On this shift, her Preceptor, Julie, was also working in the same room. Her proximity was apparent when Adele chatted to a student nurse about non-work issues and Julie reminded her that her patients' monitor alarm was sounding. Adele responded defensively with a "Yes but" and made an excuse.*

*Later, the baby required a Serum Bilirubin (SBR) blood test for jaundice. As preparation began, Julie joined Adele, even though she had not been specifically asked for help. Julie stood on the opposite side of the incubator to observe Adele's practice. Adele prepared her equipment and verbally sought affirmation, e.g. that she was using the right bottle. As Adele began the blood test, Julie asked her "Are you happy doing it from that side?" Although Adele replied "yes", shortly afterwards, Julie asked her this question again. This time Adele emphatically stated that she preferred this side because she was left-handed. Nevertheless, Julie moved round to Adele's side to check the angle and position of her hands before returning to the other side. Julie advised Adele how to put Vaseline on the baby's heel but struggled to find the right word and used a hand action. Following a pin prick of the heel, Adele double-*

*checked her technique by asking Julie brief questions as she tried to extract blood. At this stage, Julie's arms remained tightly folded but her hands were restless, as if she was suppressing a desire to use them. When the blood did not flow easily, Julie tried to explain how to squeeze the heel to encourage blood flow but again accomplished this by demonstrating the action with her hands rather than with words. Eventually, Julie placed her hands inside the incubator as if to sooth the baby (although the baby was quiet). Once her hands were inside, she began to actively assist until the blood test was complete.*

Vignette 5 is included because it conveys the detail of a typical close interaction between a Preceptee and her Preceptor which centres on the need to directly transfer technical knowledge and skill rather than on a broader process. This particular episode was chosen because not only does it show the transmission of explicit and tacit knowledge, it also sets the scene of the interaction in a particular moment in time but one which is dynamic and not seen as separate to other ward activity. In other words, it focuses in on a particular activity but also highlights the context of the activity. This helps to draw out the themes of *direct* and *indirect* forms of Preceptorship which are further explored below.

*Indirect Preceptorship activity*

Preceptorship unfolded during certain moments, some of which were anticipated by Preceptors through monitoring Preceptees 'from a distance'. The blood test described in Vignette 5 is noteworthy because this learning moment arose from Julie's *indirect* monitoring of Adele. Unbeknown to Adele, Julie anticipated when she needed support. I witnessed this happening on other occasions, and not just by 'official' Preceptors. This was evident on CCU when a diabetic nurse did some impromptu teaching with a Preceptee, Michelle (Interestingly she called Michelle a "student" during the conversation). On a different occasion Adele needed to give a Vitamin K injection to a baby. A midwife on the unit (SCBU employs nurses and midwives) noticed Adele preparing the injection and offered to support as she knew this was Adele's first time giving this medicine. During the interaction, the midwife did not become physically involved, but gave clear advice; the process ran seamlessly. Adele later explained that the midwife had been her student mentor and they had often worked together, "*She trusts me".* This is also an example of 'unofficial' Preceptoring, where despite the professional boundary a pre-existing relationship (here, student and mentor) endured to meet Adele's existing needs.

Interestingly, Adele later revealed that she had not recognised that these were learning episodes as her concentration was on tasks to hand: *"It seemed more like teamwork to me other than a student/mentor type situation"*. This highlights the difficulty of reflection on all nuances of practice *during* activity

(Nicolini and Roe, 2014). This is important when thinking about what form Preceptorship takes and whether it is always recognised as such. This also shows that even though people are continuously learning, they tend to 'box this off' from other aspects of their work.

Although it was easier for Preceptors to observe Preceptees' activities in smaller wards (and directly intervene if needed), this was not always a positive experience for Preceptees, particularly when close monitoring continued throughout the Preceptorship period. As Donna explained in a focus group *"The support's brilliant"* but that everything had to be *"By the book"* as interpreted by her Preceptor, Polly. Observing Donna working in theatre recovery I noticed Polly watching her. I would see Polly frown, interject and advise on Donna's activity. One day Donna and an Operating Department Practitioner (ODP) went to collect a patient from theatre. As they wheeled the patient into Recovery, Polly realised the patient was not wearing an appropriate blood pressure cuff and asked the ODP to apply one. Donna argued that the patient *was* wearing one, but as Polly pointed out, the patient was only wearing half a cuff. Polly was vehement in showing her disapproval to the ODP and also to Donna for not noticing. Later Donna mentioned how difficult she found both the scrutiny and meeting standards she thought were expected of her, namely to replicate the practices of Polly. A few weeks later, Polly telephoned Mia expressing her concerns that Donna was not progressing as well as expected. Mia reassured her that Donna had satisfied Portfolio requirements and asked her to sign off Donnas' Preceptorship period. Similarly, during an ethnographic conversation, Judy, a Preceptee on a medical ward at Riverton

also told me how she found her Preceptor to be very ‘prescriptive’ when they worked together, even designing another version of a Portfolio to complete.

The above situations highlight the complexity of relationships between a novice and more experienced practitioner when there are different ideas about learning styles. In theatre recovery, Polly advocated a ‘show and tell’ model of teaching to transmit ‘ideal practice’ by inviting Donna to directly copy her own ways of working. This style of Preceptoring may have occurred as a way of overcoming the struggle when trying to recall tacit knowledge amidst the complexity of fast paced work (Nicolini and Roe, 2014). In Polly’s case, she was concerned about her own accountability during knowledge transfer. On the other hand, Donna saw Polly simply as a ‘go to’ person and someone to sign off the competencies she had learned through wider experience.

The layout on large wards made it more difficult for Preceptors to observe Preceptees working. Nevertheless, many Preceptors believed, as a Preceptor Liz explained, that they were *“mindful”* of Preceptee activity. Susan, a Preceptor from Riverton also explained:

> *“I am acutely aware of what everyone is doing… oh yes, I know what they are doing…and I warned them don’t try to slip anything past me because you won’t.”*

However she conceded *"You do get busy and you can't always go [to Preceptees]".* Liz also admitted that she was often unable to work directly with her Preceptee Gemma but stated: "*I do see the improvements"*.

The perception of Preceptors being 'mindful' is important because it shows again that Preceptees may not always be aware of being observed and that their Preceptors look for opportunities to support them. This mindfulness has implications for managing expectations of Preceptees, who may not always realise the efforts Preceptors make. Of note however is that Susan's statement suggests Preceptors may be more concerned about Preceptees fitting in with organisational routines than by gaining particular professional skills.

*Direct Preceptorship*

A second form of Preceptorship occurred when there were more direct or intentional learning interactions. For example, Preceptees would ask Preceptors for advice if they 'crossed paths' during a shift when there was a sudden need for learning. These brief encounters also served the purpose of allowing them to briefly reconnect, as a Preceptor noted- *"Just to stop and chat, have a natter even if it's only for two minutes"*. Another example of 'direct Preceptorship' is 'meeting in the middle'. This was when Preceptors and Preceptees would have slightly longer meetings which were held away from patients and other staff. In such cases, the two nurses would meet as a Preceptor described *"out of the patient's earshot"* and use the notes trolley as a makeshift desk, or

occasionally a back office. This was often when a Preceptee urgently needed to learn a skill or process. As a Preceptor noted, *"If there are any problems she will come and see me and we'll have 10 minutes if we can to discuss whatever the issues are"*. A Preceptor on CDU also explained how her Preceptee would "bypass the ward coordinator" and "she will always come to me" to seek help or reassurance from someone with whom she had built up a good mentoring relationship.

I noticed how Preceptors would often reach for official forms and guidelines when trying to explain processes during these moments. For example, on SCBU one day Adele answered the phone to a doctor who rang to say a baby needed phototherapy. Adele asked him if he wanted single or double light units. The doctor did not know the answer (he was new to the speciality) and Adele therefore asked the sister on duty (her second Preceptor) to decide. The Sister explained it should be 'double' based on the blood results but immediately told Adele about the existence of the official flow chart. This was placed in the office situated off the main ward. The chart was pinned high up on the wall and according to the Sister it wasn't used very often. They had to take the flow chart from the wall to look at it and spent five minutes going through it step-by-step, as the Sister talked Adele through the arrows and options. The Sister did not appear familiar with the exact wording on the chart as she was hesitant in her explanation and the two of them worked out the route that they needed to take. It was indisputably 'double' lights that were needed for the baby. The chart thus appeared to give even the most experienced nurse

reassurance that she was teaching the correct, 'by the book' method during direct Preceptorship.

In a second example, one morning, I observed Sally ask her Preceptor, Anne, for help with a Continuing Care assessment form. Anne commented she had little time but nevertheless spent ten minutes explaining the process carefully, giving tips to Sally who filled in the form. Sally was happy that the process was much clearer and that she better understood the complex needs of patients. In particular, Sally learned the implications of filling in the form incorrectly.

The above example appeared to be a form of an 'ideal' Preceptorship moment, with immediate access to a Preceptor and smooth transmission of knowledge. Anne understood the need for 'light touch mentoring' that did not impact on developing professional identity. Interestingly, she had returned to practice three years previously and appeared better able to relate to Sally's needs. Rather than a 'show and tell' form teaching, this was co-constructed practice between two professionals as newcomer and relative old-timer (Lave and Wenger, 1991). During an interview, another Preceptor recognised this need for reflexivity and a 'light touch' style:

> *" You need to identify in your own mind what you do is second nature…you have to be in a position where they have room to*

*develop their own way…if you've got the staffing in place you should be able to do it".*

A further reason that these direct meetings took place was to catch up with progress on the Portfolio, as Julie explained during an interview: *"I'll often sit in quiet periods with her [Adele] and say right let's get your paperwork out… is there anything you want to see*". Nevertheless, this situation was more unusual. I did not observe this happening rather that most Preceptors and Preceptees struggled to meet regularly due to rostering or busy wards.

As Vignette 5 showed, direct Preceptorship activity was evident on small wards because the proximity of patients meant that Preceptors could observe their Preceptees more closely. During the SBR, the interaction appeared to be a form of mentorship, similar to that of student education, i.e. Julie was a practical advisor. However, the episode revealed interesting tensions, for example there was a power struggle when Julie was unconvinced by Adele's technique. Julie appeared to feel strongly about the correct way to practice, but deciding whether to intervene or not was not easy. As another Preceptor explained: *"You need to know when not to push things"* and "*I probably do interfere too much… I keep asking her how far she got what she's doing I don't feel I can back off."* Nonetheless she admitted that she and her Preceptee only worked together occasionally. The above examples show how practical knowledge is contested between two accountable practitioners, and how it can be difficult under the gaze of mentors who have developed habits and consider

themselves ‘experts’. This was supported by data from the group interviews, as discussed in the previous chapter, where Preceptees would question the habits of some experienced nurses such as in the example of measuring blood pressure.

Vignette 5 also demonstrates the difficulty incurred when intentionally trying to transmit and share tacit knowledge during direct Preceptorship. For example, Julie struggled to find words to explain how to put the Vaseline on the baby’s foot and later, how to squeeze the heel. This was a routine practice on SCBU, a practice likely to have become embedded in her tacit knowledge. This shows how explaining physical practices is often difficult and places pressure on the person who has to explain, not just clinical skills but other processes. It was also interesting to observe that Julie was unable to resist the urge to place her hands on the baby, following which the course of the interaction changed and control passed from Adele and became dispersed across the two practitioners. This reveals it is difficult for Preceptors to stand back and observe; they cannot resist ‘doing’.

The examples I have given of Preceptor-Preceptee interactions have revealed how learning situations unfold in time and takes the form of direct and indirect Preceptorship activity. The data reveals tensions over control of practices and exposes some of the difficulties when expecting two qualified and accountable members of staff to negotiate this relationship.

The final major theme of this chapter explores how Preceptees leave Peripheral practice by addressing latent knowledge gaps and 'pushing back' against rules or established organisational practices that were seen as 'unprofessional'. This section also shows the fragility of their position and shows events that can destabilise their 'becoming'.

## Leaving the Periphery

It appeared that a significant stage in the 'becoming' of Preceptees was to move away from a peripheral position on the ward, towards one where they could act with more authority and no longer as the newcomer. There appeared to be drivers that were important to make this move. First, they needed to graduate from Preceptorship, and pass through the first pay 'gateway', both of which relied on showing competency. Secondly the arrival of Preceptees from a later cohort also signified a change in practices. In order to accomplish this move away from the periphery, Preceptees needed to complete their Portfolios, address obvious knowledge gaps and decide when to 'push back' and when to 'fit in' with prevailing organisational practices. They also identified less with being a Preceptee and more as an ordinary Band 5 nurse on the ward. As Preceptees had limited remaining time with Preceptors, it was interesting to observe how this was accomplished.

*Completing the portfolios*

As previously noted, the Preceptorship Portfolio was the material representation of the Preceptorship programme. Completing this document was therefore an important 'rite of passage' that signified leaving Preceptorship and 'becoming' a nurse. It was interesting to hear the view expressed by Preceptees that the Portfolio was directly related to the 6 month 'pay gateway' appraisal and who appeared surprised to hear that some previous Preceptees had not completed it- *"But they have to finish it in time don't they, for the six month pay rise?"*. Ward leaders would talk to Preceptors before they held the review meeting. As one explained, *"I have spoken to their Preceptor beforehand* [to be sure of competency]*".* Preceptors were therefore seen by some ward leaders as a mode of assuring performance. The ward leader of CDU also explained how she kept in close contact with Preceptors to monitor performance so that she knew "who copes well and who doesn't cope well". However, as previously discussed, according to the Clinical Education Team, not all ward leaders appeared engaged with the programme and my findings showed that the allocation of Preceptors or time for Preceptorship was not always prioritised. As they did not respond to my request for an interview, I was unable to fully verify the reasons for this but the pressures described in the previous chapters could suggest that competing demands prevented them from fully realising the benefits of Preceptorship.

There appeared to be pushes and pull on completing Portfolios on the wards. Although Preceptees would bring their Portfolios to work, I noticed that they

would be often kept in a locker or staff room and not be completed during the shift. However, the opportunity to complete them and therefore complete written reflections soon after learning moments could vary. In Recovery, for example, Preceptors would try to help Preceptees reflect soon after an event: *"we'll sit down and talk…and do a bit of reflection"*. On the other hand, Preceptors on busy general wards claimed they did not have to opportunity to discuss reflective practice until the end of Preceptorship. A Preceptor on medical ward explained to me during an interview how this conversation took place, *"Right at the end [of Preceptorship], after it was all done and finished"*. Preceptees would complain to me that it was usually too busy to bring them out during the shift and that it was difficult for their Preceptors to stay behind. For example, a Preceptee commented *"they've [Preceptors] all got young kids…and they're not going to want to stay behind after work to get the paperwork done".*

There were other explanations offered regarding the delay in Portfolio completion. Portfolios could appear 'mysterious', e.g. as a Preceptor admitted, *"I don't know a lot about them [Portfolios]"*. This suggests that Preceptors were not always informed or even pro-active in understanding the written aspect of Preceptorship. However, it was also felt that Preceptees should be more proactive, as two Preceptors explained in different interviews:

*Liz "She is very reluctant to bring in her paperwork to be looked through so you know that gives us a headache, gives us a problem because we don't know what evidence she has gathered to say she had achieved her skills."*

*Janice: "I put the responsibility and onus on them…. It's their period not mine, if they need paperwork doing they have to come to me and say, " I need help with the paperwork thing" I'm not going to chase after[her], it's not my job."*

Preceptees were therefore seen to lack organisation skills to maximise potential time. However, other Preceptors did not blame Preceptees, rather 'the system' as one stated:

*"It's so unfair on them that by the time they've finished their six or nine months you haven't actually done anything towards their paperwork… I think as a Preceptor you should be given at least some time together…how are you expected to get an all rounded nurse if they don't know everything?"*

This shows frustration and also a lack of confidence in what the Preceptor would be signing off.

There were therefore barriers to overcome and Preceptees adopted strategies to be 'signed-off' which they explained to me during the group interviews. One was to be opportunistic and maximise the time during the working day, as a Preceptee admitted, *"I tend to squeeze bits in"*. Other Preceptees were able to persuade their Preceptors to meet them out of the working day, albeit as one confessed, "*In a bit of a rush*". Another Preceptee developed her relationship with her Preceptor to such an extent that she considered her a friend and they would meet out of work. This appeared to be a more unusual situation however. In another example, a Preceptee explained she used her allocated study time for her degree, "*because if not, you just don't get it done*".

Completing Portfolios was therefore challenging and Preceptees developed strategies to overcome this hurdle. As noted, some Preceptors distanced themselves from this responsibility and saw the Portfolio completion to be distinct from every-day mentoring, and a 'tick-box' process that should be owned by Preceptees. Arguably Preceptors may have been able to help Preceptees create more opportunities for learning by advocating on their behalf for more time to complete. However, this was not commonly part of Preceptorship activity which instead appeared to be often *ad-hoc* and bound to temporal, organisational pressures. This is significant in the 'professional becoming' of Preceptees because it shows the work that they have to do to accomplish being *'signed off'*, an important mode through which to move away from peripheral practice.

Completing the portfolio thus required pro-activity which was increasingly evident in Preceptees practice.

*Addressing knowledge gaps*

Preceptees became more active in their learning. Rather than trying to seize opportunities, they created the right moments. This was apparent on CCU when Michelle asked a consultant if she could join the ward round (usually this was the remit of the nurse-in-charge). During the round, the consultant asked the gathered team a question about a drug to test their knowledge. When Michelle was the one who gave the correct answer he told her: *"I am very impressed with you Michelle"*. Michelle proudly told fellow Preceptees about the incident on the following study day. This was a powerful moment in Michelle's 'professional becoming' as she felt legitimised and a sense of belonging. The above incident shows a strategy of seeking learning opportunities. It was noteworthy that Michelle also told me that the Preceptorship in the classroom *"Has not been any good"* due to irrelevant course content but that she enjoyed peer support from other Preceptees. This shows the disconnection between ward and classroom-based activities.

In another example of seeking specific knowledge, towards the end of the programme Clara needed to complete her ward 'pack' for inserting 'a venflon'[4]. She was frustrated because she was struggling to be observed the

[4] A cannula used to gain and keep access to a vein

required ten times doing this procedure, despite having learned and practiced this skill as an HCA. One day, the only person free to observe her was an HCA. They attended the patient together and the patient asked Clara why the HCA was supervising her. After several attempts (the patient was said to have *"difficult veins"*) Clara had to give up trying. During the episode, the HCA sat passively and offered little advice. Failing to insert the venflon correctly and having to explain why an HCA was supervising her, upset Clara who complained that this was the most *"humiliating moment of my career"*. Clara later told me that this had led to a determination never to be put into that low position again. Instead, she had proactively sought opportunities to be observed by qualified staff. By the end of the programme, Clara had been 'signed off' demonstrating how adverse 'positioning moments' such as these can be positive in helping Preceptees overcome barriers to learning.

Although Clara had been proactive in her learning, moments of crisis where a knowledge gap was suddenly exposed would still occur towards the end of Preceptorship period. The following section explores this as 'reactive' learning which is explored with a final Vignette.

*Reactive learning from crisis*

I noticed how Preceptees began to appear more confident at work; rather, they were 'getting on with the job'. This was observed at Runnysea, when a Preceptee who had previously been reticent in being shadowed, asked me *"would you like to come with me?* [To observe]" and explained she no longer

felt as self-conscious. Further, I did not see Preceptees cry as often. This transitional period was noticed by Preceptors, as explained to me:

> *"Instead of coming to you and saying what do I do now, they come and tell you I've done this…it's just this confident person as opposed to a head down looking at the handover, they're actually looking at you."*

By the final few weeks of Preceptorship there was much progress in terms of proactively gaining knowledge and skills in addition to other, more unconscious forms of learning. There were also occasions later on during Preceptorship where there were specific moments of crisis that discombobulated their 'becoming'. As I show, these are moments when they are suddenly faced with the realisation that they did not know something important. Hence, there continued to be reactive learning moments where Preceptees sought help from Preceptors or others. Vignette 6 shows the first example of this.

**Vignette 6: I need my Preceptor!**

*Gemma was working on a cardio-respiratory ward. Her shift wasn't "too bad" but she was upset from an incident the previous day when she felt the doctors had been slow to respond to her reports of a deteriorating patient. Gemma was also tired; this was her eighth shift in a row. She told me she felt*

*"reasonably supported" but "stressed and busy" and didn't think she had been rostered with her Preceptor enough. However, their shifts coincided today.*

*Gemma began to complete a Continuing Care assessment form. She grumbled about this to another staff nurse who remarked that Gemma having to do a form like that was "stupid". Gemma explained her frustration because she was attempting it for the second time. She rang the district nurse to arrange catheter care but there were questions she could not answer and had to explain she was newly-qualified. When she put the phone down she exclaimed "I need my Preceptor!"*

*Standing by the notes trolley, Liz (her Preceptor) and Gemma had a long talk. They referred back to the Continuing Care assessment form to consider the problem. Gemma complained she had been told to do this by another staff nurse. She was unsure about the resulting high score which meant the patient would be unsuitable for her care home. Liz looked at the scores and told Gemma her scores were very wrong. Gemma started to cry, seen by the tears rolling down her face and said "I've screwed up". Liz spoke to her in a 'motherly' tone and completed the chart herself, telling Gemma it was easier for her as she'd "been doing it for years". Later I spoke to Liz in the staff room and was surprised at her changed attitude. She did not express empathy towards Gemma, rather explaining how Preceptees had to get 'up to speed': "It's really busy here; they are really thrown in at the deep end - sink or swim".*

The above vignette is included because it shows what can happen when a Preceptor is required to quickly convey a complicated process to a Preceptee when 'white knowledge' suddenly becomes apparent. The vignette highlights two issues. First, the skills needed by Preceptors and second whether they are able or willing to transmit such knowledge. Second, the vignette also shows how such interactions can be emotional for the Preceptee, seen by what appeared to be demonstrated Gemma's tears rolling down her face and her self-blaming. I often saw Preceptees in tears in similar situations on the wards; especially where they felt they had not achieved the desired standard and shortly give a second example. This shows the tenuous nature of Preceptees' confidence which can be undone in situations where they become aware of 'white knowledge' for example in this case, background knowledge (i.e. implications) of the scoring.

The above vignette highlights the skills needed by a Preceptor to give confidence to the Preceptee and recognise her learning needs. As noted earlier, such moments could be seen by skilled Preceptors as an opportunity to try to transmit knowledge, yet the above vignette shows that this was not always the case. The knowledge required to fill in the form was not explained to Gemma. During the interaction, Gemma was positioned as unknowing and 'illegitimate', she was not yet 'up to scratch' and she was made to understand that she had to learn more before being considered competent. This episode appeared to cause an emotional reaction which has previously been noted in the literature. Fuhrer (1993) describes how emotions are exacerbated by the way that practice unfolds and that this is particularly powerful in novices. This is

relevant because it shows that emotion is an important aspect of 'professional becoming'; it appears to show points of 'disruption' to existing self-identification (Elkjaer, 2003). In other words, emotion may signify moments when Preceptees question their professional identity because of their lack of knowledge. These moments also show their urgency to learn the knowledge required to belong to their professional community.

It was noteworthy that in the above vignette we can see that the means to learn a process was withheld by an expert. It is possible that the Continuing Care process was embedded in Liz's tacit knowledge and difficult to explain. However, I showed earlier how this was accomplished by another Preceptor. The episode could therefore show an example of closure within the profession that protects Liz's position as an expert. These could be examples of the "silence and the silenced" in learning (Blackman and Sadler-Smith, 2009:569). This is where tacit knowledge prevents an explanation; however knowledge can be withheld to increase a sense of self during uncertainty. Hence, the learner is 'silenced'.

A second example of learning from crisis arose on a Runnysea surgical ward where I observed Lucy during the seventh month of the programme. On this shift, Lucy initially appeared more self-assured than previously but ran into difficulties using suction on a patient with a tracheostomy (a tube into the throat to aid breathing). Lucy burst into tears (seen by tears rolling down her cheeks) that she tried to hide before asking an HCA for advice: *"I always go to*

*them, they know everything"*. The HCA pointed out that somebody else had put the wrong tubing on the machine. This could have had more serious medical implications and was an embarrassing learning moment for Lucy. Her lack of practical knowledge positioned her as less knowing than an HCA on this practical matter. On the other hand, she told me she had learnt the importance of always checking the equipment.

A final example of learning from moments of crisis was seen towards the end of the Preceptorship period when Louise was discharging a patient. This was significant because her Preceptor, Susan, was known as the "*Queen of Discharges*" and had previously been reluctant to allow Preceptees to undertake this process. Attempting to complete the discharge took up much of Louise's time as the patient had complex needs. Louise conferred with the patient's son; however, the patients' daughter arrived and was concerned that her mother might be discharged that day because it would require her to take responsibility for her mother's care. Susan, her Preceptor overheard this conversation and spoke to Louise angrily saying:

> *"This is a prime example of what can happen when a patient says they are desperate to go home at 7am. You need to think about what can go wrong, use all of your senses to pick up the vibes".*

Later Louise appeared upset stating *"That just blew my mind, I can't wait to get out of here"*, clarifying that she wanted to leave the ward and work elsewhere because Susan had made her *"feel so small"*. In other words, she wanted to work in a situation where she would be perceived as more authoritative. It is of note that Louise did eventually leave, taking up a position at Burydale.

Although the above example exposed Louise's lack of awareness of the wider implications of discharge, the situation was handled in a way that was insensitive to her tenuous confidence. Louise was positioned as unknowing and 'illegitimate' through her Preceptor's assertion of power when she disciplined her, yet this was also a learning experience. Louise learned she did not want to adopt the habits of those on the ward.

Preceptees appeared to start to exercise greater agency and move from a peripheral position towards the end of the programme. The next section gives examples of this.

## Pushing back against organisational practices

There were many examples of Preceptees 'pushing back' against prevailing organisational practices i.e. taking a more proactive role in their 'professional becoming' and deciding their own way of practicing. Some of this 'push back' began earlier in the programme. For example, I saw a Preceptee chatting with a

patient and furtively looking over her shoulder. She told me she was being 'naughty' and deliberately breaking the rules, having been previously reprimanded by a sister for doing this. The Preceptee did not feel newly-qualified nurses had enough time to chat to patients unlike HCA's who were able to build a better relationship with patients. This example shows how 'push back' was used against established practices and also occupational jurisdictions. 'Push back' was also evident towards the end of the programme as the following examples show.

During one shift that I observed on SCBU, Adele was asked to assist a registrar to insert a cannula into a baby's arm by holding it straight whilst the registrar attempted to find the vein and insert the needle. The procedure did not go smoothly and Adele's facial expressions (such as rolling her eyes) suggested that she was unhappy. After fifteen minutes of trying, the baby was distressed, and Adele strongly remarked upon this and suggested to the registrar that she should stop and warm the arm before she tried again. The registrar ended the activity and left without thanking Adele for her help. In this case, Adele was able to overcome the hierarchical constrains on the situation and act professionally in the baby's interests.

Kim on CDU explained in conversation how she recently needed a doctor to urgently catheterise someone at risk of danger from urine retention. Although the doctor said he could not attend immediately, Kim told me how she insisted because of the emergency situation:

> *"I said you are actually getting paid to sort this patient out. He's at a high risk of falling. He* [doctor] *said you'll have to get me a trolley ready and I said well I'm trying to do everybody's observations so I'll get one done as soon as I can…"*

Kim's smile when telling this story suggested that she was pleased that she had been able to assert herself in a situation characterised by what she felt was poor prioritisation.

At Riverton, I watched Louise, a Preceptee try to 'decipher' the doctor's handwriting on a medicines chart. She admitted incidents such as this were an ongoing obstacle for the smooth running of her work. Misinterpreting poor writing on a medicine chart had previously got her into trouble over a drug dose, but as she told me *"I gave as good as I got"*. Louise persisted and with help from another nurse, eventually deciphered the writing. This showed how Louise defended her 'mistake' in the face of what she saw as a more complex problem.

On the same ward, Sally also told me a story to explain her progression in becoming more assertive:

> *"I had …an elderly man in his 90's who had become very poorly and who was not eating and drinking, and there had been a problem getting an IV up and he didn't have anything going in artificially. I said to the sister, 'I want to ring the doctor, this man will die without fluids and he didn't express a wish to die and nor did his family'. The sister told me I was being ridiculous. I said 'I'm not going to let this man die and I will call the doctor' and I did. The next day I came on [*the ward*], the man was being fed nasogastrically and he recovered".*

Hence, Sally had explained how she had the confidence to overcome what she saw as poor organisational practices and instead realised her professional responsibilities. 'Push back' against established practices was also seen when the aforementioned Preceptees tried to change the process of handover on a Riverton ward.

It became apparent that adversity encouraged Preceptees' proactivity and their ability to overcome and transform practices. This incident and the earlier example of the three nurses and handover shows how practice can sometimes be elastic (Antonacopoulou, 2009) and transformation can occur. Early interactions can thus be constrained by Preceptees being positioned as 'newcomers' but as Preceptees negotiate learning and increase their repertoire of skills, they are better able to 'push back'. Although it has been traditionally argued that doctors enjoy a greater amount of symbolic and cultural capital

(Bourdieu, 1977) than nurses, some studies have critiqued this notion (Svensson, 1996; Allen, 1997). The incident with the baby's leg was interesting as it showed how Adele found her authoritative voice. Moral imperatives and the need to advocate for the baby appeared to prompt brevity. Adele also showed how Preceptees can also be politically astute in the way she phrased her words (which would 'save face'). Adele learned she could advise and challenge a doctor, part of becoming a professional in the current era. In short, the capacity to change a situation (or not) unfolds in practice, in time, and is tied up with morality and power. This shows the complexity involved in decision making in practice, something that is difficult to explicitly teach. Expressing knowledge can be suppressed unless there is a change in conditions, in this instance a pull upon Preceptees' 'moral' instincts of what is right and wrong. In the above examples, Preceptees managed these situations alone, and did not seek advocacy from either Preceptees or others, thus were moving towards their desired professional identity. As such, it appears to implicitly show that they no longer identified as strongly with being a Preceptee.

*When organisational norms prevail*

Although Preceptees in the above examples were able to exercise agency there was evidence that long term change in the face of strongly habitual ward practice was difficult. Preceptees often gave up trying to make a difference and adopted the habits around them.

An example of prevailing practices was seen in the case of writing patient notes. At first I noticed that at the end of shifts Preceptees would stay longer than other nurses to complete their notes. There appeared to be an interesting explanation for this on a surgical ward at Runnysea. The end of the morning shift coincided with visiting time and I saw how other staff nurses would sit behind the desk and appeared to direct their gaze to their notes which prevented interruptions by relatives. On the other hand, the Preceptee Gemma would stand by the front of the desk or at the notes trolley and was therefore more accessible to relatives. Yet, towards the end of the programme Gemma also appeared unavailable to relatives, leaving the HCA's and others to answer queries, showing her conformity to organisation norms.

Similarly, Clara would push the notes trolley into the patients' bay to write her notes. She explained that this was because it allowed her to write her notes and talk to patients without interruptions. Nevertheless, by the end of the programme Clara was writing her notes at the desk. She explained she had stopped trying to push the notes trolley into the bay *"because no-one else does it*".

In a further example, I noticed Angela on SCBU talking to an HCA explaining how a new baby she was caring for had enjoyed skin-to skin-contact with his father. The HCA's response was to laugh (at this evidence-based practice) and tease Angela, saying *"You're going soft on us"*. It therefore appeared from the HCA's reaction that Angela had done something that wasn't '*the way we do*

*things around here'.* Angela's facial expression showed that she was upset and embarrassed and she became subdued.

During interviews, Preceptors stated that Preceptees did not suggest their ideas for practice improvement. I raised this issue in group interviews and discovered that some Preceptees had got so used to their ideas being rejected they had simply stopped trying. As a Preceptee noted:

> *"I find on occasions, I've said something and you just feel like it's been dismissed, and then you hear the same idea said by someone else"*

The above conversation demonstrates that Preceptees felt they lacked legitimacy, even by the end of the Preceptorship period. When discussing their experiences during a group interview at the end of the programme many of the Preceptees expressed negativity and frustration about having to fit in to what they saw as inferior practice. As a disillusioned Preceptee said, "*I am just doing it for the money now".* Another Preceptee described being "emotionally wrecked, fragile, anxious…and negative". It appeared that it would not have occurred to some Preceptors that Preceptorship might be a useful way to learn insights into their own culture or that they might have been able to help Preceptees to evidence and implement their ideas for practice improvement (Roe *et al*., 2014).

A final example of prevailing organisational norms was seen during an observation of Clara. I noticed how confident and more integrated in the team she appeared and she told me she was now giving IV medicines. Her manner was relaxed (she used humour with the team) which was in contrast to the manner of a new Preceptee on the ward who was rushing around, appearing flustered and at one point said to herself: *"Now what am I doing?".* I noticed Clara rolled her eyes at the new Preceptee, and later told me that she thought her lazy. This was interesting because during ethnographic conversations the junior sister on this ward also told me about how lazy Preceptees generally were, for example, ringing in sick and expecting time off for school events. Significantly, it appeared Clara had adopted the view on the ward that positioned the new Preceptee as a peripheral member of the team.

The above examples of prevailing organisational practices show how 'professional becoming' can be constrained and unyielding under certain ward conditions. Again, this appears to suggest that Preceptorship cannot always empower Preceptees, nor prevent cases of prevailing local practices over what Preceptees might have considered counter to their professional ideal.

## Conclusion

In this chapter I have shown the Preceptee journey from early ward practices to those at the end of the programme. I initially showed how many Preceptees experience relative isolation, often preferring to interact with each other when possible. They would call for help from anyone in the absence of Preceptors

but if there was time, they would carefully choose who they asked, often having to navigate through complex relationships with HCA's and other staff. During this period, Preceptees have to navigate the ward layouts and the different routines of day and night shifts, and are often happy to remain in a peripheral positon in order to avoid trouble. I demonstrated how Preceptees had learned to seize more opportunities to participate in practices. This often necessitated a more proactive approach to negotiating access to learning opportunities. I revealed more about the nature of the Preceptor-Preceptee relationship in everyday work and showed how it occurred during certain moments amid the fast pace of often difficult working conditions. Of particular note was the way that Preceptorship was more or less apparent to Preceptees; it was more overt on small wards where Preceptees often had a higher level of contact with Preceptors, though this could sometimes make it difficult for Preceptees to progress. On larger wards, Preceptorship was less apparent with Preceptors trying to remain 'mindful' of Preceptees' practice. Preceptorship activity could take the form of 'show and tell' activities similar to student education, or ad hoc meetings as situations arose. I also discussed the material nature of Preceptorship, showing the difficulty of explaining esoteric knowledge. Finally I showed the practices manifested later in the Preceptorship period, during which time Preceptees still had many moments of reactive learning. During this period, Preceptees were seen to try to 'push back' against what they saw as poor practice, indicating how they constructed safety in everyday practice. Yet despite this, there were some organisational norms that prevailed and evidence of Preceptees continuing to participate in '*the way we do things around here'*.

The ward based practices considered were noteworthy because they show rich detail of aspects of the Preceptees' 'professional becoming'. I have shown key moments during mundane practice that typified Preceptees' experiences both with and without the presence of an official Preceptor. It is important to show the practices in both situations because each party had certain professional expectations of the programme and were often left disappointed because of organisational constraints. Preceptors wanted more time to help Preceptees but even when available, were not always aware of the very basic issues that could cause an emotional reaction. Furthermore, there was little awareness Preceptees could be seen as a resource for practice improvement. On the other hand Preceptees were sometimes unaware they were being supported and did not always recognise Preceptorship activity. Generally, Preceptorship on the wards appeared to be an important but underdeveloped resource for Preceptees who sought other strategies to learn how to 'be'.

This chapter shows two important concepts. First, that post-qualification 'professional becoming' under Preceptorship is a hybrid activity in which Preceptees try to learn and realise practices they associate with professionalism. At the same time, as new starters in an organisation they are faced with organisational pressures which can constrain their opportunities to learn and change practices they regard as unsafe. In the end, under certain conditions such as during adversity some practices are 'elastic' (Antonacopoulou, 2009) and can be changed by Preceptees whilst others are

more powerful and enduring and it is necessary for them to ‘fit in’. The second concept is that ‘professional becoming’ can be understood as an identity endeavour; Preceptees directed efforts to realising their notions of professionalism. There were moments in practice when Preceptees were positioned on the periphery of the community (Lave and Wenger, 1991). However these moments encouraged Preceptees’ agency and learning and encouraged Preceptees to question their past, current and aspirational identity and move from peripheral practice to a legitimate position.

# Chapter 8: Discussion

## Introduction

In the introduction of this thesis, I suggested we do not understand the nuances of the practices of post-qualification 'professional becoming', specifically for newly-qualified nurses as new starters to the organisational workforce and who undergo Preceptorship. In this chapter I elaborate and extend the findings presented in the preceding chapter and locate these within wider debates about professional socialisation. I start by summarising the findings that arose from studying the Preceptee journey. I then draw out and discuss three cross-cutting themes that appear to characterise the practices of 'becoming' from which I seek to contribute new empirical about professional socialisation. These include understanding the dynamics of emotion, position and identity found during the practices of 'professional becoming'. I then analyse and interpret the Preceptorship programme as part of a contemporary effort at organisational control, especially through the targeted socialisation of newly qualified professionals so they align with organisational rather than occupational interests. I also discuss the significance of resistance and 'push-back' during 'professional becoming'. I conclude this section with a discussion of how whether Preceptorship constitutes organisational socialisation or professional socialisation and how this enriches our understanding of hybrid 'professional becoming'. Finally, I deliberate on the implications of this study for Preceptorship policy and practice.

## Summary of findings

In this ethnographic case study, I explored the post-qualification 'professional becoming' of Preceptees at Oldshire NHS Trust. Chapter 5 explored the local context of the three distinct sites where my fieldwork took place. Overall, I found a troubled NHS Trust that was experiencing regulatory issues and attracting poor media attention. As described, the NHS Trust comprised three hospitals located in different towns and cities, and I noticed subtle differences between these sites. For example, each had a slightly different appearance and maintained distinct practices such as paperwork and how they stored equipment. The regulatory problems were particularly evident at one site, Runnysea, (the more geographically isolated hospital) which some Preceptees considered to be 'a back-water'. At Runnysea, I heard much talk about the Care Quality Commission (CQC) report on their failings and on a tour of the hospital noted that newly-qualified nurses were named "*babies*" and considered to be a "*nuisance*" by some more senior staff. These common external pressures and local differences provided the organisational backdrop to which the Preceptorship programme was implemented.

Chapter 5 also showed how the Clinical Education (CE) Team was both socially isolated from Trust Management and was under-resourced to undertake its' work. Practicing at the intersection between profession and organisation (Waring, 2014), the team appeared to have issues with identity (whether it was an organisational or professional concern) and sense of purpose (having undergone a name change in the light of regulatory problems) and being perceived as removed from everyday practice. This sense of turbulence

was reinforced in the early stages of data collection where I found one Preceptorship cohort was cancelled due to a recruitment freeze.

The implementation of the Preceptorship programme within Oldshire Trust might be considered a strategic initiative on the part of senior hospital managers to address these external pressures and raise standards amongst newly recruited nurses. The programme was also something of an experiment, as its introduction to the Trust predated the implementation of the Preceptorship Framework (Department of Health, 2010a). However, there was also evidence within the Trust of low 'buy-in' from senior ward staff, who were needed to act as Preceptors to the newly-recruited nurses. As a new policy that negatively impacted onto ward resources without the benefit being completely apparent, low buy-in might be expected. However this appeared exacerbated by the CE Team's low cultural and social capital (Bourdieu, 1977:114). That is, the CE Team had few established connections or affiliations at ward level, limited reputation or legitimacy with ward leaders, and also limited appreciation of the subtleties and nuances evident across different clinical domains. The CE Team was also unable to fund regular Preceptor training or able to influence the allocation of, or keep a register of, the ward-based Preceptors. In designing the Preceptorship programme, the CE Team appeared unsure if it needed to be more focused on professional development or meeting organisational imperatives. I found that the content of the Programme was imbued with Trust imperatives of quality and safety, and was considered to be "hijacked" as a team member termed it.

In Chapter 6, I studied the early practices of Preceptorship with a particular focus on the more formal classroom-based interactions between the Preceptees and the programme leaders. I found a strong need to persuade Preceptees that the Trust's version of Preceptorship was valuable and that the CE Team could deliver what it promised. For both the CE Team and Preceptees, the configuration and delivery of the Preceptorship programme was clearly shaped, even constrained, by wider organisational and contextual pressures, with a sense that the programme was targeted at establishing desirable behaviour and practice in light of regulatory expectations and perceived poor standards of care. As such, there was an underlying sense of ambiguity about the programme regarding whether it was primarily aimed at supporting and developing the competencies of newly-qualified nurses or rather addressing organisational problems. In some ways, the practices of the CE Team and its interaction with the Preceptees showed how it often sought to achieve both aspirations, and in doing so contributed to processes of hybrid 'professional becoming'.

The early reactions of Preceptees to Preceptorship revealed an 'elephant in the room' that was rarely addressed in formal settings - namely the emotional aspects of entering a new workplace and integrating into the wider workforce; facing for the first time the realities of frontline clinical work as an accountable professional, and having to deal with the organisational pressures and expectations of the hospital. However, within the classroom environment there were few opportunities or routes to discuss and address these emotional aspects

of becoming. At the same time, where emotions or rather 'emotive language' were found in the classroom settings, they were often framed by wider organisational pressures and used by the CE Team to position Preceptees in a particular way, e.g. 'unsafe' or 'inexperienced', in order to justify the relevance of the Preceptorship programme. As such, emotional rhetoric was used to enrol nurses into the programme, but the emotions nurses expressed that they felt when entering the organisation were marginalised. The chapter also showed how the practices of Preceptorship were largely prescriptive or a 'tick box' exercise to evidence competencies. In particular, within classroom settings the Preceptorship programme was articulated and enacted as a form of organisational induction rather than post-qualification professional development (Gherardi and Perrotta, 2010).

In Chapter 7, I discussed the practices of professional becoming and the continuing experiences of Preceptorship on the hospital wards, where Preceptees learned through interactions with Preceptors and members of the clinical workforce. The findings show how they accomplished their learning through negotiating simultaneously the demands and expectations of both the hospital ward and Preceptorship programme. At first, Preceptees had to navigate their way around the ward (and often hospital) environment and resources. This was often complicated as it involved learning local customs and practices, especially the aspects of practice that were often taken for granted by others and embedded in language routines and objects. Once their knowledge gaps were exposed, Preceptees had to compete with others to gain experiences and develop their learning. At this stage they were 'surviving' and often had to

work without the support of Preceptors, either because they were unavailable or because interpersonal relationships were under-developed.

During this early period of 'professional becoming', I showed how Preceptees wished to avoid trouble and displayed much hesitancy. In this period, they constantly double-checked what they were doing as a way to deal with uncertainty. Simultaneously, they became more aware that others do not always practice 'by the book'. Later, however, I showed how Preceptees became more proactive and seized opportunities to learn. There appear to be two forms of Preceptorship, 'direct' and 'indirect', which was dependent upon local context. Preceptees on small wards were more likely to receive 'direct' Preceptorship in the form of a close mentoring relationship. However, on large general wards it was noteworthy that there was more 'indirect Preceptorship', an aspect of Preceptorship that was hidden from Preceptees. On small wards, Preceptors could monitor Preceptees more easily while those on large wards found this difficult (but claimed they were mindful of what Preceptees were doing). I also found that as Preceptees became more accustomed to the clinical workplace there was 'push back' against prevailing practices considered to be poor or unprofessional. Newly-qualified nurses have to make decisions about what to adopt, what to do differently or, as I showed, when to 'give-in' to strongly held cultural norms that are too difficult to change. I drew attention to how Preceptees move from peripheral practice, which is driven in part by wanting to leave Preceptorship and to pass through the pay and performance gateway. During this period, they addressed important knowledge gaps and continued to learn reactively through crisis.

By highlighting the significant practices of the post-qualification period of 'professional becoming', a time when Preceptees were also new starters to an organisation, I was able to build a rich picture of Preceptees' learning whilst undergoing Preceptorship.

The following section discusses what the findings tell us about the dynamics of learning in the contemporary post-qualification period when undergoing Preceptorship. It discusses three cross-cutting themes that have emerged; emotion, positioning and identity.

## Emotion

I draw out emotion as a cross-cutting theme because it appeared to be an important aspect of the 'professional becoming' of Preceptees. Although I did not use a psychodynamic approach to this study (e.g. Vince and Martin, 1993), emotion could not be ignored as an emergent concept as I saw what appeared to be much expressed emotion during Preceptees' practices and emotion was also a strong theme that was found in their accounts of practices during the group interviews and ethnographic conversations. For example, I described how Preceptees' conversations in the group interviews were imbued with descriptions of their feelings, for example when the uniforms were described as a 'badge of shame'. Emotional words and phrases used during the group interviews draw also revealed strong emotions such as 'sad' 'anxious',

'emotionally wrecked' and 'fragile' however these emotions were not all negative, as they also talked about feeling 'proud'.

I observed many expressions of what appeared to be intense emotion on the wards. For example, it was interesting to note that Preceptees would cry (seen by the tears rolling down their faces) whilst appearing to hide this from others. Significantly, feelings of being upset, as observed in Preceptees crying or retelling emotional events, appeared to be significant moments in their learning. It is noteworthy that these expressions of emotion appeared to be less apparent towards the end of the programme, which could indicate that Preceptees became less emotional over time or that they had learned to conceal or manage their emotions, or for other reasons that I explore later. I now relate approaches to emotion and learning to my findings.

*Why 'professional becoming' is emotional*

To understand the role of emotion and learning in organisations we can first turn to a well-established literature which has drawn on both psychodynamic and sociological approaches. Psychodynamic approaches to learning in organisations have shown the anxiety and shock that is closely associated with learning and change due to the need to negotiate uncertainty (Kramer, 1974; Schein, 1993, Vince and Martin, 1993). As such, my findings show that being asked to undertake a new task, for example a complex discharge, created uncertainty as it exposes the 'white knowledge' (fuzzy knowledge) of Preceptees. I also showed how in the light of such uncertainty, Preceptees initially appear to choose what to ignore or side-step as 'too difficult', and what

they would seek to address at both a practical learning and emotional level, as they became more established in the social setting. As such, Preceptees appeared to develop a staged approach to learning that was influenced by their emotional resilience. This is important because it does not necessarily match the pace of prescribed learning by the organisation that required them to develop specific competencies within a given time-frame. However, the problem with applying psychological theory to these situations is that similar to many studies of organisational socialisation they are often individual in focus and do not consider nuanced, practical relations with others during moments of anxiety such as those I show in my findings.

An alternative and more sociological understanding of organisational learning recognises that it takes place through interactions between humans who have feelings and attachments to ways of working. It has been noted how this aspect of learning is often ignored by management because it is "uncomfortable knowledge" and is seen as something that should be rationalised, rather than accepting that people can feel emotions such as 'joy', 'fear' and 'shame' in learning (Vince, 2002:73). This is important to note because during structured 'professional becoming' there was little opportunity for Preceptees to express their emotions in the classroom. Yet, expressions of emotion were evident in the group interviews, conversations in the café and ethnographic observations and conversations with Preceptees. The emotional aspect of 'professional becoming' was therefore an 'uncomfortable' aspect of learning for the CE Team to acknowledge and address. It was unquestioned and rationalised on the introductory study day as "reality shock" (Kramer, 1974:53) and something

that could be ‘fixed’ by the Preceptorship programme in providing correct competencies to work towards and by assigning a Preceptor. Although Preceptorship was promoted as pastoral care this appeared to be limited by time spent on the official agenda. Hence Preceptees learnt to stop talking about their feelings in the classroom, which gave the impression to the CE Team that learning was more trouble free and smooth than it was.

Other sociological theories can help explain the interplay between emotion and learning. Social constructionist approaches to learning have acknowledged emotion as integral to action and how the self is presented. Emotion has long been argued to be central to socialisation when expected emotions are shaped by social interaction (Fineman, 1993). We look to others and learn to anticipate embarrassment, for example, so that we can avoid acting in a way that might break taboos (Goffman, 1969; Fineman, 1993). This could explain the hesitancy of Preceptees wishing to avoid trouble in their early ‘professional becoming’.

I also described how Preceptees were sometimes seen appearing to fight back tears on the wards. This suggests that new professionals learn not to show their emotion -and thus reveals an important performative aspect to early ‘becoming’. Drawing on the work of Goffman, Hochschild (1983), differentiates between ‘surface’ and ‘deep acting’ to show how some professions have to cultivate deep acting and ‘become’ the part that they are playing. Professions such as nursing are public-facing and it is suggested that they have to appear to care (Bolton, 2001). Newly-qualified nurses have not yet

become the professional who is expected to display such emotions by the public and therefore it could be argued they are learning to both 'surface' and 'deep' act (Hochschild, 1983). Preceptorship and other induction programmes do not recognise this aspect of socialisation because they emphasise the 'ideal' version of the nurse but not the emotional aspect of the work that characterises everyday practices.

However, in line with acceptance that emotion is part of everyday work, it is argued that the need for nurses to 'perform' emotions at work is no longer valid. For example, Dingwall and Allen (2001) discuss the concerns about healthcare reforms and the worth of emotion work in nursing, noting the unrealistic expectations made of nurses in this respect. As such, emotion work is seen as a myth which is deployed as part of the nursing mandate. If nursing is no longer regarded as emotional work, there could be a different explanation to why emotion is a feature of the 'professional becoming' of newly-qualified nurses.

Many studies suggest that during professional development programmes, learning activities are often designed around individuals and not relations between groups as part of a local learning system (Vince 2002). This is significant when considering the comments made by Preceptees about the difficulty of reflection. It is therefore important to consider whether learning is constrained by newly-qualified professionals' fear of being seen as not fulfilling expected competencies and thus not being 'signed off'. However, there appears to be a fundamental problem with studies that describe emotion

as an impact on occupational learning (Vince, 2002) rather than constitutive of learning. To help develop the role of emotion in my theoretical understanding of 'professional becoming', I turn to practice-based studies of emotion and learning. These are important because they do not separate emotion and learning, but rather accept that emotion is integral to relational learning in every-day practice.

## A practice-based understanding of emotion and 'professional becoming'

It could be argued that practice-based approaches cannot address the emotional dimension of learning as they do not study inner feeling as separate phenomena to interaction. However, more recently emotion has been studied in practice-based research. Emotions can be seen as a positive and constitute the passion involved in everyday knowing in organisations. For example, practice theorists, such as Gherardi *et al.* (2007), argue that we cannot separate practices from emotion. Their approach moves beyond the psychology of the individual and sees everyday interactive work as imbued with passion in terms of enthusiasm and a desire to learn. This implies that professionals are passionate about learning professional knowledge not just because it is prescribed by the organisation but because it is integral to their sense of professional identity and community membership. That is, newly-qualified professionals act as they do because they feel passion for working and learning which in turn gives them a sense of control or autonomy in their practice and sense of a belonging. Gherardi *et al.* (2007) suggest this is a view long held by pragmatists which

runs counter to modern approaches to working and learning which have a more economic and rational view.

Gagliardi (2007) suggests that ethnographic approaches help us to understand this non-rational aspect to learning and allow *pathos* (the way reality is perceived) to resurface in research. Gagliardi (2007) also notes how Aristotle argued that a situation describes not only the conditions of activity but also the emotion arising within it. In ethnographic approaches we can see how learning is emotional, relational, sometimes impulsive, and found in everyday, mundane work. Although it could be suggested that only psychological tools can be used to understand emotion, Gagliardi (2007) suggests that during ethnographic research, the researcher can use their sensory understanding of what they are observing. This is deemed acceptable and not thought to require positivist, scientific language. This is not about auto-ethnography rather making informed judgements on the detail of the situation. An approach that uses careful aesthetic judgement helps us to understand how situational learning shape identities (Martin, 2002; Gagliardi, 2007), a point which I discuss in following sections.

The above points are important because what I observed during 'professional becoming' was in part, the natural manifestation of emotion in everyday learning. The Preceptees as human beings were passionate about what they needed to learn. They were also attached to the idea of learning 'ideal' nursing professional knowledge (because it directly connected to who they wanted to become). This was seen to sometimes run at odds with organisational norms

and attempts to make the organisation a "desirable object of identification for individuals" (Gagliardi, 2007: 335). In other words, newly-qualified Preceptees did not learn only for the organisation, but also for themselves. However there also appeared to be other phenomena occurring, notably 'positioning' episodes. In the following section I explore these moments and propose how they also relate to 'professional becoming'.

## Positioning

As well as emotion being an important, if somewhat neglected aspect of 'professional becoming', my research also shows how 'positioning' and 'positioning episodes' were significant features of this process. By this I mean that social interactions and practices involved in the Preceptorship process, and socialisation more broadly play an important role in locating or positioning participants within the field of social relations, often in relatively marginal, low-status or peripheral positions within the organisational and social hierarchy. As Preceptees developed their learning in terms of clinical knowledge, shared customs and tacit assumptions, their positions changed as they moved, for example, from more peripheral to more central positions within the field of relations (Lave and Wenger, 1991).

### *Defining positioning episodes*

Although the notion of social positioning is open to interpretation, a useful definition arises from anthropological studies, e.g. they are "pivotal moments in which social and psychological phenomena come to inter-animate and

interpenetrate one another" (Holland and Leander, 2004:127). As a concept closely related to identity, this definition means that the person and the social world are mutually constituted during practices or moments of ordinary discourse, spatial organisation (e.g. ward or classroom) or through some form of media (e.g. documentation, newspaper reports). Positioning moments are argued to be one of the most important ways that the self is shaped through power relations (Holland and Leander, 2004). In this perspective, power regimes (e.g. du Gay, 2007) are seen to categorise people who are treated as a particular subject. Hence, during 'professional becoming' power relations socially locate the newcomer in a certain position at a certain time. This is a perspective on power that sees structures not as external to interactions but found within them. As Fernandes (1997:137) states, structures are "the codification of power through movement, space and position". In other words, power produces subjectivities in real-time.

Drawing upon Bourdieu (1977), Holland and Leander (2004) suggest actors can accept or try to refuse a position. This is a useful approach to explain the positioning moments I described in my findings where, for example, Preceptees appear to be positioned in the community as 'unsafe' and 'unknowing'. At first, they had to accept this position because they lacked technical skills or 'insider' knowledge. However, these moments appeared to be powerful learning episodes, closely related to strong emotion. During these moments, I often observed tears or what appeared to be annoyance. I also showed how positioning episodes were manifest for example when an HCA supervised the Preceptee inserting a venflon, due to the blurring of professional

boundaries. HCAs could perform a number of extended tasks that Preceptees were not allowed to do, which again was a source of negative identification and positioning for Preceptees. The importance of this for 'professional becoming' is that positioning situations continue until practitioners have learned key ways of practicing and can act with more authority.

*Positioning and history*

It was not only Preceptees who were positioned on the periphery of the organisation, but the CE Team, and by implication the role of professional development, also appeared to be constrained by resources and be seen as of low importance. However, positioning episodes can be momentary or described as long-term episodes arising from wider institutional pressures that can impact on the positioning of an occupation. Positioning episodes are described as historically specific moments that can "travel from one locale to another" affecting both individuals and groups of people (Holland and Leander, 2004:128). This is a practice-based perspective which describes how relations are connected across communities and also over time. Positioning episodes are therefore more than a fleeting moment during mundane work, historical pressures also matter. This is important because it shows how practices move between overlapping communities of practice (Gherardi and Nicolini, 2002). As such, the history of a profession can play an important role in the positioning of a newly-qualified professional. For example, I showed how the history of nursing is important to current 'professional becoming' as there have been lingering historical debates over how a nurse should behave and where nurses are seen in the nursing/medical social order. Hence, both

historical positioning and moments in everyday work are important sources of identification in 'professional becoming'. The following section explains why positioning is important as a feature of learning and as such becoming.

*Positioning and learning*

Positioning is integral to the learning and transformation of the newly-qualified professional. Wanting to move position is a driver for learning, and positioning episodes appeared to give momentum to this process. There appeared to be two different learning styles that were connected with positioning, both of which I describe in this section.

As previously discussed there is 'prescribed learning' in the form of competencies and the need to become 'signed off'. This became increasingly urgent especially during moments when 'white knowledge' was highlighted during interactions. On the wards, particularly large general ones, Preceptees often had to opportunistically seek help from available human and material resources. As Mol (2002:170) recognises, technicality depends on "social matters: practicalities, contingencies, power plays and traditions". This shows that 'professional becoming' is contingent on power relations, the situational unfolding of work and the ability to master technology. As such, a programme that structures 'professional becoming' may not manifest as intended because of contextual barriers to learning. The realities Mol (2002) refers to will possibly exert influence on accessing resources and a Preceptorship programme could acknowledge these realities and although will not be able to

contain them, drawing attention to these pressure could help Preceptees deal with complexity.

At first, Preceptees have no choice other than to accept their position, at least on the surface. They enter into a bargain with the CE Team, whereby each fulfils the others' agenda. Until Preceptees' prescribed competencies are legitimised through being signed off, they remain peripheral. Signing is both a symbolic and material activity that connects practices of the CE Team, the Trust and Preceptorship on the wards. Signing off the portfolio connects two practice worlds and co-produces (at least on paper) the 'desired' nurse. The portfolio is thus a site of socio-material accomplishment. Signing the portfolio also accepts the historical legitimacy of the signature to demonstrate accountability and serves to uphold the act of signing as a mode of legitimising the professional (Hopwood, 2014).

The second form of positioning is found in more 'organic learning' in everyday work. Newly qualified professionals first have to recognise their 'white knowledge' before they move beyond their peripheral position. Preceptees involved in this study achieved this not only by working with Preceptors and other qualified nurses, but also through interactions with other occupations. This is important for understanding professional becoming because until 'white knowledge' is manifest, newcomers are not always future focused and pro-active. Preceptees tend to function reactively at first. Once 'white knowledge' is evident, Preceptees can make an effort to address it and tend to do so. This

equates to the rejection of their allocated status through positioning and increases their ability to move to a more central position.

Positioning is not a one-way power relation, nor necessarily something that needs to be remedied through a programme or other intervention. This is because Preceptees respond to positioning by trying to increase their "cultural capital" and therefore reject their peripheral position (Bourdieu, 1977:114). This was seen when I showed how a Preceptee exclaimed *"I will push, I will learn"*. Although Preceptees were aware of competency gaps (such as venepuncture), others such as safe medicines management were highlighted to them in the classroom as part of the Trust agenda. However, through observing their practices I saw that most were highlighted during their work on the wards. As such, newly-qualified practitioners do not want to copy the practices of 'anti-role' models; they have a professional idea of who they want to be. This is significant for 'professional becoming' because newly-qualified practitioners do not remain passive when positioned although at first they have no choice but to start from the very periphery. Once they had begun to move position, Preceptees responded because they were future orientated and aspired to move from the periphery, to 'know' and decide what they wanted to adopt as part of their professional repertoire. In the following section, I discuss this in terms of identity and 'professional becoming'.

## Identity

My third cross-cutting theme relates to the importance of identity and its interaction with emotion and position. In the literature review, I explored different theoretical perspectives that see identification as integral to professional socialisation and 'becoming'. First I noted how contemporary healthcare professionals identify with more administrative duties as managerial and clinical duties increasingly overlap (Hunter, 1996). I illustrated how professional identity can be subjected to institutional pressures which frame how professionals negotiate their position and thus has been theorised as a site of control (Alvesson and Wilmott, 2002). I also discussed how newly-qualified professionals experiment with different selves during their 'becoming' (Ibarra, 1999). Finally, I introduced the organisational learning perspective to identity (Gherardi, 2001; 2011; Nicolini, 2009; 2012) which helps us to explore all of the above ideas from an approach grounded in everyday work. Identity is seen as an ongoing, provisional accomplishment that is not complete or settled. Furthermore, identity and identification are inherently shaped by relations of power and wider institutional pressures, rather than possessing a single, reified form of identity (Jenkins, 1996). Studying the practices of 'professional becoming' has illustrated how Preceptees identify with certain practices which helps to reveal the ways in which newly-qualified professionals move from identifying themselves as peripheral members of the community as 'Preceptees', to identifying with being more central members, i.e. 'nurses'.

In my findings, I demonstrate that Preceptees try to accomplish mastery of their work not only with Preceptors but also other occupations and with their own ideals. They may try to copy others or more often will adopt aspects of

practice that they identify with. This is often accomplished when 'white knowledge' is highlighted to Preceptees through relational work. It is noteworthy that this learning is often not aimed at meeting prescribed competencies, but rather, as noted above, is a more organic process of 'in the moment' and wanting to know what to do next. In other words, they want to learn particular skills and processes because they are required by the immediate needs of the ward rather than learning more abstract skills such as dignity and safety, which is considered to be already known. In this way, mastery is closely related to immediate needs of the context. Hence, Preceptees learn 'to be' through working with HCA's, for example but, as I showed, do not identify with them. Rather, they take steps to elevate their social positon in order to be seen as more knowledgeable.

The following sections discuss two other aspects of identity and professional becoming which are performativity and morality. These are relevant to becoming because they are often hidden in mundane practice.

*Identity and performativity*

To work towards attaining local mastery Preceptees were proactive in seeking out opportunities for learning, and I highlighted common situations in which Preceptors and Preceptees interacted, e.g. standing at the notes trolley, using charts and forms, or centring on a specific activity such as the blood test or a discharge. Hence, there is a material and performative aspect to 'becoming'. These moments are performative because experienced practitioners try to explain tacit knowledge using props and tools. By referring to official charts

and forms, and using, for example, the notes trolley as a formal site of learning, they appear to anchor their identity in material artefacts as they provide certainty (Nicolini and Roe, 2014) when there are many possibilities for action. Preceptors have to choose a 'best way' and describe this to Preceptees because, as described in Chapter 2, mentors also have to account for what they do both verbally and in their actions. As we saw in Chapter 7, Preceptors are aware that they do not always practice 'by the book'. Although newly-qualified professionals have immediate needs from learning context-specific skills, we can understand why they want to learn 'by the book' (as seen in the aforementioned 'double-checking'). This can be seen as constituting how 'to be' professional rather than copying sub-optimal practices. This is an interesting dynamic of identity which shows how professional and organisational dynamics and identity occurs during 'becoming' in the early post-qualification period.

*Identity and moral concerns*

Another dimension which can be discussed from the research data is morality. During early 'becoming', the newly-qualified professional has to establish what it is acceptable to do and what is not through relational practices. In my study, I showed how prior socialisation and personal histories and identities are also important. Preceptors and other mentors decided what should be explained based on their own socialisation and sense of morality (Edwards, 2010). Each had their own particular way of practicing, for example the Preceptor who took control of discharges. Preceptorship itself also appeared to be a moral issue

because more senior nurses did not identify with the need for a special programme of support and considered it to be morally wrong, for example a waste of resources. Preceptors and ward leaders often spoke about Preceptees in derogatory terms, for example babies and often referred to the 'golden era' of nursing, (Dingwall and Allen, 2001). This is where we can again see history at play during interactions of 'professional becoming'. The nature of historical and local pressures is described by Holland and Lave (2001:5):

> *The two come together again and again in conflicted practice undertaken not only in the face of changing material and social circumstances but also in the changing terms of culturally produced forms. The two histories come together with the result that local practice always has the unfinished quality of an experiment for the future of these structures.*

This demonstrates how conflict can happen as Preceptorship draws attention to 'professional becoming' as a special case. This was at odds with existing beliefs about how newly-qualified nurses should socialise. More senior nurses socialised by being thrown in at the deep end as it were and often did not understand why Preceptorship was necessary.

*Identity and educators*

When studying how Preceptorship was developed and organised, my research found that the CE Team also engaged in managing its identity regarding its positioning within the organisation and because of recent scandals. The name change and 'hard selling' of the Portfolio suggests that the team tried to anchor its identity to material artefacts (Nicolini and Roe, 2014). The CE Team was positioned at a 'theory-practice' boundary (e.g. Maben *et al*., 2006) and had to appear to coherently co-ordinate its' effort to fulfil organisational expectations. This is important as in parallel with this, it was engaging in the 'production of the nurse' through the vehicle of Preceptorship, and as such, was carrying out two inter-related sets of practices. By asking naïve questions, I was able to surface doubts and insecurities about what it could provide.

The practice of chatting in the office shows that the CE Team did not just comprise practice educators but also reminds us that its' team members had personal histories. They were parents, friends and carers, and were all experienced nurses. Most importantly, they were already socialised in Oldshire Trust and some, including Mia, had been working there for many years. The collective practice of calling Preceptees 'babies' tells us that previous histories come into play here as the CE Team members identified themselves as 'experts' or even parental figures. This helps to explain why they positioned Preceptees as a homogenous group that lacked competencies; again, it fulfilled their agenda.

## Emotion, positioning and identity in learning

My study has noted an important dynamic seen in the contemporary .post-qualification period of 'professional becoming' that centres on the interaction between emotion, positioning and identity. Although these aspects of learning are recognised in various ways as integral to professional or organisational learning, they have not been empirically developed within the post-qualification period or indeed linked to offer an integrated and novel understanding of 'professional becoming'.

My study suggests that during learning moments, when knowledge gaps are exposed in mundane everyday working, emotion and positioning play an important role in both stimulating and framing the learning process. I have drawn attention to the emotional nature of learning. Because there is an inherent passion for learning (Gherardi *et al.*, 2007), emotion was often evident during certain moments that involved positioning and self-identification. There was evidence of both structure and agency in this dynamic, and it arose in different scenarios. For instance there were occasions when 'top down' power relations with senior practitioners positioned the Preceptees on the periphery of practice. There were also often emotional responses to this positioning which manifest as distress but which also often expedited learning. However, during other learning moments, Preceptees could also self-position in response to being identified as lower in the hierarchy than HCA's, for example. This would be emotional and a trigger for more pro-active learning. The third scenario occurred when Preceptees became aware of 'white knowledge' and pro-

actively tried to learn because of their passion for knowledge (Gherardi *et al.*, 2007) In these cases, Preceptees developed strategies to learn aimed at progressing their idea of how a professional nurse should be and what they should know. When their knowledge was legitimised their position became more central in the community of practice (Lave and Wenger, 1991).

As such, newly-qualified professionals worked towards 'becoming' because they were future-focused and wish to "self-author" (Holland and Lave 2001:10). This process of 'becoming' did not appear to have an end point and was not necessarily prescribed by fixed or abstract ideals or notions of morality; rather, newly-qualified nurses learned to accept some local practices that they did not agree with but which were aspects of the local organisational environment. This is because, as I noted, it is not possible to 'author the self' as a complete project. Rather, the newly-qualified professional has to choose a gradual path which is subject to the dynamics of the practice environment. This understanding of emotion, position and identity is important because it is a previously unexplored dynamic of 'professional becoming' and shows how a practice perspective can expand our understanding of socialisation.

## Organisational and professional socialisation

In the literature review I suggested that socialisation essentially involves learning how to *become* a professional (Scanlon, 2012). This involves learning *particular* competencies that help to co-ordinate the situated, discursive and

material practices of a profession (Sandberg and Pinnington, 2009). As Gherardi and Perrotta (2010) note, learning how to be a professional is complex because although competencies and practices can be abstracted and formalised, they are often transmitted tacitly in a community. Goodwin (1994) also showed how professional learning is accomplished in situated activity. This reminds us that newly-qualified professionals are also new starters to an organisation.

When drawing attention to the contemporary context of 'professional becoming', I discussed to what extent post-qualification socialisation is aimed at enrolling new members of a profession into an organisational discourse of expected practices, or whether socialisation was more about fostering adherence to broader professional or occupational expectations about practice. In the literature review, I noted how the organisational and the professional socialisation literatures tended to focus on different aspects of socialisation. The organisation studies literature is concerned with new starters, whilst the professional socialisation literature emphasises pre-qualification socialisation during education. I highlighted that increasingly the professional and organisational aspects of expert work are seen as co-constructed and that post-qualification socialisation as a new organisational member is empirically under-researched. Further, we do not understand how this plays out in the context of new developments such as Preceptorship. I now consider how the Preceptorship programme and 'professional becoming' more broadly are increasingly linked to strategies for organisational control over professional socialisation and future work.

First, I consider whether initiatives such as Preceptorship are used to promote a more positive image of the organisation. Second, I discuss whether organisations use Preceptorship to structure and shape post-qualification socialisation so as to ensure professional adherence to prevailing organisational imperatives. Third, I note how organisations specify nursing competencies as a way to measure socialisation. I consider whether such organisational initiatives not only act as a form of control over new workforce entrants but are also configured to offer a counterbalance to established forms of professional power. Finally, I discuss the nature of resistance and control and how this study shows that post-qualification 'professional becoming' in organisations is a hybrid phenomenon.

The findings suggest that organisations, in particular those that have experienced safety problems can be an early adopter and promoter of Preceptorship because of external and internal pressures which affect reputation and recruitment. Preceptorship is in part aimed at addressing these problems. The study highlights how the organisation will use Preceptorship as an explicit public relations exercise to attract nurses into the organisation and retain their loyalty and commitment. Unsurprisingly this is a particularly important strategy for healthcare organisations perceived to be in trouble or possessing a negative reputation, which can render it difficult to recruit and retain staff. The need to address this reputational problem and retain staff might explain Oldshire Trust's early adoption of the programme. In other

words, Preceptorship was the organisations way of trying to enmesh professional values with its own by painting a positive picture of the organisation and nursing. The organisation's second purpose appeared to be directed towards gaining public support. Both on its website and in the Portfolio, the Trust advertised Preceptorship and explicitly linked it to appraisal systems. This shows how NHS Trusts use policy not just to attract nurses but also to reassure the wider public that they are appropriately managing newly-qualified nurses (who could be seen as lacking the right experience and skills), and therefore working to promote patient safety and care standards. In short, the Preceptorship initiative might be interpreted as an organisational response to not only enhance nursing competencies but to allay public concern and restore reputation, by showing how new nurses are supported in post.

In the light of regulatory problems or other organisational issues, Preceptorship programmes attempt to align post-qualification staff to organisational imperatives, as manifest in the attempted alignment of Preceptees to competencies and desirable behaviours. The Oldshire Preceptorship programme was instrumental in Oldshires' effort to try to foster certain behaviours that were seen as lacking within the Trust and to an extent in the wider NHS. Oldshire attempted this through the use of particular discourses, both borrowed from the policy and seen in its own behaviour framework and the language of educators. As I noted in Chapter 3, the language of the Preceptorship Framework encouraged people to see it as a tool that could modify the attitudes and behaviours of newly-qualified nurses. This was

because, Preceptorship promises "enhanced quality of care" and that the Preceptee will feel "proud and committed to the organisation's corporate strategy and objectives" (DH, 2010a:14). This prompts organisations to attempt to merge the language of the Framework (DH, 2010a) with their own corporate objectives. In this case however, no explicit connection was made during the 'selling' of Preceptorship, rather, the Framework (DH, 2010a) was first presented as a general legitimising concept, and the organisations own behaviour framework as running parallel to it. It was more difficult for the organisation to make explicit connections between them as the two frameworks did not synthesise easily. (The Trusts' framework was intended to structure behaviours of all occupations). Although, some adaptation of the national framework was to be expected, my findings show how Oldshire used it to legitimise its own agenda as a form of control and to counter-balance professional power (McDonald, 1995), and other NHS Trusts might do the same.

When considering other ways in which Preceptorship acts as a form of control, it appears that in this case, the CE Team used the programme to restrict activity of Preceptees by controlling when Preceptees learned particular skills. Hence, Preceptees were not allowed to undertake advanced skills such as taking blood or doing blood glucose monitoring until they had received standardised training during the Preceptorship programme. Furthermore, they were not allowed to begin training to administer IV Medicines until they had been qualified for four months. Newly-qualified members of a profession enter into the organisation on the periphery of the community and I have shown how they lack capital,

e.g. “social” or “symbolic capital” (e.g. Bourdieu, 2003:114). In other words, they lack the resources that they need to progress to a more central position. The Oldshire Trust therefore had a major role in controlling resources which Preceptees needed. Without these resources Preceptees lacked legitimacy and power which impacted on their developing professional identity. Although there were complaints about this from both wards and Preceptees, these were downplayed in the name of quality and safety. In this case, Oldshire Trust was instrumental in keeping Preceptees and their concerns on the periphery. This local policy meant that Preceptees self-positioned themselves lower in the hierarchy than HCA’s because they were not seen as skilled in some respects. This was both an organisational and professional issue for nurses: On the one hand they needed the skills to fit in to the clinical workplace; on the other, extended skills were important because Preceptees wanted to advance their visible skills beyond that of HCA’s to achieve a sense of professionalism.

Perhaps the most important way that an NHS Trust can control socialisation is through specifying competencies considered to be ‘ideal’ in a nurse and which were related to performance management through the National Learning Management System. As I noted earlier, in the light of such competencies, newly-qualified professionals are required to enter into a form of unspoken bargaining with the organisation that allows them to move from peripheral practice. The CE Team, or other provider of education, creates a programme of competencies for which they need to be legitimised. In the case of Preceptorship, this involves designing different ‘ideal’ components including the relationship between a Preceptor and Preceptee, of which but not all they

have control over. Of note is that this is a material accomplishment. The 'right' competencies and behaviours need to be codified and captured through material means, hence the Portfolio. The Portfolio helps to sustain the practice of Preceptorship. As Nicolini (2009:228) argues, "Tools mediate a historical and social dimension in the accomplishment of any practice", and hence codify work. The Portfolio thus becomes what Latour (2005:181) has termed a "generalizer" in which organisational learning is condensed along with other macro-level pressures. These pressures were evident in the work and meetings between members of the CE Team and management to design the Portfolio; hence the work of management was embedded into it. The Portfolio also became a form of surveillance, particularly as it was linked into performance management systems. The Portfolio was thus a mediator of practices and shows the contemporary tensions between organisation and profession during 'professional becoming'.

As such, Preceptorship programmes are concerned with organisational socialisation, producing professionals that meet organisational objectives, and trying to shape their identities and practices to the interests of the organisation not the profession, and therefore might be seen as divergent from traditional accounts of professional socialisation. This is what has been described as professionalism occurring "from above" (Evetts, 2003:407) when professionalism is constituted by stakeholders outside of the occupation and is aimed at controlling professional practice in line with organisational or political interests. These organisational practices might therefore be seen as strategies for reshaping professionalism, moving it away from occupational to

organisational professionalism -and therefore a strategy of organisational control. However, the following section suggests other phenomena exist as there were also situational and professional influences on 'becoming'. The following section also discusses a more agentic view by discussing issues such as resistance and 'push back' during 'professional becoming'.

*The agency of Preceptees*

Although Preceptorship aims to increase professional autonomy I have showed how it was also limited in many regards, due to under-resourcing and consequently a lack of Preceptor activity. At first it appeared that organisational pressures on socialisation were stronger than broader professional ones. Local practices and customs which nurses needed to learn in their clinical practice persisted. However, there were elements of resistance to the programme for example slow adherence to the 'organisational' portfolio which might be seen as a re-assertion of professional socialisation and identity formation.

The Preceptees began to break unwritten rules to realise their professional identity, for example chatting to patients. This suggests that early socialisation from education (and possibly before) can predispose newly-qualified nurses to more traditional ideas of nursing work with which they identity. Some resistance to organisational routines was also evident in their talk and story-telling in the café. These examples show that a newly-qualified professional

may appear to be socialising into an organisation but can still remain dissociated from many organisational practices they consider to be unprofessional. They have to decide 'in the moment' whether to comply with organisational pressures or take the opportunity to reassert their professional identity. Professional aspects of socialisation were also evident during moments I spent with Preceptors who, when accounting for their practice and teaching referred to more professional ways of working. Professional identification thus remains multifaceted, performative and negotiated amid dynamic practices.

My study therefore connects to a growing body of research that calls for analysis to move beyond a straightforward control and resistance perspective and instead to see professionals and their organisations as co-constructed. What we see through the Preceptorship programme is the interaction and layering of professional and organisational interests through practices of learning. At first these are largely shaped by the initial encounters with the programme and ward practices as a form of induction, but when nurses begin to find their feet on the wards other local organisational and professional imperatives characterise the learning process they experience. As new nurses became more established and able to navigate the field, they reflexively and actively combined elements of professional and organisational imperatives, as they needed both to survive. This show how hybridity occurs in practice for newly-qualified nurses.

## Preceptorship Policy

In this final section, I discuss what my findings mean for Preceptorship policy and the socialisation of newly-qualified nurses more broadly. Through a synthesis of the literature and relevant policy and regulatory documents, I was able to elicit the concerns of the government, the wider profession, regulatory bodies and public interest regarding how nurses learn to 'be'. Upon first examination of the literature the principal concern of Preceptorship appeared to be supporting newly-qualified nurses through a difficult transitional period. Indeed, most of the Preceptors and Preceptees in this case study saw Preceptorship as a simple model of support. Yet a deeper analysis shows the heterogeneous economic, political and professional concerns that are manifest in Preceptorship and its subsequent use. The resulting Preceptorship Framework (DH, 2010a), and other documents such as *The NMC Response to the Francis Report* (2013) are interesting because they use persuasive language such as 'autonomy' and 'leadership' that I have argued are contestable concepts which may be difficult to realise. The overarching aim can be seen to forward an agenda that seeks to prevent attrition and standardise attitudes and behaviours towards producing a safer, cost effective member of the NHS workforce. When this becomes manifest in policies, directives or recommendations all of these heterogenic voices and wider concerns are hidden, but are nevertheless present in a policy that gets 'talked into practice'. I argue that Preceptorship could be thus described as trying to standardise the nurse, not as a criticism, rather, to explain its manifestation in its wider historical context.

Preceptorship was a new programme at the time of this study and the CE Team discovered that there was no 'one best way' to accomplish its aims. The CE Team thus abstracted what it needed from multiple sources to create an ideal, 'identikit' model of an Oldshire nurse, codified through a set of competencies and expected local behaviours. I now discuss what my findings mean for the notion of Preceptorship by relating it to three concepts of identity competence and the theory-practice divide.

*Preceptorship and identity*

There are two interesting dynamics of identity that occur during Preceptorship, the first of which relates to the CE Team. Preceptorship is interesting when it is delivered by teams which are positioned at the intersection of profession, organisation and education and whose own ongoing identity work reflects this complexity. The CE Team was subject to institutional pressures which exacerbated the difficulty in trying to teach and refine what I argued is very difficult i.e. how 'to be' a nurse in all situations. In this case, the CE Team was asked to be innovative in designing a Preceptorship programme but was given little guidance and only basic resources to do so. Hence, the CE Team did what it thought was expected rather than anything formally-mandated by the organisation.

The instability of the CE Team's identity is interesting as it was responsible for modifying the behaviours and attitudes, and stabilising the identity, of the Preceptees. Towards the end of my fieldwork, the CE Team did reflect upon its overall implementation of Preceptorship when interviewed, yet showed little awareness of the pressures placed on it by the Trust. This implies that much of the time actors are not perspicacious; they do not have the insight into the historical factors that are embedded in everyday work. Preceptees were positioned as 'unknowing' during Preceptorship which validated the need for the CE Team's within the organisation. As the CE Team were under pressure to deliver a programme that standardised behaviours, I suggest that this type of approach encourages a programme that was relatively inflexible and closed to the possibility of Preceptees contribution to reform.

The second interesting dynamic is how Preceptees responded to efforts to manage their identity as a singular, homogenous group. The findings showed that Preceptees will play along with performing a singular identity that is 'unknowing' and compliant because of the need to become 'signed off' and the relationship of Preceptorship with performance management. However, the group interviews, conversations and observations showed that Preceptees have multiple identities (such as wives, mothers, carers and members of the public) and varying knowledge. They often had excellent ideas for practice improvement that were not explored. No homogenous group existed but the Preceptees were encouraged to have a bounded sense of who they were from structured socialisation processes that attempted to ignore these other identities and establish new behaviours.

*Preceptorship and competencies*

My thesis draws much attention to how newly-qualified professionals are under pressure to overcome the theory/practice divide and provide evidence of competencies during Preceptorship. The notion of competency is associated with professionalisation as it refers to a specific body of knowledge associated with the skills of the profession (Antonacopoulou and Pesqueux, 2010). At the same time, I described how non-specific 'good' organisational behaviours were also meshed into the programme. While this is not new or surprising, (indeed CE Teams have an obligation to their employing organisation), it became problematic when prescribed in the Portfolio and measured against an organisational behaviour framework. This is because to define a competence is also to abstract it in some way, and thus it becomes difficult to transmit the learning out of 'the situation'. Yet, as soon as this process becomes extracted and material, for example incorporated within the programme it comes to compete with the very situated process that it aims to capture. In other words, extracted competencies compete with situated and more organic forms of learning. The Portfolio immediately standardises learning and accountability. This shows the lack of trust in nurses gaining the skills they need without someone to sign them off. The implication for professional socialisation is that when it becomes structured and abstracted in this way it conceals the power which positions the newcomer to enter into a bargain to become signed off. The process thus reduces the autonomy of individuals while structurally requiring them to go through this process to show they are 'real' autonomous

professionals. This shows the nature of the practices that evolve from policy and explains the difficulty of a 'one size fits all' programme that is manifest in part through abstracted competencies and does not tap into what nurses actually do which is often invisible (Allen, 2015).

*The practice-based curriculum*

In this section I draw attention to a practice-based curriculum which ran at odds to that of the classroom. Structuring Preceptorship is difficult when there are differences in the way knowledge is understood within each context. For example, I showed the situation of Adele doing a blood test in Chapter 7. This episode was understood differently by each actor, for the Preceptor, it was mentoring. To Adele it was a demonstration of collegiality. This research shows that it matters *where* learning takes place and illustrates the difficulty in combining formal pedagogic learning with workplace learning. However, it is unwise to see workplace learning as *ad hoc* as it takes place within community norms and expectations, which is its own learning curriculum (Lave and Wenger, 1991; Billett, 2004). I have shown that Preceptees within this environment have agency and work towards realising their professional identity. The problem with Preceptorship as a rigid curriculum is that it does not recognise this.

The second important aspect of recognising the practice curriculum that existed alongside the pedagogic programme is that Preceptors appear to be an

untapped resource in clinical environments. Although it was hard for them to recall their tacit knowledge, it appears that Preceptees were not always pro-active in using them as a resource that could help them tailor their individual learning needs (Billett, 2004). This tells us about the environment needed to run a Preceptorship programme, equipping the learner with the skills needed to access knowledge rather than prescribing particular competencies. It would also appear that the success of Preceptorship can depend on the learning environment of a ward, local 'buy-in" to the programme and the way power is manifest between actors. That said, power relations and the contested nature of knowledge do not appear to prevent learning. Rather, they often encourage agency. Reduced interaction time with Preceptors may not necessarily be problematic because Preceptees have to become more proactive. Lave and Wenger (1991:93) call this "benign community neglect", thus adversity can be an antecedent of transformation of the self.

A third aspect of the apparent practice curriculum was a hidden one that took place away from the eyes of educators and wards. I showed how Preceptees had liminal conversations in the classroom during activities, I explained that Preceptees kept in touch as friends and had exchanges on Facebook and how they would offer peer support in the café. Although they had a tendency to draw out negative aspects of their becoming in these sessions, they allowed them to be reconstructed safely and discuss what they considered to be professional practice.

The practice perspective on organisational learning has been able to offer a unique insight into Preceptorship policy. By studying the enactment of Preceptorship, we can see that the formal aspect of the programme does not reflect the situated, relational nature of learning, but rather, takes a structural view of knowledge and is largely a 'top-down' imposition that is at odds with existing practice, identities and professional relationships. It is assumed that the transfer of knowledge as a 'thing' is easy and smooth. Further, it assumes that professionals want to share their knowledge. Ironically, it could be argued that the Preceptorship Framework (2010a) leaves itself too open to interpretation because it is difficult to capture what professional nurses do, as their work is situated at the intersection of a wider, complex system (Allen, 2015).

## Conclusion

In this chapter, I have discussed the findings in relation to my research question -which was to specifically understand the practices of 'professional becoming' in the context of Preceptorship. I divided my discussion into three sections. I studied the dynamic of emotion, position and identity, which I have argued are the essence of 'professional becoming'. I have returned to understanding organisational and professional socialisation as hybrid practice and have shown how Preceptees reflexively combine aspects of professional and organisational interests because they need both when learning how to 'be' a professional in an organisational context. I then discussed the enactment of Preceptorship policy. I drew out the tensions when delivering an experimental programme in a troubled Trust and revealed how wider forces can pervade the agenda and

determine the choice of competencies. This also revealed tension when trying to structure socialisation without an influence on, or a good understanding of, the nuances of the local practice environment. Hence Oldshire's version of Preceptorship was very different to the ward-based, situated curriculum.

Despite these tensions, I discussed how Preceptees enter into a development bargain with the Trust as this helps them to move from peripheral practice towards becoming what they saw as a more professional nurse. However, as many of their needs were downplayed or ignored by the CE Team and some clinical staff such as Preceptors and clinical educators, the Preceptees formed their own network and peer supported each other created and opportunities to reconstruct safe practice.

Through using a practice perspective on organisational learning (Gherardi 2001; 2011; Nicolini, 2009; 2012) I have drawn out these three areas of focus and have developed a unique, previously untapped insight into the hybrid nature of 'professional becoming' within a turbulent early 21st century context of Preceptorship.

# Chapter 9: Conclusion

## Introduction

This thesis has argued that we do not sufficiently understand professional socialisation in the early 21st Century (Evetts, 2012), especially in the public sector where a variety of governance and organisational control strategies have refashioned professional work (Hood, 1991; Dunleavy and Hood, 1995; Clarke *et al*., 2000). Over the last three decades there have been important institutional changes to the nature of professional work, blurred knowledge boundaries and the emergence of new forms of professionalism (Hunter, 1996; Noordegraaf, 2007). These have been relevant in the NHS, which has undergone significant reforms and reconfigurations since the 1980's, from the introduction of general management through managed markets and more progressive forms of governance.

This turbulent environment has implications when learning how 'to be' an NHS professional in the early post-qualification period. This is when new professionals refine their knowledge and skills while trying to make sense of their responsibilities amid multiple pressures from the public, the profession and employing organisation. Studies of occupational socialisation tend to arise from either an organisational or a professional perspective. That is, they either emphasise the dynamics of the organisational socialisation of new starters through induction and training when employees are shaped to meet the performance and practice expectations of their employing organisation. Or alternatively, they emphasise professional socialisation through the ways new

members of an occupation develop and acquire the expected knowledge, customs, values and identities of their profession during pre-professional education.

With growing recognition that professions and their organisational contexts are co-constructed, or mutual influential, my starting point was to understand socialisation as hybrid 'professional becoming' (Noordegraaf 2007) and that further empirical research is needed to understand how newly-qualified professionals acquire their knowledge and professionalism during every day work in the early post-qualification period. I suggested that the literature recognises 'professional becoming' during this period as a learning process. I thus explored relevant theories of knowledge and organisational learning and argued that the practice-based approach to organisational learning (Gherardi 2001; 2011; Nicolini, 2009; 2012) offers a powerful conceptual lens through which to understand hybrid 'professional becoming' because it foregrounds neither organisation or profession, but rather, sees learning as rooted in everyday interactions. The nursing profession makes a novel case through which to study the practices of 'professional becoming' due to its' particular turbulent history of professionalisation and recent scrutiny following major NHS scandals. I suggested that this new study is useful and timely because of the recent development of new training and socialisation schemes, such as Preceptorship programmes, which are designed to ease the transition of newly-qualified nurses into the workplace. Preceptorship is an interesting policy because it structures early socialisation and seeks to influence the attitudes and behaviours of newly-qualified nurses (e.g. DH, 2010a).

In light of these debates, my study asked the following research question:

> *What are the practices of 'professional becoming' in the context of novel organisational socialisation and induction policies? Specifically, what are the practices of 'professional becoming' for newly-qualified nurses as they enter the clinical workplace and participate in an NHS Trust's Preceptorship programme?*

By addressing this question, my study aimed to understand the dynamics of professional becoming of newly-qualified nurses during the early post-qualification period when they were also enrolled on a Preceptorship programme.

## Main Findings

In this thesis I have studied Preceptorship policy and found that the Preceptorship Framework (DH, 2010a) appears to hinge on commonly-held assumptions about the need to support the early transitional stages of post-qualification healthcare (nursing) work, especially through supporting the acquisition and development of professional knowledge and skills, and meeting organisational standards. The policy presents a rosy picture of nursing and assumes that nurturing relationships can be formed between newly-qualified nurses and their Preceptors. The framework appears to hold a structural view of

knowledge (Newell *et al.*, 2009) whereby knowledge is seen as something tangible that can easily be transferred between individuals. Preceptorship policy does not acknowledge organisational pressures on professional learning and possible conflict within the workplace. It therefore appears that Preceptorship policy is designed to standardise the attributes of 'the nurse', and thus appeals to current NHS discourses that centre on assuring safety and quality (Waring, 2005).

My empirical research first studied the context of the case study and found an NHS Trust experiencing financial and regulatory issues. The Clinical Education (CE) Team responsible for the Preceptorship programme had low resources and appeared to have an uncertain role within Oldshire Trust, confused identity, and a liminal position working between professional and organisational pressures. This shaped the design and implementation of the Preceptorship programme which was strongly influenced by the Trust's quality concerns. I also found that the CE Team perceived it had low staff buy-in to the programme and was resigned to organisational difficulties in influencing how Preceptorship was experienced on the wards. This highlighted the difficulties in applying standardised professional developmental guidelines, such as Preceptorship, to local contexts that are shaped by particular organisational practices and discourses.

I studied the enactment of Preceptorship in the classroom and on the wards. The classroom delivery of Preceptorship revealed how hospital managers,

professional leaders and the CE Team needed to strongly 'sell' Preceptorship. Early reactions to being a Preceptee reveal a hidden, often emotional aspect of learning which was rarely acknowledged by the programme, leaving nurses feeling isolated and unsupported. Rather, the CE Team appeared to have its own agenda for professional induction and socialisation that was reflective of, and aimed at, addressing Oldshire's external and internal pressures regarding standards of quality and safety, and staff retention. In seeking to meet these aspirations, the CE Team sought to homogenise newly-qualified nurses into workforce cohorts that meet generic behavioural expectations of the Trust. This required the CE Team to secure nurses' 'buy in' to a Portfolio based model of individual reflection and learning. Hence, I show how the organisation attempted to codify knowledge and competencies as something tangible and amenable to being measured with performance management systems. However, Preceptees enacted a parallel learning agenda and used the programme time to identify additional modes of learning, often through peer support, which was largely hidden to the CE Team.

The practices of ward-based Preceptorship revealed the ways Preceptees experienced, coped with and survived the first few weeks of work. This included navigating ward contexts and becoming familiar with basic routines, skills and technologies. Often working without Preceptors, they approached other occupations to access information and immediate learning requirements. Wishing to move from a peripheral position within the workforce, Preceptees become more proactive in learning by seizing opportunities. Learning often

occurred through ‘positioning episodes’ and situational awareness of ‘white knowledge’ (my term for ‘fuzzy’ knowledge) which was often emotional. If there were favourable conditions, Preceptees took steps to learn through relations with others. My study also develops new insight into knowledge transmission between Preceptor and Preceptee, showing how it manifests depending upon the ward context. Later, Preceptees ended their Preceptorship period by filling enough knowledge gaps to satisfy the Portfolio and ward and being signed off by the CE Team.

In the preceding chapter, I discussed three main areas where my findings have implications for research and policy. First, I am able to expand upon our understanding of ‘professional becoming’ by showing the interplay of emotion, position and identity as an important dynamic of ‘professional becoming’ within the context of Preceptorship. This could apply to other situations where there are interventions, for example HRM, in the early newly-qualified period. Although learning is gradual I have shown there are particular moments when this dynamic relates to proactivity and transformation. This helps to better explain agentic aspects of change, how we ‘become’, because despite structural pressures, we able to author our own identity through reflexive practice (Holland and Lave, 2001; Cunliffe, 2002).

Second, my research shows how the practice of professional becoming for newly-qualified nurses is characterised by hybridity between organisational

and professional expectations and imperatives. Newly-qualified nurses worked reflexively, retaining some fidelity to the version of nursing they learned in education and even before, including wider expectations about professional standards and identity. At the same time nurses needed to socialise into the specific organisational context of day-to-day work, which was shaped by the Preceptorship programme geared specifically towards facilitating this transition. Although appearing to socialise into the organisation, Preceptees also 'pushed back' against organisational practices that they did not identify with as being professional. Newly-qualified professionals often gave the impression of being compliant, but retained a sense of detachment where professional or moral issues were at stake. In this sense, as others have noted (Scanlon, 2012, Noordegraaf, 2007), there can be no end point to 'becoming', because as conditions change, people manage each situation as it arises and will reflexively decide if they identify with relational practice.

Third, my findings are important for policy as they show a different understanding of NHS Preceptorship than that promoted through government and organisational discourse. The enactment of Preceptorship shows that the curriculums of learning are different between classroom and ward. The 'organisational' classroom prescribes learning through imposed sessions that meet organisational needs which can outplay broader professional requirements. This version of learning needs to be measured and becomes a 'tick-box' exercise that does not reflect ward-based learning. However, Preceptorship on the wards is less predictable and context-specific, shaped by

local norms and priorities, and for the new nurse is geared towards survival. This bears little relation to the Portfolio model promoted through formal systems and shows a marked difference in the prescribed learning competencies. Yet this 'real' form of Preceptorship is not necessarily harmful to 'professional becoming' because Preceptees often used adversity to expedite their learning and choose role models. Preceptors were an untapped resource and Preceptorship could have better reflected the nature of learning and manage expectations and helped to foster relationships accordingly.

## Limitations of the Research

I do not claim to have gained a whole understanding of 'professional becoming' as practices are 'open-ended' and multi-faceted (Nicolini, 2009). I could not be in all places at all times, but through a collection of complementary qualitative methods, I was able to better understand the phenomenon. I have not produced a master theory of 'professional becoming', but rather used an approach that is able to see socialisation from a perspective grounded in everyday work.

Nevertheless there are limitations to the research. The first relates to any approach that uses a practice theory perspective (e.g. Schatzki, 2001; Nicolini, 20109; 2012). As I noted, it is impossible to observe all practices and I have acknowledged where the data was limited. Additionally, as ethno-methodologists argue, the world is recreated at every moment. In many ways, practice-based approaches can be seen as creating a 'Russian doll', only adding

complexity to a study. However I tried to avoid this by theming the findings in a way that highlights the most important phenomena, and which add to our empirical understanding of professional socialisation in the post-qualification period.

Defining practice perspectives prior to commencing this study has allowed me to move beyond a normative understanding of daily work and helped me to consider the material dimension of 'professional becoming'. I have thus been able to define the language needed and by using an ethnographic approach I have taken a nuanced approach which could apply to other professions or organisational problems.

A second limitation concerns the ability of the methods to address issues of emotion. I did not intend to study emotions when designing my study, rather, emotions were a finding and so the limitations of the methods used should be acknowledged. Similarly to identity, emotion can be understood as an inner, invisible phenomena, unreachable by conventional without empirical methods. Indeed, some authors have suggested that emotion should be biologically measured although this is impractical, invasive and not usually seen in ethnographic approaches (Turner and Stets, 2005). Such approaches recognise that some emotions and feelings are unconscious, however, this thesis does not take a psychological approach, instead, explores the emotion expressed during learning.

Interviews are often used to understand emotions (Holland, 2006) and the 33 group interviews were seen in this study as a source of rich data. Yet interpretation can be difficult because of the researcher's own inter-subjectivities. For this reason I did not take the data from the group interviews at face value, instead, I saw them as an active process. Further, to counter-balance possible weaknesses of the approach, the interviews were not taken as standalone data but analysed in their social context, in what has been described as 'localism' (Alvesson, 2003). This recognises that participants may try to present a coherent self for the benefit of the interviewer or for 'political' reasons. Hence it was important to triangulate the data with the observational data and to account for both the local context within the Trust and also the context of the media attention on the Trust and nursing. Similarly there are limitations of only using observational data to reach conclusions about emotions. Although not a 'controlled' and objective methodology, observations have nevertheless been recognised as a method that can situate intense emotions in the context of wider social structures (Turner and Stets, 2005). My empathetic stance encouraged the Preceptees to express and communicate emotions to me. When strong emotions appeared evident, I was careful to look for and describe other evidence including tears or accompanying ethnographic conversations. As discussed in Chapter 4, I also took a reflexive approach to the fieldwork and constantly questioned my interpretation of Preceptees' emotions. As such, although there are limitations, I am confident that I have used a rigorous approach to understanding emotion and professional becoming.

One of the biggest limitations to this research is my identity as both an ethnographic researcher and former healthcare professional. First, as a former nurse, it was sometimes difficult to take a reflexive stance. In particular, it was difficult to study Preceptees' emotions and it was not my intention to portray them as victims. Indeed, they creatively responded to difficult situations and were agentic. Yet, detachment from the world we experience is not possible and I interrogated my position and above all tried to focus on describing emotion as integral to learning. I also discussed my anonymised findings at nursing conferences and with nursing academics and my view of the situation of newly-qualified nurses has resonated with practitioners and academics.

As a PhD student I was a novice researcher. There is a strong feeling of wishing 'I knew then, what I know now', particularly to deepen my understanding of some of the phenomena through more fieldwork. In particular, I could have persevered in following practices for example through email trails and other internal documentation. Yet this was a sensitive situation due to the turmoil in the Trust which perhaps tempered what I asked of the participants. Additionally, understanding how to do research as any practice is part of a situated and collective arrangement of practices, in this case spanning the university and the research sites, and is thus always a process of 'becoming'. As an outcome of this research, I have learnt much which will serve me well in my future career.

A final limitation could be seen in this being a single study site, based on one Preceptorship programme. Some of my findings could be interpreted as site specific. Yet in the course of my conversations with practitioners it has been apparent that my study has been seen as authentic and credible (e.g. Lincoln and Guba, 1985) and there are clear implications for practice. These are outlined below.

## Implications for Practice

I offer cautious recommendations for practice due to the complexity of understanding 'professional becoming' that this study affords. The thesis may not be suitable to help a practitioner in its current form; neither would abstracting the findings in a practitioner journal be enough. Workshops that explain practice-perspectives on learning may offer a more useful way of communicating some of the findings to practitioners ,whilst small documents, 'BITES' of theory has been successful in the NIHR East Midlands Collaboration for Leadership in Applied Health Research and Care (CLAHRC EM, 2014).

The study has already made some impact in the Trust as my simple questions helped the CE Team think about the implications of the current form of the programme. I would suggest that classroom situations are perhaps better avoided as a main component of a programme. One recommendation to help newly-qualified nurses learn would be a general call for clinical/professional

development educators to try and develop a new form of pedagogy. The aim could be to compensate for the ever problematic 'theory-practice' divide and understand how the concept of teaching competencies can become power laden. It would be useful for educators to manage the expectations of all involved with Preceptorship so that Preceptees' expectations are better managed (as many of them were left feeling let down). They were also unaware of 'indirect Preceptorship' and that their Preceptors were 'mindful' and often orchestrated events to help them learn. Moving beyond reflective to diffractive practice may also be helpful as it would also allow practitioners to consider what they didn't do or might have done (Nicolini and Roe, 2014). Preceptees could be taught more about the nature of tacit knowledge and the conflict which is inherent in situated learning and which could help them to learn. Crucially, Preceptorship programmes could be seen as a two-way effort and a potential source of innovation, as newly-qualified nurses are so often surprised by what they see.

This chapter has discussed and concluded my thesis which has sought to better understand the practices of early 21st century 'professional becoming', specifically when newly-qualified nurses enter the workplace and become enrolled on a Preceptorship programme. My final point is to suggest that when working towards health improvement with their stakeholders, healthcare organisations should not forget the important contribution that newly-qualified professionals can make to understand their own learning and working situation.

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# Appendices

## Appendix 1: Topic guide for Non-Clinical Staff

**Appendix 1: Topic Guides for interviews non-clinical staff**

**Topic Guide for Management**

- What do you think are the key issues around/for newly qualified nurses
- Understanding/interpretation of Preceptorship
- Important of Preceptorship for the profession and the organisation
- Hopes for Preceptorship for departmental objectives
- Benefits to the organisation so far
- Important components of a Preceptorship programme
- Preceptorship a management or professional concern
- How to 'sell' Preceptorship to a novice nurse

## Appendix 2: Topic guide for Preceptors and Ward Leaders

**Appendix 2**

**Topic Guide for Preceptors and Ward Leaders**

- Expectations of being a Preceptor
- How they see their role in supporting to novice learning
- How supported by the team, resources used, barriers, enablers.
- Thoughts about the Preceptorship programme
- Participating in Preceptorship, meeting expectations
- Anything surprising about the Preceptor experience
- Have any new ideas arisen when interacting with the Preceptees
- Has working with a Preceptee given them thoughts about own practice
- Have any ideas been taken forward, if not, what are the barriers

# Appendix 3: Invitation Letter

Invitation Letter

(Final Version 1.0 20/07/11)

REC ref: 11/EM/0300

TITLE OF STUDY: The Preceptorship of the Novice Nurse: xxxx Trust

Bridget Roe is a PhD student at the University of Nottingham carrying out research at xxxx NHS Trust investigating nursing Preceptorship.

As part of her research she would like to interview you to understand a range of issues concerned with understanding how Preceptorship contributes to the learning and development of the professional practice of newly qualified nurses.

Bridget may also wish to observe you during Preceptorship activity which may be classroom learning, meetings or other practical activity.

During the observations of learning activity she may also ask if she can video you, this is subject to your consent. If you agree to this, she will try to film in a way that will not identify you – she will avoid taking images of faces or if any faces are captured, they will be obscured. You may of course, decline to be videoed.

Some participants may also be invited to keep brief diary entries of their learning experience.

All data will be reported anonymously.

An information sheet has been provided that gives you more details about the study.

If you do not wish to participate in this study, please inform Bridget Roe, within 10 working days of receipt of this letter and information sheet. Bridget can be contacted by email: lixbr4@nottingham.ac.uk

Unless you let it be known that you do not wish to participate in the study of nursing Preceptorship, Bridget will contact you and answer any further questions you may have. If you participate in this study, any costs in addition to those incurred through your daily work responsibilities will be fully reimbursed by the research team.

Yours faithfully,

xxxxxxx

## Appendix 4: Consent Form

Nottingham University Business School

UNITED KINGDOM · CHINA · MALAYSIA

NHS Trust

**CONSENT FORM**
**(Final Version 1.1 22/09/2011)**

**Title of Study: The Preceptorship of the Novice Nurse, xxxxx Hospitals NHS Trust**

**REC ref: 11/EM/0300**

**Name of Researchers: Emma Rowley, Justin Waring, Bridget Roe**

**Name of Participant:** **Please initial box**

1. I confirm that I have read and understand the information sheet final version number 1.1 dated **22/09/11** for the above study and have had the opportunity to ask questions. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving any reason, and without my legal rights being affected. I understand that should I withdraw from the study then the information collected so far cannot be erased and that this information may still be used in the project analysis. ☐
3. I understand that relevant data collected in the study may be looked at by authorised individuals from the University of Nottingham, the research group and regulatory authorities where it is relevant to my taking part in this study. I give permission for these individuals to have access to these records and to collect, store, analyse and publish information obtained from my participation in this study. I understand that my personal details will be kept confidential. ☐
4. I understand that interviews will be audio recorded and that anonymous direct quotes from the interviews may be used in the study reports and other publications. ☐
5. I understand that I may be asked to be re-interviewed towards the end of the study (optional) ☐
6. I understand I may be asked to be videoed and that my face will be obscured on any video used and I will not be identified (optional). ☐
7. Once I have consented to be observed in a group session, I understand I cannot remove my data from the group session ☐
8. I agree to take part in the above study. ☐

| Name of Participant | Date | Signature |
|---|---|---|
| Name of Person taking consent | Date | Signature |

2 copies: 1 for participant, one for study record

# Appendix 5: Participant Information Sheet

Info sheet Final Version 1.1 22/09/11

Nottingham University Business School

UNITED KINGDOM · CHINA · MALAYSIA

[redacted]

Participant Information Sheet

**Study Title:** The Preceptorship of the Novice Nurse: United Lincolnshire Hospitals Trust
**Researchers:** Emma Rowley, Justin Waring and Bridget Roe
**REC reference:** 11/EM/0300

Before you decide whether you would like to take part in this study, please read the following information carefully and understand why the study is being carried out, why you are being invited to take part and what it involves. Take your time to read the information carefully, discuss it with anyone you wish and please ask if there is anything which is unclear or which you would like more information about. Please take your take time to read the information and decide whether you would like to take part in the study before giving your consent. Thank you for taking time to read this.

**What is the purpose of the study?**

This study will form part of Bridget Roe's PhD. It will aim to understand what happens when newly qualified nurses undergo a period of preceptorship, a period of structured transition to help develop confidence and refine values, skills and behaviours and improve retention. Preceptorship is now policy for most NHS Trusts yet little is known about the process of learning supported by preceptorship or about the impact onto the organisation. This study will aim to shed light on how knowledge is gained in day-to-day practice and the process through which novice nurses move towards expertise. It will also seek to understand more about the benefits of preceptorship for the individual, patients, the hospital and possibly the wider public.

**Why have I been asked to be involved?**
You have been identified as someone who may agree to participate in the study because of your involvement in the xxxx Trust Preceptorship Programme. This may be because you are a preceptee or a preceptor or because in some way you work with new nurses or are involved in the running of the programme.

**Do I have to take part?**
No, you do not have to take part in this study. You are free to withdraw from the study at any time and do not have to provide a reason for this. Your withdrawal from the study will not affect your employment, involvement in the Trust, your benefits or any of your rights. If you decide to withdraw, any information gathered up until that point cannot be erased and may still be used anonymously as part of the study.

**What will happen to me if I take part?**
You do not need to do anything at this stage; your details will be passed to the research team 10 days after you have received this information sheet and letter. One of the researchers will then contact you to discuss the study further and if you wish to take part- arrange the most convenient time and place for you to take part in the study and to sign the consent form.

If you do not wish to take part or be contacted further please contact Bridget Roe within 10 working days of this letter being sent, who can be contacted via: lixbr4 @nottingham.ac.uk

If you agree to participate, there will be five parts of the study in which you could be involved. The study is expected to take place over the next 12 to 14 months from October 2011.

- **Interviews:** You will be asked to take part in at least one interview with the researcher at a place and time which is most convenient to you. This may take place during work-time subject to management approval, or in your own time if you agree. This may be at a place in the hospital

place off the hospital premises. The interview will be audio-recorded and will be completely confidential and anonymised. If you are a preceptee or a preceptor, you will most likely be interviewed up to three times in 9 months, although you may be asked for a final fourth follow-up interview. The interviews will last around an hour to an hour and a half. If you are another practitioner or manager it is likely you will be interviewed just once, unless you are very closely involved with the management of the programme, in this case you may be asked to be interviewedl 3 times. The interviews will cover various issues relating to your ways of working, your practical concerns, involvement with, or understanding of preceptorship. These interviews will also last from one to one and a half hours.

- **Observations:** Meetings and episodes of working will also be observed of preceptors and preceptees to enable a better understanding of how knowledge is exchanged in practice. We would also like to observe all of the classroom study days that preceptees attend. If you are present at any of these meetings, activities, or study days and you wish the researcher not to be present, you may ask that the researcher leave. During periods of observations the researcher may seek to engage you in short conversations to seek clarification on issues, and may also be taking part in some of the learning activities with you. If you are a nurse or other practitioner who works alongside a preceptee you may be observed during episodes of team working. If you are a manager you will only be observed if you work directly or teach preceptees.
- **Videoing:** If you are being observed, you may also be asked if video can be taken of the learning sessions either in the classroom or with your preceptor, as a way of capturing some of the more unspoken and spatial aspects of learning. No payment will be made to you, or the Trust, for this. The video will not include images of your face and you will not be named in any of our data. By consenting to the use of video, you will be asked to agree that we can use the video images in our work. You will also be waiving any rights, claims, or interest you may have to control the use of your identity or likeness in whatever media. The researcher is not responsible for any expense or liability incurred as a result of your participation in this video, including medical expenses due to any sickness or injury incurred as a result.
- **Diaries:** If you are a new nurse, you may be asked to keep a diary of your learning experience. This will require making brief entries to record your ideas, and reflections from your learning experience..
- **Documents:** There will also be some documentary analysis of individual portfolios, group presentations, and anonymous feedback forms.

**What are the possible risks and disadvantages of taking part?**

We will try as much as possible to arrange for the interviews to take place during your work time. There are no anticipated risks to taking part in this study. We will make every effort to interview you in a sensitive manner, however if during the course of the interview you feel that it is causing you distress or upset in any way you are encouraged to withdraw from the interview and if you feel it is inappropriate, withdraw from the study altogether. It should be also be noted that if you take part in a group session that is being observed, and you subsequently decide that you do not wish to continue to participate in the study, then this data cannot be removed. It is possible that something may be disclosed or observed on the wards that raises the concerns of the researcher. The xxxx policy (April, 2011) will be followed at all times.

**What are the possible benefits of me taking part?**

The study may help you to reflect on your experience of preceptorship and your learning achievements during this period. Your contribution to the study will certainly provide feedback for the Trust which may contribute to improvement in practices at the Trust and may help to inform policy on preceptorship.
Participants will not be paid to participate in the study, however expenses incurred for any additional costs to their usual duties will be paid. There may also be the offer of gift vouchers as compensation to participants who give extra time to the study for example those who also agree to be observed on the wards and/or keep diaries

**What if there is a problem?**

If you have any concerns or thoughts about any aspect of the study you may speak to the researcher about this who will try their best to answer these. If you feel you want to speak to the lead investigator, Emma Rowley, whose details are provided at the end of this information sheet, you may also do so. If you feel that you are unhappy about any part of this study or have any concerns about how you have been approached and want to complain formally you may do this through the NHS complaints procedure, details may be obtained from your trust.