2019

Being on track: A phenomenological study of the lived experience of staff development nurses’ transition from a Ward-based role to the role of staff development nurse in a hospital in Western Australia

Penny Keogh

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BEING ON TRACK: A PHENOMENOLOGICAL STUDY OF THE LIVED EXPERIENCE OF STAFF DEVELOPMENT NURSES’ TRANSITION FROM A WARD-BASED ROLE TO THE ROLE OF STAFF DEVELOPMENT NURSE IN A HOSPITAL IN WESTERN AUSTRALIA

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Submitted in fulfilment of the requirements for the Doctor of Nursing

School of Nursing and Midwifery
Fremantle Campus

November, 2019
# Table of Contents

Table of Contents ....................................................................................................................ii
List of Figures ..........................................................................................................................v
List of Abbreviations ..............................................................................................................vii
Declaration of Authorship .....................................................................................................viii
Acknowledgements ...............................................................................................................ix
Abstract .................................................................................................................................x

## Chapter 1: Introduction ........................................................................................................1
1.1 Introduction ......................................................................................................................1
1.2 Background to the Study .................................................................................................1
1.3 History of Nurse Education in Hospitals ....................................................................4
1.4 Continuing Education .................................................................................................5
1.5 Hospital-Based Staff Development Service ..................................................................6
  1.5.1 Centralised model .....................................................................................................7
  1.5.2 Decentralised model ...............................................................................................8
  1.5.3 Combination model .................................................................................................8
1.6 Nurse Educators ............................................................................................................9
1.7 Hospital-Based Nurse Educators ................................................................................10
1.8 Research Topic .............................................................................................................11
1.9 Research Questions ......................................................................................................14
1.10 Chapter Summary ......................................................................................................15

## Chapter 2: Literature Review ............................................................................................17
2.1 Introduction ....................................................................................................................17
2.2 Nursing Staff Development .........................................................................................19
  2.2.1 Models of Staff Development .............................................................................21
  2.2.2 Staff development nurse ....................................................................................24
  2.2.3 Relevant theories .................................................................................................30
2.3 Chapter Summary .........................................................................................................34

## Chapter 3: Methodology ....................................................................................................35
3.1 Introduction ....................................................................................................................35
3.2 Research Paradigm .......................................................................................................35
  3.2.1 Positivism ............................................................................................................38
  3.2.2 Interpretivist .........................................................................................................38
  3.2.3 Paradigm for this study .......................................................................................40
3.3 Research Design ..........................................................................................................41
  3.3.1 Phenomenology ....................................................................................................44
  3.3.2 Origins and focus of phenomenological inquiry ................................................45
  3.3.3 Hermeneutic phenomenology ............................................................................47
3.4 Research Methods ........................................................................................................50
  3.4.1 Participant recruitment .........................................................................................50
  3.4.2 Inclusion criteria ..................................................................................................51
  3.4.3 Consent ................................................................................................................53
  3.4.4 Ethical considerations .........................................................................................53
  3.4.5 Data collection .....................................................................................................54
  3.4.6 Guided questions .................................................................................................56
Chapter 4: Context ............................................................................................................. 81
  4.1 Introduction .............................................................................................................. 81
  4.2 Setting for this Study ............................................................................................. 81
  4.3 Researcher Profile ................................................................................................ 84
  4.4 Review of the Staff Development Service .......................................................... 88
  4.5 Responding to the Review .................................................................................... 90
  4.6 Developing the Staff Development Service Model ............................................. 91
      4.6.1 Service model implementation ................................................................. 92
      4.6.2 ICIC Staff Development Framework ....................................................... 93
  4.7 Post Implementation ............................................................................................. 98
  4.8 Chapter Summary ................................................................................................. 100

Chapter 5: Findings ........................................................................................................ 101
  5.1 Introduction ........................................................................................................... 101
  5.2 Participant Characteristics .................................................................................. 102
  5.3 Presentation of Themes ........................................................................................ 105
      5.3.1 Stumbling in the dark .............................................................................. 106
      5.3.2 Becoming aware of the scaffolding ....................................................... 112
      5.3.3 Using the scaffold .................................................................................... 137
  5.4 Chapter Summary ................................................................................................. 145

Chapter 6: Discussion of Findings .............................................................................. 147
  6.1 Introduction ........................................................................................................... 147
  6.2 Being on Track – The Overarching Theme .......................................................... 148
      6.2.1 Stumbling in the dark .............................................................................. 148
      6.2.2 Becoming aware of the scaffolding ....................................................... 150
      6.2.3 Using the scaffold .................................................................................... 150
  6.3 Comparison with the Literature ........................................................................ 153
      6.3.1 The importance of orientation and managing expectations .................... 154
      6.3.2 The importance of support and instruction ............................................. 157
      6.3.3 The importance of an organisational scaffold of support ....................... 161
  6.4 Comparison to Relevant Theories ..................................................................... 164
      6.4.1 Scaffolding theory ................................................................................... 164
      6.4.2 Work-role transition theory .................................................................... 166
  6.5 Limitations ........................................................................................................... 170
  6.6 Chapter Summary ................................................................................................. 170

Chapter 7: Conclusion ................................................................................................. 172
  7.1 Introduction ........................................................................................................... 172
7.2 New Knowledge Generated by This Study .................................................. 172
7.3 Nursing Education Implications ............................................................... 173
7.4 Nursing Education Recommendations ..................................................... 173
  7.4.1 Staff development service model ......................................................... 174
  7.4.2 Scaffold the SDN transition ................................................................. 174
  7.4.3 Recognise role transition ................................................................. 175
  7.4.4 Orientate to the role and role supports ............................................. 175
  7.4.5 Provide professional development and training .................................... 176
  7.4.6 Provide tools for the job ..................................................................... 176
  7.4.7 Determine line management, mentors and networking opportunities .... 176
  7.4.8 Promote an understanding of staff development service and role functions ................................................................. 177
7.5 Research Implications ................................................................................ 178
7.6 Research Recommendations ...................................................................... 179
7.7 Summary .................................................................................................... 180

Epilogue ............................................................................................................ 181

References ........................................................................................................ 183

Appendix 1 Invitation to Participate ................................................................. 205
Appendix 2 Information Sheet .......................................................................... 206
Appendix 3 Consent Form ................................................................................ 208
Appendix 4 University Ethics Approval ............................................................ 209
Appendix 5 Health Service Ethics Approval .................................................... 210
Appendix 6 Approval from Director of Nursing .............................................. 211
Appendix 7 Interview Guide ............................................................................ 212
Appendix 8 Transcriber Confidentiality Agreement .......................................... 213
List of Figures

Figure 2.1. Schema of the literature review ............................................................... 18
Figure 2.2. Removed due to copyright restrictions ...................................................... 32
Figure 3.1. Interview field note ............................................................................. 58
Figure 3.2. Generating categories ......................................................................... 60
Figure 3.3. Initial codes and themes ..................................................................... 61
Figure 3.4. Transcript with green pen reflecting the latest codes. ....................... 62
Figure 3.5. Researchers interview note ................................................................. 63
Figure 3.6. Researchers study journal .................................................................. 64
Figure 3.7. Attaching codes to text ...................................................................... 66
Figure 3.8. Generating categories ....................................................................... 67
Figure 3.9. Researchers journal identifying emerging themes. ......................... 67
Figure 3.10. Researchers journal identifying evidence to support themes .......... 68
Figure 3.11. Researchers journal pictorial of SDN lived experience .................. 69
Figure 3.12. Researchers journal reflecting discussion with supervisor .......... 70
Figure 3.14. Refining the themes ........................................................................ 72
Figure 3.15. Researchers journal weaving the analysis ..................................... 73
Figure 4.1. Photo of the hospital in 1800s. .............................................................. 82
Figure 4.2. Photo of the hospital in 1990s. .............................................................. 82
Figure 4.3. Organisational chart reflecting SDN reporting to DSD ................. 84
Figure 4.4. Graphic depicting the revised SDS model .......................................... 92
Figure 4.5. ICIC Staff Development Framework .................................................. 94
Figure 4.6. Example of ICIC Staff Development Framework to plan organisational goals ........................................................................................................ 95
Figure 4.7. Revised organisational chart reflecting SDN reporting to SDE ....... 97
Figure 5.1. Pictorial presentation of themes ........................................................... 106
Figure 5.2. Theme of stumbling in the dark ........................................................... 108
Figure 5.3. Theme of becoming aware of the scaffold ......................................... 115
Figure 5.4. Screenshot of shared drive how to instructions ................................ 124
Figure 5.5. Screenshot of shared drive forms ........................................................ 125
Figure 5.6. Screenshot of shared drive templated resources ............................... 125
Figure 5.8. Theme of using the scaffold ............................................................... 138
Figure 5.9 Flow chart of the three emergent themes depicting transition ......... 144
Figure 5.10 Flow chart of transition under the overarching theme ...................... 146
Figure 6.1. Illustration representing transition from nurse to SDN role ................ 149
Figure 6.2. Removed due to copyright restrictions ........................................ 165
Figure 6.3. Adapted Purposeful Scaffolding (Sam, 2011) for organisational
scaffolding of the SDN ........................................................................ 166
Figure 6.4. Removed due to copyright restrictions ........................................ 167
<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
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<tbody>
<tr>
<td>CINAHL</td>
<td>Cumulated Index of Nursing and Allied Health Library</td>
</tr>
<tr>
<td>CNE</td>
<td>Clinical nurse educator</td>
</tr>
<tr>
<td>CNM</td>
<td>Clinical nurse manager</td>
</tr>
<tr>
<td>CT</td>
<td>Corporate trainer</td>
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<tr>
<td>DSD</td>
<td>Director of staff development</td>
</tr>
<tr>
<td>FSH</td>
<td>Fiona Stanley Hospital</td>
</tr>
<tr>
<td>FTE</td>
<td>Full-time equivalent</td>
</tr>
<tr>
<td>HBNE</td>
<td>Hospital-based nurse educator</td>
</tr>
<tr>
<td>HEI</td>
<td>Higher education institute</td>
</tr>
<tr>
<td>ICIC</td>
<td>Induction, Competency, In-service and Continuing</td>
</tr>
<tr>
<td>ICU</td>
<td>Intensive care units</td>
</tr>
<tr>
<td>MKO</td>
<td>More knowledgeable other</td>
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<tr>
<td>NSQHSS</td>
<td>National Safety and Quality Health Service Standards</td>
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<tr>
<td>PDP</td>
<td>Performance development pathway</td>
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<tr>
<td>SDE</td>
<td>Staff development educator</td>
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<td>SDM</td>
<td>Staff Development Matters</td>
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<td>SDN</td>
<td>Staff development nurse</td>
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<td>SDS</td>
<td>Staff Development Service</td>
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<td>WA</td>
<td>Western Australia</td>
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Declaration of Authorship

This thesis is the candidate’s own work and contains no material that has been accepted for award of any degree or diploma in any other institution.

To the best of the candidate’s knowledge, the thesis contains no material previously published or written by another person, except where due reference is made in the text of the thesis.

Penny Keogh

5th November 2019
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And to Deb: I don’t think I’d have completed it without you. You have made sure that I did not crack under the pressure and gave me the encouragement and the occasional push I needed to achieve my goal when I wanted to give up. This achievement is yours too.
Abstract

Continuing education is widely accepted as a means to remain competent in nursing and knowledgeable about the numerous changes in health care and the health care environments in which nurses work. The ward-based staff development nurse (SDN) role is considered a vital support for clinical staff (Armstrong & Laschinger, 2006; Conway & Elwin, 2007), with the role responsible for organising orientation and continuing education for nursing staff in their respective area of specialty. There is a dearth of research on the lived experience of the hospital-based SDN, most of whom have no formal training or preparation for their role. Newly appointed SDNs can experience a difficult transition, resulting in role tension, role conflict and role ambiguity (Sayers & DiGiacomo, 2010). This can make the job of SDN unappealing and result in a challenge for recruitment and retention to the role.

A tertiary teaching hospital in Perth, Western Australia (WA) implemented a staff development organisational model and framework to provide role support for their SDN workforce. The purpose of this study was to explore the lived experience of the hospital’s SDNs’ transition from a ward-based role to the role of the SDN.

The study used a qualitative research with a phenomenological approach, which facilitated thematic analysis of 10 SDNs’ lived experiences of their transition to role. Demographic data and responses from open-ended semi-structured questions were gathered from the participants during one-on-one interviews, and then subjected to content and thematic analysis.

Through the process of data analysis, it became clear that each participant was talking about identifiable dimensions of the experience of transition to the SDN role. In analysing the data, themes emerged suggesting the SDNs’ lived experience of the transition to role involved them going through a process to achieve a state of ‘being on
track’. The following themes emerged from the data analysis: (1) stumbling in the dark, (2) becoming aware of the scaffolding, and (3) using the scaffold.

This study provides findings that contribute to the current knowledge around the transition of a nurse to a hospital-based clinical nurse educator. The study uniquely contributes to the nurse education body of knowledge, by providing a rich description of the nurse transitioning to SDN experience in the hospital setting, and the factors that acted as facilitators and barriers.

The findings of this study provide insight into the process that occurs during the transition from nurse to SDN. The study explains this transition and identifies an organisation’s scaffolding support for a successful role transition. Attributes of the SDN role transition were also identified. The findings from the study can be used to better inform an organisation as to the factors that facilitate or impede transition to the SDN role, role orientation and role support for the SDN.

Results of this study provide new knowledge and information useful to hospital-based educators, staff development departments and administrators, hospital nurse managers, and ultimately, the recipients of nursing care. Increased knowledge regarding transition of a nurse into an SDN role may generate new or improved organisational scaffolding strategies, resulting in an expedient, timely transition to role. Finally, implications and recommendations from the study findings were provided for nursing education administrators, as well as recommendations for further research.
Chapter 1: Introduction

1.1 Introduction

When a nursing workforce is well qualified and competent, there is a decreased risk to patient safety (Aiken, Cimiotti, Sloane, Smith, Flynn & Neff, 2011). Continuing education is widely accepted as a means to remain competent in nursing and knowledgeable about the numerous changes in the healthcare environments in which nurses work (Donner, Levonian & Slutsky, 2005; Gallagher, 2007). The ward-based staff development nurse (SDN) role is considered by the nursing profession a vital support for the continuing education of clinical staff (Armstrong & Laschinger, 2006; Conway & Elwin, 2007). The appointment of an SDN in the clinical setting to provide education is a ‘pragmatic and cost-effective way of dealing with the realities of patient safety, continued professional development and maintenance of competency’ (Manning & Neville, 2009, p. 42).

The purpose of this chapter is to provide an overview of a study into a hospital staff development service model. Specifically, this chapter provides a background to this study, an overview of continuing education and staff development service models and a description of the role of nurse educators in hospitals. It also outlines the study methodology, its significance and the organisation of the thesis.

1.2 Background to the Study

Hospitals manage continuing education support for their employees in a variety of formats. In Western Australian (WA) public teaching hospitals, continuing education support is generally referred to as staff development and organised by a nurse education department or a staff development service. These departments/services provide continuing education and training for health service employees. Staff development employees who provide training may be located centrally (centralised, as explained on
page 7) in the department or deployed (decentralised, page 8) to specific areas. In WA, staff development education specifically for nurses is provided by two roles: the Staff Development Educator (SDE) and the SDN. The SDE is a senior nurse responsible for staff development and education programs across a hospital, usually by managing a program portfolio. A program portfolio may include providing education consultancy to specific units and/or managing a set of programs such as undergraduate clinical practice placements, preceptor programs, continuing education and graduate transition programs. The SDN is generally a ward-based nurse responsible for in-service education, organising orientation, providing clinical teaching and continuing education for nursing staff in their respective areas of specialty. In-service education is provided to employees while they are on the job, and clinical teaching in a clinical setting can include activities such as assisting new clinicians to develop nonclinical skills to manage workplace demands, teaching specific clinical skills to experienced and non-experienced staff and providing knowledge through formal education.

The role of the SDN is varied, complex and includes many components. In Australia, there are inconsistencies between SDN nomenclature, role boundaries and responsibilities. The position titles and functional activities assigned to nursing staff development are varied and numerous and can depend on the size and traditions of a given organisation (Conway & Elwin, 2007). The literature describes the SDN role as multifaceted, encompassing aspects of teacher, facilitator, leader, change agent, consultant, coach, mentor, and role model, and as having responsibilities for identifying training needs, planning education opportunities, clinical teaching and conducting competency assessment (Billay & Yonge, 2004; Conway & Elwin, 2007; Davies, Laschinger & Andrusyszyn, 2006; Horner, 1995). Nursing has a professional expectation that seasoned clinicians will provide role modelling and guidance to less
experienced colleagues. As nurses gain experience and develop their own clinical expertise, they can find themselves teaching on the run and mentoring other clinicians and support staff. Often, this is a natural career path towards the role of a designated SDN, and it is reasonable to suggest that the SDN may initially come into the role because of their clinical experience, clinical qualifications and a desire to be committed to such an important task (Donner et al., 2005).

Newly appointed SDNs can experience a difficult transition to the role, resulting in role tension, role conflict and role ambiguity (Sayers, DiGiacomo & Davidson, 2011). This can make the job of the SDN unappealing and result in a challenge for recruitment and retention to the role.

A public tertiary teaching hospital in Perth, WA conducted a review of its staff development service (SDS), which identified issues of concern with SDN workload strain, role preparation and job ambiguity, and role support and development needs of the SDN. Recruitment and retention issues around the SDN role were identified. At the time of review, 40% of the 35 SDNs were either providing relief cover or newly employed in the role, and occupational churn was an issue for the SDN line managers. It was noted that there was a lack of role preparation for SDNs and an ad hoc approach to providing professional development and role support for SDNs. More than 50% of the SDNs reported a lack of understanding of the role expectations and believed that Clinical Managers did not understand the SDN role. They experienced feeling that their work efforts were not appreciated by ward staff.

Organisations providing clinical education support are more successful in attracting and retaining staff, and with engaged and competent staff, it has been demonstrated that patients are at a lower risk of experiencing an adverse incident during their hospital admission (Aiken et al., 2011). Nurse-sensitive health outcomes are linked
to patient mortality in hospital settings, and are influenced by staffing, education, communication and professional support (Aiken et al., 2011). Historically, the nursing profession has consistently demonstrated an investment in the provision of education to support patient care that is safe and evidence based.

1.3 History of Nurse Education in Hospitals

Florence Nightingale established the first nurse training school in Britain in 1860; nurse education services and educators were formally recognised and Nightingale’s model of nurse education was subsequently adopted worldwide by supervisors of public health institutions (Keane, 2016). In 1868, Florence Nightingale sent Lucy Osburn and five other English nurses to the Sydney Infirmary and Dispensary to improve the standards of the hospital and start a School of Nursing (Keane, 2016). The other nurses, in due course, took up positions as matrons at other hospitals, spreading the Nightingale teaching model across the hospital system of the colony (Keane, 2016). From the 1800s to early 1980s, the training of registered nurses in Australia was modelled on an apprenticeship structure, which saw student nurses rotated through clinical areas to gain experience under the direct supervision of the ‘ward sister’ in each area (Henderson & Winch, 2008). It was considered essential that the ward sisters be trained nurses who were qualified, able and willing to teach and supervise student nurses. With the implementation of hospital-based Schools of Nursing or nursing education units, this method of nursing education remained mostly unchanged until the early 1980s, which saw the transfer of the hospital-based apprenticeship model of training to a professional degree preparation in the higher education sector (Henderson & Winch, 2008). During the 1980s, hospital-based Schools of Nursing reconfigured their services into nursing education units, charged with providing continuing education to the hospital-qualified nursing staff. Specific nursing
positions with a focus on education were created and implemented within the different career structures across Australia (Keane, 2016), with continuing education provided by SDNs appointed in hospitals.

1.4 Continuing Education

Continuing education terminology is used interchangeably with other related terms, including continuing professional development, continuing professional education, lifelong learning and staff development (Munro, 2008). While there is some confusion as a result, essentially, these can be viewed as the same concept (Munro, 2008). The nursing literature has reflected the importance of continuing education since the beginning of the profession, with writings from Florence Nightingale encouraging nurses to continue learning as a lifelong activity (Gallagher, 2007). Continuing education is essential for nurses to maintain currency of nursing practice and is now an accepted practice in all healthcare facilities (Keane, 2016).

The implementation of the National Safety and Quality Health Service Standards (NSQHSS) across the Australian health system to ensure the safety and quality of patient care highlights the importance of continuing education for nurses (Keane, 2016). According to Keane (2016), continuing education is a variety of formal and informal education and training activities that aim to improve nurses’ knowledge and skills, with the goal of improving the delivery of patient care. Nurse continuing education is considered a professional development process designed to give an individual further knowledge and skills to support them in their line of work (Gallagher, 2007). It has been defined as post-registration activities that facilitate learning within the workplace and enhance the professional self (Govranos & Newton, 2013). Continuing education programs mainly consist of short or part-time courses, cover
aspects of the employee’s job, such as new advancements in the workplace, and are used to develop an individual within a given field (Keane, 2016).

Post-registration nursing education is predominantly undertaken in the clinical area, and according to Govranos and Newton (2013), nurses prefer learning to occur in their workplace environment. Nurses undertake continuing education for a variety of reasons: it allows them to maintain, improve and broaden their clinical knowledge, expertise and competence (Keane, 2016). While continuing education may be optional for some, others may be required to undertake continuing education to maintain certification or their licence (Munro, 2008). Continuing education is generally organised and provided to nursing staff by nurse educators affiliated with a hospital-based staff development department or service.

1.5 Hospital-Based Staff Development Service

Many early hospital-based SDSs fell within the nursing service division, with the sole purpose of supporting nursing personnel. As hospitals expanded into multifaceted health care organisations, the focus of these SDSs changed to some extent, to become a corporate department serving all clinical health care personnel, though nursing personnel remained the largest supported group (Blocker, 1992). These SDSs have multifaceted roles, including the induction and orientation of new staff, competency management and training to support practice, and continuing education (Narayanasamy & Narayanasamy, 2007).

A SDS plays an essential role in creating a culture of learning within an organisation; a supportive learning environment is important in supporting continuing education and ongoing development of staff to improve service delivery and patient care (Burke & Hellwig, 2011). Apart from personal responsibility for staff development, progressive and successful organisations have a clear strategy for staff development
According to Munro (2008), the employer has a responsibility in encouraging and facilitating professional development for individuals to ensure that professional learning occurs in the workplace and that the organisation continues to develop.

The primary objective of the SDS is to function efficiently and effectively to produce measurable outcomes for the organisation and justify its cost in regard to the organisation’s financial bottom line (Keane & Alliex, 2018). Service models to illustrate or communicate SDS structures have been described in the literature as centralised, decentralised and combination models (Bille, 1982; Horner, 1995; Keane, 2016; Kelly-Thomas, 1998; Roussel & Swansburg, 2009).

1.5.1 Centralised model

In a centralised structure, the SDS is organised to provide a range of defined services to staff; requests for service follow an established communication pattern (Kelly-Thomas, 1998). There is an organisational-wide approach to staff training in which a central department has the responsibility of meeting staff training requirements across the whole organisation (Keane, 2016). All education staff, even those placed within the clinical areas, report centrally to the SDS (Keane, 2016). In a centralised structure, staff development personnel may have a working relationship with clinical staff but not necessarily a formal attachment to a given unit; thus, staff development staff are assigned to a specific area and develop informal structures (Swansburg, 1995). According to Keane, (2016), clear evaluation of outcomes and goal achievement for the service is possible with all educators reporting to one coordinator. A centralised service facilitates support of education as a specialty within the organisation and provides a career pathway for nurses (Keane, 2016). Most nurses move into the education role with little formal qualifications in education, and it is important that when commencing in
the educator role, nurses are given adequate education, training and support by the SDS, so they can develop into effective educators (Donner et al., 2005). In a centralised nurse education service, educators benefit from close collegial relationships with other educators, with whom they can share and build their identity as education specialists (Gilbert & Womack, 2012).

1.5.2 Decentralised model

In a decentralised service model, nurse educators work within individual clinical areas and are responsible for meeting the training needs of nurses within their areas (Cummings & McCaskey, 1992). In collaboration with the nurse unit manager, the individual nurse educators have autonomy and authority for education within their clinical areas and do not report to an education service. In this model, the nurse unit manager directs the nurse educator and has governance over education (Keane & Alliex, 2018).

1.5.3 Combination model

The third service model is the combination model: a centralised education service that delivers programs across the whole of the organisation, such as induction, with a decentralised component consisting of clinically placed nurse educators managed by nurse unit managers (Cummings & McCaskey, 1992; Keane & Alliex, 2018). There is no formal connection between the two governance areas of the education service and individual nurse educators situated in the clinical areas (Keane & Alliex, 2018). The combination model allows for the education service to meet organisational-wide training requirements, with some standardisation and support flexibility to meet the training needs of specialised clinical areas (Keane & Alliex, 2018). It also provides ward-based nurse educators autonomy within their individual clinical areas while allowing collegial support between educators (Keane & Alliex, 2018).
While there is some controversy regarding centralisation and decentralisation of education resources (Sheriff & Banks, 2001), staff development can be arranged in ways that are rational for situations and organisations, and a combination model of centralisation and decentralisation can provide the advantages of both (Kelly-Thomas, 1998; Sheriff & Banks, 2001). The service model can have an impact on how nurse educators are situated in the organisation.

1.6 Nurse Educators

Conway and Elwin (2007) acknowledge the diversity of nurse educator role descriptions and consider the role of the nurse educator as multi-faceted and dependent on the context of practice and employment. Nurse educator titles also vary between organisations, and the terms nurse educator, nurse teacher, clinical nurse educator, staff development educator, staff development nurse and nurse lecturer are used interchangeably when referring to an array of nursing education roles, whether within a higher education institution or hospital (Conway & Elwin 2007; Sayers, 2013; Thornton, 2018). The majority of published literature concerning nurse educators has focused on the roles and functions of nurse educators in higher education institutions (Thornton, 2018). Nurse educators in higher education institutions are primarily responsible for the formal education of undergraduate and postgraduate nursing students, whereas nurse educators within the hospital setting are focused on the continuing education and development of hospital-based nurses, maintaining practice standards and managing and facilitating clinical education and competency (Conway & Elwin 2007; Sayers, 2013; Thornton, 2018). Nurse educators in the UK and the US may have dual roles in academia and the hospital setting or in academia alone and are referred to as nurse academics; in comparison, nurse educators in Australia work primarily within hospitals (Sayers et al., 2011).
1.7 Hospital-Based Nurse Educators

Professional development is widely accepted as a means to remain competent in nursing and be knowledgeable about the numerous changes in healthcare. Since the time of Nightingale, hospitals have organised professional development opportunities for nurses to develop their expertise (Avillion, 2008; Gallagher, 2006). According to Sayers (2013), in Australian acute care hospitals, there are two distinct educator roles: the nurse educator (in WA, also called the SDE) and the clinical nurse educator (in WA, also called the SDN).

During the 1920s, senior nurses in hospitals were given responsibility to organise orientation activities and provide education classes for the nurse ‘in-service’. The term ‘in-service education’ was used for describing this work, and it was unusual for nurses to be assigned exclusively to the continuing development of nurses in employment (Avillion, 2008; Kelly-Thomas, 1998). As nursing became more complex, during the late 1970s, the role of the clinical nurse educator, also known as the SDN, emerged, and nurses were assigned to this because of their good clinical skills (Kelly-Thomas, 1998). Clinical nurse educators were dedicated to specific areas of nursing practice (i.e., critical care, surgery) and provided orientation and continuing education to nurses employed in those areas.

The hospital-based nurse educator (HBNE) role in Australia changed significantly following the transfer of nurse education from hospitals to universities (Conway & Elwin, 2007). The role evolved from one where the HBNE had responsibility for pre-registration training of nurses and professional development in a hospital-based system, to providing support to students and facilitation of professional education, nursing practice and organisational goals (Conway & Elwin, 2007). HBNEs collaborate with organisational leadership to determine nursing practice priorities and
subsequently manage professional development initiatives to address these priorities (Conway & Elwin, 2007; Sayers, 2013). HBNEs generally work in partnership with clinical experts, such as clinical nurse specialists, to provide meaningful education opportunities for hospital-based nurses (Thornton, 2018), including the development and contextualisation of varied learning activities to the practice setting, new staff orientation programs, graduate nurse transitional education, delivery of continuing professional development through provision of in-service sessions, and delivery of workshops or carefully designed education programs.

In contemporary service settings, the role of the CNE is less well defined, and role description and boundaries vary between employing hospitals as well as between wards within the same hospital (Conway & Elwin, 2007; Sayers & DiGiacomo, 2010). Internationally, there is inconsistency in job descriptions, expectations and nomenclature for nursing staff development roles and the HBCNE role is unclear and poorly described (Conway & Elwin, 2007). A new CNE can experience feelings of role confusion caused by lack of defined role expectations, orientation information or educator knowledge, which can adversely affect quality of performance and wellbeing (Davies et al., 2006). This can make the job of CNE unattractive and result in a challenge for recruitment and retention to the role; when organisations provide access to information, resources and support to carry out work activities effectively, staff have lower job stress and job tension and are more satisfied with their work (Conway & Elwin, 2007).

1.8 Research Topic

The hospital in this study had 3,000 staff, inclusive of a nursing service of 1,500 full-time equivalent nurses. Organisationally positioned within the nursing structure of the hospital, the SDS had a number of assigned staff development roles within its
service; director of staff development (DSD), SDEs (eight) who line manage the SDN (34), nonclinical trainers for general organisational training needs and administration staff. I was the substantive Director of Staff Development at the commencement of this study and in the role of Director, was responsible for providing leadership and strategic direction for the hospital wide SDS. The SDN position was not a direct line report to my position and I had minimal operational contact with SDNs.

The SDS in this hospital, through a review of the service, identified a problem with recruitment, transition and retention to the SDN role. In response, the SDS re-engineered work design and organisational structure of the SDS and developed an organisational model to depict the SDS structure and role functions. The purpose of the organisational model was to provide the means to develop and articulate operational plans, arrange resources and provide a guide for SDS staff in work planning and outcome measurements. The SDS organisational model includes two components: (1) SDS structure and (2) staff development framework.

1. **SDS structure:** this component describes operational arrangements for the SDS such as staff recruitment and retention, role and responsibilities, line management arrangements, department policies and standard operating procedures.

2. **Staff development framework:** this articulates what the staff development staff at the hospital do to deliver a hospital staff development program. It is utilised as a guide to identify activities and resources required to operationalise the program in alignment with the hospital’s organisational goals.

The framework consists of four elements:

- **Induction and orientation**
- **Competency maintenance and skill development**
- In-service that is coordinated and synchronised
- Continuing Education for ongoing professional development.

Known as the ICIC Staff Development Framework, the SDS staff use the framework to distinguish training needs, prioritise use of resources, monitor program performance indicators, organise work activities and identify role expectations. Designed for people whose training is in technical fields but have been called on to take up a staff development role, the aim of the SDS structure and ICIC Staff Development Framework is to provide managers, workplace trainers and new SDNs a model for providing the staff development service in their workplace.

A formal review of the SDS model had not been undertaken since it had been established. This study offered opportunity to undertake a formal exploration of the SDS model and its relationship to the transition of a ward-based nurse to SDN role.

Potential Significance

The literature mostly describes the transition experience of nurse academics and clinical teachers engaged by higher education institutes (HEIs), with a dearth of literature on the experience of hospital-based SDNs or similar roles. The literature regarding both HEI clinical teachers and hospital-based SDNs notes a lack of preparation, orientation and role definition, with few strategies offered for transitional and ongoing support of nurses to the SDN role. Strategies found in the literature to assist new clinical teachers include providing an orientation to role, responsibility and organisation, and mentoring and providing technical support to increase teaching skill (Conway & Elwin, 2007; McArthur-Rouse, 2008; McLean, Cilliers & Van Wyk, 2008).

This study is potentially significant for hospital administrators employing SDNs, SDNs working in staff development and nurses considering a move to the role of SDN. The results of the study may also be significant for other professionals who transition
from technically orientated jobs into organisational training positions. It is an expected outcome of this study that the findings will provide an appreciation of the transition process to the staff development role and result in the development of a framework that identifies strategies to support career change, seamless transition to role and ongoing role support.

The literature review revealed gaps arose in the knowledge of the experience of clinical nurses transitioning to the role of SDN in the hospital setting. The literature predominantly focused on higher education teachers and the transition experience of SDNs had not been identified in the literature. No strategies had been identified for hospital administrators to utilise to specifically facilitate or manage the transition of clinical nurses to the role of SDN.

**Statement of Purpose**

The purpose of this qualitative study is to explore SDNs’ lived experience of the staff development service model at a metropolitan hospital in Perth, WA.

This study provided an opportunity to identify strategies SDNs may utilise to facilitate their journey into the role of SDN. In undertaking this study, I hope to identify strategies and organisational factors that facilitate transition to the role of SDN.

**1.9 Research Questions**

The objective of the study is to develop a framework that explains transition of a ward nurse to SDN. Thus, the following research questions were formulated:

1. What is the SDNs’ lived experience of using the SDS organisational model?
2. What is the context in which SDNs commence and transition to the role?
3. What barriers and facilitators do SDNs experience during this transition?
4. What strategies do SDNs use to facilitate their transition?
1.10 Chapter Summary

The literature highlights the value the nursing profession holds for staff development and the nurse educator role, but demonstrates that there are issues related to the SDN role such as job ambiguity and a lack of role preparation and support. While the literature highlights the issues, there is a dearth of work describing strategies to support the role beyond providing role definition, orientation and mentoring. A study to explore the SDN role within an organisational model would help to fill this knowledge gap, as it would help identify strategies an organisation can use to facilitate role transition and provide role support, resulting in making the SDN job attractive to experienced nurses. This study adds to the body of nurse education knowledge via the identification and development of a framework to explain transition to the role of SDN and describe organisational role support that may be required.

This thesis comprises seven chapters, with references and appendices located at the end. Chapter 1 provided a background to this study, an overview of continuing education, SDS models and a description of the role of nurse educators in hospitals. It also outlined the study methodology and study significance. In Chapter 2, a literature review is presented to provide insight into what is known about staff development, SDNs and work-role transitions. Chapter 3 describes the methodological approach to the study. An explanation is given of the philosophical underpinnings of the research and rationale for using a phenomenological approach, including methods of data collection and analysis of the data. Ethical considerations are also addressed. Chapter 4 provides the context of the study, including the history of the phenomenon experienced by the participants of the study. Chapter 5 presents demographics of the participants, and the identification of themes with a discussion and explanation of the findings. Chapter 6 provides discussion of the relationship between the findings and the literature.
New knowledge gained from the study and limitations of the study are also discussed. The conclusion, in Chapter 7, provides a summary of the study findings and suggests recommendations for the future. Following the conclusion, there is an epilogue.
Chapter 2: Literature Review

2.1 Introduction

The previous chapter introduced the topic and purpose of this study, providing a background to the study and identifying the potential significance of the research. In this chapter, a literature review is presented to provide insight into what is known about staff development, staff development nurses (SDNs) and work-role transitions. This review of the literature highlights challenges for organisations in supporting the SDN role and the challenge of transition to a new work role.

According to Streubert and Carpenter (2011), when using a phenomenological approach, having fewer preconceptions promotes a greater openness to the phenomenon under study. Streubert and Carpenter (2011) support superficial scoping of the literature prior to data collection to gain insights, but not in-depth knowledge, about the phenomenon to enhance data collection and analysis (Kvale, 1996; Poland, 2003). In view of this, Chapter 6 provides further discussion of the literature relevant to the interpretation of the lived experience of SDNs to position the findings within the context of what is already known (Streubert & Carpenter, 2011). I conducted a literature search for models of staff development in hospitals, looking for studies and descriptions of the components of staff development. My search revealed a dearth of literature in this respect. I included the more recent textbooks on nursing staff development, which principally provided instruction to clinical teachers or nurse academics on teaching and assessment methods for undergraduate students of nursing. I turned to the seminal nursing education texts of the 1980s to mid-1990s, as these described nursing staff development in the hospital setting. A limitation of this literature review on nursing transition from clinical practice to education was the scarcity of research studies on hospital-based clinical educators. There was very little recent literature that described or
focused on the SDN role, and most of the recent research described the role and/or transition of hospital-based nurses to university academics.

Figure 2.1. Schema of the literature review.

For this literature review, I undertook a search of the Internet and the following databases: Medline, Cumulated Index of Nursing and Allied Health Library (CINAHL), Proquest and EBSCOhost. Electronic databases were searched for articles, unpublished dissertations and published articles prior to data collection. Classic works, frequently cited in the literature, were also included. Search terms included staff development and nursing, models of staff development, staff development service, staff development department, staff development and organisation, decentralised and centralised organisation, nursing education, continuing education and nursing, medical education and hospital, allied health and continuing education, hospital-based and staff development nurse, SDN, nurse educator, clinical nurse educator, clinical education facilitator, clinical educator, clinical teacher, transition and bedside nurse, nursing role
transition, transition and nurse. Literature related to staff development and professional development for the medical, nursing and allied health professions were examined. Both medical and allied health literature discussed continuing education in relation to maintaining professional competency and continuing education requirements for maintaining professional licensure. There was no equivalent role in medicine or allied health to that of the SDN. As there were no points of comparison for the SDN role in the medical and allied health literature, this was excluded from this review. The first section of this chapter describes the purpose and models of nursing staff development education. The chapter then discusses SDNs and the factors that affect their role and transition to role. It concludes by reviewing the theoretical literature of work-role transition.

2.2 Nursing Staff Development

Continuing education has been an accepted method for nurses to maintain and advance professional competence to work effectively within the health care environment, and to be knowledgeable about the numerous changes in health care (Gallagher, 2006; Kelly-Thomas, 1998; Levitt-Jones, 2005). Nurses have a professional responsibility to engage in continuing education and the concept of staff development is not new: it has existed since the time of Florence Nightingale, who considered staff development an integral part of nursing practice (Gallagher, 2006; Narayanasamy & Narayanasamy, 2007). In the past few decades, there has been continued demand for continuing education; drivers for this include a range of factors such as technological change, ever-changing operational environments, rapid changes in the health care system and the consequent changes in nurses’ roles (Cheetam & Chivers, 2005; Griscti & Jacono, 2006; Shanley, 2004). Although the topic has been discussed there has been
no real identification of the context. Thus, this study asks what is the context in which SDNs commence and transition to the role.

According to Narayanasamy and Narayanasamy (2007), there is an expectation of excellence in performance and provision of service from those receiving care, and staff development is concerned with all the activities that advance knowledge, skills and attitudes of staff. An effective organisation that invests sufficiently in short- and long-term educational initiatives is better able to achieve care delivery, safety and quality outcomes (Munro, 2008; Ridge, 2005).

Describing nursing staff development frameworks, Karen Kelly-Thomas (1998) and Russell Swansburg (1995) referenced Donald Bille’s (1982) approach to nursing staff development, based on a systems approach to both job performance and the staff development function. Bille (1982) argued that staff development should be an integral component of every organisation, as it assisted in preventing professional obsolescence and attainment of overall organisational goals, and defined a systems approach to job performance as including:

- Inputs: entry staff behaviour, level of education, prior experience
- Throughputs: orientation, policies, procedures and managerial direction
- Outputs: the final staff behaviour and quality patient care.

A systems approach is a means of looking at all parts and structures in an organisation and how these relate to organisational outcomes or goals. According to Bille (1982), the staff development function cannot be understood in isolation from the other components of the organisation. With the other functions of the nursing department and organisation, the concept of staff development within a systems framework can assist a manager of staff development to plan, implement and evaluate the impact of staff development on an organisation’s goals (Bille, 1982). Bille (1982)
advised that staff development provides the following professional development
opportunities:

- Induction education: to introduce new staff to the specific setting
- Remedial education: to fill gaps left by the nursing education program, and to
  allow re-entry to practice
- In-service education: to increase competence in specific areas of practice, and
  keep abreast of technological, procedural, policy and organisational change
- Continuing education: to enhance the professional knowledge base.

This review of the literature on nursing staff development is relative to this study’s
objective to explore what is the SDNs lived experience of using the SDS
organisational model.

2.2.1 Models of Staff Development

There are contextual factors that have impacted on nursing staff development
historically. All of the literature in this section is to build the rationale for identifying
the lived experience of SDN at this particular hospital of this particular service model.
The literature on staff development models was analysed to support this study’s
objective to understand what is the context in which SDNs commence and transition to
the role.

The setting and structure of an organisation are important elements to
operationalising an effective staff development program; Bille (1982, p. 23) proposes:

The administrative setting and climate within an organisation will determine
not only whether staff development exists at all, but also how effectively
staff development can carry out its given responsibilities.

The structure of the SDS in some organisations may be based on historic
organisational tradition, whereas in other organisations, structures have been developed
to address identified problems related to efficiency and effectiveness (Cummings & McCaskey, 1992; Horner, 1995; Roussel & Swansburg, 2009). SDSs can be organised in different ways, depending on the preference of the organisation’s leadership and the ability of the SDS leader’s skills to articulate an efficient structure to provide required services (Kelly-Thomas, 1998; Roussel & Swansburg, 2009). Models used to illustrate or communicate nursing staff development structures have been described as centralised, decentralised or combination (Blocker, 1992; Cummings & McCaskey, 1992; Horner 1995; Kelly-Thomas, 1998; Sheriff & Banks, 2001).

In a centralised structure, educational activities are initiated and conducted by the staff development department, who are also responsible for training need assessments, implementation and evaluation of education programs. According to Kelly-Thomas (1998), some nurse leaders consider this approach the most economical and effective for meeting quotas and standards. A centralised department can ensure the organisational objectives are reinforced, staff development does not get lost in day-to-day management of priorities, rationalisation of resources can occur with common function and activities implemented, and it is more likely that strategic standardisation can be efficiently achieved (Cummings & McCaskey, 1992; Horner, 1995; Roussel & Swansburg, 2009). According to Bille (1982), in a centralised structure, staff development personnel may have a working relationship with clinical staff but not necessarily a formal attachment to a given unit. Bille (1982) suggested that, ideally, in this type of structure, SDNs are assigned a specific area and that such an assignment can foster familiarity and develop informal structures. Swansburg (1995) considered a centralised service as efficient, effective and economical, as being a centralised service allows for the one service to have control over training quality and content, service staffing, budget and evaluations.
Blocker (1992) defines decentralised models as involving instructors who are specialists assigned to or based in specific units. In a decentralised model, each clinical area is responsible for its own staff development program, with a designated unit educator. While the literature describes some of the merits of the decentralised model, such as greater immediacy of response, cost effectiveness and less complex systems (Horner 1995), it also speaks of disadvantages (Conway & Elwin 2007; Cummings & McCaskey, 1992; Horner 1995). The decentralised model’s success or failure can be dependent on the ability of the unit-based designated educator, and if they are able to function within their assigned capacity, and if this capacity is communicated and understood by the staff, the role will be successful (Conway & Elwin 2007). There is a risk to the success of the role when there is failure to remove or quarantine the designated unit educator from the staffing pattern for direct care, in which case, they are unable to fulfil the requirements of the job (Kelly-Thomas, 1998; Siehoff, 2003). The staff development function can fail in decentralised models, resulting in inconsistency, poor quality because of a lack of centralised standards, difficulty with accountability and difficulty pooling resources (Bille, 1982; Cummings & McCaskey, 1992; Horner 1995). Haggard (1984) cautioned that the most serious problem in a decentralised system is communication breakdown. Cost effectiveness is not achieved unless there is good communication and coordination of activities between the unit educators, to avoid the situation where each unit independently identifies the same learning need of staff and the unit-based educators spend a great deal of time teaching the same thing at the same time to different areas (Bille, 1982; Cummings & McCaskey, 1992; Haggard, 1984).

Cummings and McCaskey (1992) describe a combination model of centralisation and decentralisation, in which the combined structure provides the
advantages of both. Horner (1995) advises that there is a place for both management styles in any one organisation at any one time, and it does not have to be a matter of one or the other. Organisations are advised to consider structure options along a continuum of control and to recognise where some functions are better suited to centralisation or decentralisation considering organisational culture, characteristics, staff qualifications and organisational shortcomings, and not just cost effectiveness (Cummings & McCaskey, 1992; Horner, 1995). An organisation looking to promote a learning culture must demonstrate commitment to providing staff development access and a supporting infrastructure that fosters continuing education (Levitt-Jones, 2005; Ridge, 2005).

Horner (1995) defined nursing staff development as an organised ‘process of learning in an employment setting, designed to update or increase knowledge and/or skills or for personal growth and development, to improve performance or to meet advances or changes in direction or focus of a position or of an organisation’ (p. 6). It is argued that to achieve high performance and continue to develop, an organisation must consider that the staff of an organisation are just as important as material and financial resources and make a commitment to staff development (Horner, 1995; Munro, 2008). Narayanasamy and Narayanasamy (2007) claim an organisation’s success is dependent on the investment it makes in staff development and recommends each ward or unit of care should have a designated senior member of staff responsible for deploying staff development strategies, such as an SDN.

### 2.2.2 Staff development nurse

The hospital-based SDN, also called clinical educator or clinical nurse educator, is a position dedicated to continuing clinical education of nursing staff; these educators are recognised as clinical leaders, facilitators of skill development and mentors for practicing nurses (Conway & Elwin, 2007; Manning & Neville, 2009; Sayers &
DiGiacomo, 2010). In Australia, the role emerged as a staff development role with emphasis on facilitating the clinical, organisational and professional development of registered and enrolled nurses rather than on undergraduate clinical teaching and support (Conway & Elwin, 2007).

2.2.2.1 Staff development nurse role

SDNs play a vital role in the professional development of nursing staff (Conway & Elwin, 2007; Davies et al., 2006; Mateo & Fahje, 1998; Ridge, 2005; Sayers & DiGiacomo 2010; Sayers et al., 2011). SDNs are uniquely positioned to foster the professional growth of nurses (Ashton, 2012); they are considered clinical leaders, responsible for managing and facilitating clinical education and competency (Sayers & DiGiacomo, 2010). Clinical education facilitates nurses to maintain their practice currency, which is required to care for patients appropriately (Sayers & DiGiacomo, 2010). SDNs, according to Ashton (2012), are situated at the intersection of knowledge, resources and people. This gives SDNs the opportunity to support and motivate nurses to develop clinical and leadership skills to effect practice change that can positively influence patient safety and outcomes (Ashton, 2012; Sayers & DiGiacomo, 2010).

The role of an SDN can vary according to context (Conway & Elwin, 2007; Manning & Neville, 2009; Sayers et al., 2011). Therefore, their perceptions of teaching, nursing practice, clinical context, and organisational needs and priorities inform how they undertake their roles and what they teach and facilitate (Ashton, 2012; Conway & Elwin, 2007; Manning & Neville, 2009; Sayers & DiGiacomo, 2010; Sayers et al., 2011; Shanley, 2004). Mateo and Fahje (1998) assert that the success of an educator in the clinical setting is determined by a number of factors: congruence between staff and educator expectations, characteristics of the educator and an ability to plan, manage challenges and assume various responsibilities. Critical thinking, reflection and
knowledge of teaching processes are also necessary for nurse educators to perform successfully (Sayers et al., 2011); according to Mateo and Fahje (1998), successful educators are politically savvy, possess clinical expertise and demonstrate leadership, management and communication skills.

SDNs are frequently appointed because of their clinical expertise (Milner, Estabrooks, & Myrick, 2006); while they may be expert practitioners, they are likely to be novice educators (McAllister, Williams, Gamble, Malko-Nyhan, & Jones, 2011). Furnham and Taylor (2005) argue that like all professions, there should be a strong knowledge base to the training professional’s practice. They write that staff development practice has over the years largely developed by trial and error and that too much training and coaching happens without the deliverers understanding if or why it works. In Australia, educational preparation for nurse educators is not mandated by any specific regulatory authority and there are no national requirements for nurse educators to have educational qualifications (Conway & Elwin, 2007; Sayers & DiGiacomo, 2010). According to Sayers and DiGiacomo (2010), clinical competence alone is insufficient to successfully assume an educator role. Experienced nurses pass through a difficult transition to the role of SDN, as the move constitutes a career change. The role of the SDN is complex with many components and, for some, the transition from clinical practice into education is more of a shock than expected, as nurses moving into this new role from a direct patient care role are ‘indistinctly unaware of the nature of the difference’ (McArthur-Rouse, 2008, p. 402).

2.2.2.2 Transition to role

The literature has identified barriers to successful transition to the nurse educator role, in both practice-based and academic settings, as inadequate knowledge of educator skills, unrealistic expectations, role ambiguity, poor orientation, lack of support and
mentoring, inadequate preparation in educator skills and teaching techniques, evaluation and giving feedback (Anderson, 2008; Penn, Wilson, Rosseter, 2008; Sayer & DiGiacomo, 2010). Nurses who are knowledgeable and expert in their field do not automatically function as clinical teachers and it is necessary to adequately prepare nurses with formal preparation and orientation for this role (Billay & Yonge, 2004; Coates & Gormley, 1997; Garrett & Schoener, 1996; Kaviani & Stillwell, 2000). Researchers have identified challenges related to knowing how to interact professionally with staff when transitioning into the role of educator (Anderson, 2009; Manning & Neville, 2009). Many nurses entering clinical teaching roles have no specific prior education for the role and their job satisfaction could increase if provided with opportunities to become familiar with role expectations and teaching and learning strategies (Wright, 2002). Diekelmann (2004) explored new nurse educator experiences on entering the realm of nurse education from clinical practice and found that they experienced limited support from colleagues, feelings of isolation, lack of understanding of organisation structure and a lack of clarity about their role and the effectiveness of their role. Without adequate orientation and role support, SDNs can experience confusion about role expectations; this role confusion can be caused by lack of job information or knowledge and result in role conflict, overload and ambiguity for the SDN (Davies et al., 2006).

As with any career change, the role transition from a clinical role to an educator role can cause feelings of uncertainty, isolation and anxiety, and nurse educators need considerable support in making a successful transition to this role (Penn et al., 2008). In McArthur-Rouse (2008) study, new nurse educators described their commonality of having limited support in their new role, of experiencing a sense of isolation and ‘muddling through’ (p. 402).
Barriers related to expectations and role clarity were associated with unrealistic or unclear expectations on the part of either the new educator or the employer, resulting in the educator experiencing a degree of conflict, stress or discomfort (Anderson, 2009; Dempsey, 2007; Manning & Neville, 2009; McKinley, 2009; Penn et al., 2008; Wilson, Brannan, & White, 2010). Lack of mentoring and peer support were identified as barriers to a smooth transition, with several studies demonstrating new educators felt they did not receive adequate mentoring for their new role (Cangelosi, Crocker, & Sorrell, 2009; Duphily, 2011; Manning & Neville, 2009; Wilson et al., 2010).

From their study on educator empowerment, job tension and job satisfaction, Davies et al. (2006) recommended decreasing the possibility of role ambiguity, identify clear job definitions for clinical educators, consistent and articulated across the organisation. When organisations provide access to information, resources and support to carry out work activities effectively, staff have lower job stress and job tension and are more satisfied with their work (Davies et al., 2006). Organisational factors can facilitate or cause barriers to a smooth transition from expert nurse to the SDN role, and differing managerial structures can affect role clarity as role expectations may be unclear (Conway & Elwin, 2007; Kelly-Thomas, 1998). Job descriptions may not define the full range of competencies often expected of the SDN and are frequently broadly defined to allow a redefinition of the role in response to new and ongoing initiatives by organisations (Conway & Elwin, 2007; Davies et al., 2006; Kelly-Thomas, 1998).

In their study of clinical educators in New South Wales (Australia), Conway and Elwin (2007) described challenges for clinical educators in ensuring others did not have mistaken expectations of their role, their experience of little or no guidelines for their practice and the lack of available role models to facilitate realistic perceptions of their roles and responsibilities. To counter these challenges, Conway and Elwin (2007)
advise that clinically based educators need ‘a well-defined identity that validates their roles and responsibilities in facilitating professional competence as well as task mastery of clinical skills’ (p. 161). Sayer’s (2013) study on the role of the nurse educator in Australia, demonstrated educators who had a job description, were experienced in their role and met with their manager regularly were more likely to be satisfied with their workplace than those without this support structure.

In the nursing literature, studies with a focus on role transition—including student nurse to newly qualified nurse (Amos, 2001; Duchscher, 2009; O’Shea & Kelly, 2007; Whitehead, 2001), nurse to advanced practice nurse (Hill & Sawatzky, 2011; Heitz, Steiner, & Burman, 2004; Spoelstra & Robbins, 2010) and nurse to nurse educator (Anderson, 2009; Dempsey, 2007; Manning & Neville, 2009; McArthur-Rouse, 2008)—demonstrate nurses experience a variety of feelings and emotions while undergoing a role transition. Research regarding the work-role transition of nurse to clinical educator has focused primarily on clinical educators in academic settings, with numerous studies demonstrating experienced clinicians find the transition into nursing education difficult (Anderson, 2009; Bailey, 2012; Dempsey, 2007; Duphily, 2011; Goodrich, 2012; McDonald, 2004; Parslow, 2008; Paul, 2015; Schoening, 2009; Rahim & Prasla, 2012; Schriner, 2007; Siler & Kleiner, 2001; Wilson et al., 2010; Young & Diekelmann, 2002). The research by these authors indicates distinct phases experienced by nurses who make the work-role transition into academia (Anderson, 2008; Bailey, 2012; Cangelosi et al., 2009; Ramage, 2004; Schoening, 2009); however, research is lacking in exploring nurses transitioning into hospital-based SDN roles. Only one study, Manning and Neville (2009), was found, which documented the transition of clinical nurse to clinical nurse educator in a hospital setting. Manning and Neville (2009)
utilised Bridges’ (1986) transition framework to present their findings—that the participants found the transition difficult and challenging.

According to McAllister et al. (2011), the working conditions, experiences and needs of nurse educators have not been widely researched in Australia. The literature revealed a focus on academic roles, with little known about the hospital based SDN experience of transition to role. This gap in the literature supports the research questions in this study of what barriers and facilitators do SDNs experience and, what strategies do SDNs use to facilitate their transition.

### 2.2.3 Relevant theories

In the theoretical literature, transition frameworks describe commonalities of definitions, attributes and aspects of transitions (Anderson, 2009; Ashforth, 2001; Bridges, 1986; Meleis, Sawyer, Im, Messias, & Schumacher, 2000; Nicholson, 1984).

According to Meleis (1975), a role transition is a change in an individual’s identity within a context and occurs through the development of new knowledge and skills as well as a change in behaviour.

Bridges (1986) explained transition as a three-part psychological process extending over a long period of time and as fundamental to any change process. According to Bridges (1986), transition can either be nurtured or neglected, depending on a leader’s understanding of the transition process. Bridges (1986) created a model to assist individuals and organisations in times of transition, in which individuals passing through a change experience a three-phase process: ending, losing or letting go; a neutral zone or time, when the individual bridges the old to the new; and the new beginning. Chick and Meleis (1986) defined transition as a passage from one life phase or status to another, inclusive of process, time span and perception. Schumacher and Meleis (1994) identified situational transitions such as professional roles, which can
occur throughout a career. The concept of transition within nursing emerged in response to the perceived need for nurses to understand the transitional experiences of patients (Meleis et al., 2000). According to Meleis et al. (2000), transitions vary in type, pattern and defining characteristics, and are considered both complex and multidimensional. Meleis et al. (2000) described five properties of transition that describe how an individual experiences transition: a sense of awareness that a transition is occurring, the extent of engagement in the transition, degrees of change and reactions to differences, the time span over which the transition occurs, and any critical life markers that initiated the transition, such as a birth or death. Transition theories have also been considered in relation to the experiences of nurses making transitions in their employment or professional status (Anderson, 2009; Ashforth, 2001; Manning & Neville, 2009). While there are many theories that explain transition from one role to the next, the two theories below align closely with the role transition of the nurse.

2.2.3.1 Role transition

Nicholson (1984) defined work-role transitions as any change in employment status and any major change in job content, relating the work-role transition to a personal growth process. Nicholson’s (1984) theory proposes work-role transitions have an impact on both the individual and the organisation. According to Nicholson (1984), there are two forms of adaptive mechanisms: the person adapting to the environmental demands in the new role (reflecting change in their skill, perspective or identity), and manipulation of the new environment to meet their personal needs (change in role requirement, practice or behaviour). Nicholson’s (1984) model has an emphasis on outcomes of the transition, which he referred to as adjustments. Based on the amount of change or adaptive mechanisms that occur in the work-role transition, Nicholson (1984) identified four types of adjustment (see Figure 2.2):
• Replication is an outcome where there is low role and personal development—a person moves into the new role and can perform this in much the same manner as in the previous role.

• Absorption is a work-role transition outcome where new tasks and the environment are significantly different, and adaptation occurs in the person with minimal adaptation in the environment.

• Determination is the outcome accompanying low personal development and high role development; the environment is shaped to fit the individual, who remains relatively unchanged.

• Exploration is described as the outcome where there is a process of mutual shaping—the person undergoing work-role transition learns a new role and associated skills, and at the same time, uses previous knowledge and experience to modify the new environment.

Figure 2.2. Removed due to copyright restrictions
Work-role transition is defined by Anderson (2009) as ‘the human experience associated with entering a new community of practice’ (p. 203). Regarding the transition process as a ‘dynamic, developmental process with associated emotional work, critical tasks, and a diffusion through role boundaries to assume the identity, values, and knowledge base of the new role’ (p. 203), Anderson (2006) outlines four attributes of transition in line with the definition given:

- The dynamic, developmental process refers to movement and active participation of the individual undergoing the phenomenon.
- Emotional work linked to the dynamic developmental aspect of role transition is characterised by feelings of frustration, self-doubt, anxiety and uncertainty, appearing more frequently in the earlier phase of the work-role transition.
- Critical tasks relate to acquiring new knowledge and skills, developing insights into organisational structure, assimilating new values, norms, and behaviours and integrating a new identity matching the new role.
- Diffusion through role boundaries is associated with ‘letting go’ of the former role identity and ‘grabbing hold’ of the new role identity.

The models of transition discussed in this chapter follow a pattern of stages and have similar features: facing a new situation or a loss, leaving some aspect of life, managing challenges to confidence and feelings of uncertainty, and reaching a resolution involving an adaptation and adjustment to the new situation (Bridges, 1986; Meleis et al., 2000; Nicholson, 1984). Adjustment is seen as involving cognitive, behavioural and affective adaptation (Nicholson, 1984). Individuals are subject to internal and external influences during transition and can face social and psychological risks during periods of change (Meleis et al., 2000; Nicholson, 1984).
The transition of interest in this study is situational; specifically, a change in work role for a hospital-based nurse transitioning to the role of an SDN.

2.3 Chapter Summary

This chapter reviewed the literature, with a discussion on staff development, the SDN and work-role transition. Chapter 3 introduces the chosen methodology for the study.
Chapter 3: Methodology

3.1 Introduction

The purpose of this study was to explore and describe the participants’ lived experiences of a hospital’s SDS and the factors that facilitated or impeded transition to the SDN role, role orientation and role support for SDNs. The study was undertaken from within a qualitative framework, specifically drawing on phenomenological understandings. The research method employed a phenomenological interpretive approach to describe and interpret the lived experiences of SDNs using the hospital’s SDS model and transitioning to the role.

The purpose of this chapter is to provide a description of the research paradigm, research design and methods used to conduct this study. The chapter begins by briefly discussing research paradigms and outlining the term ‘qualitative research’ and then proceeds to examine the concept of phenomenology and why this methodology is appropriate for this study. The research design, a qualitative phenomenological methodology using individual interviews, is described along with the rationale for this design. Finally, the participant population is identified, followed by discussion regarding the guided questions and procedures used to collect data and the ethical implications relevant to this study.

3.2 Research Paradigm

Researchers have their own set of beliefs and ways of viewing and interacting with their surroundings, and these influence the ways in which research studies are conducted. The research paradigm provides a set of principles that guide a researcher’s position and actions to make the research value free. Lincoln, Lynham and Guba (2011) define a paradigm as a ‘set of basic beliefs’ or world view that for the holder, defines the nature of the ‘world’ (p. 107). A research paradigm can be seen as a function of how
a researcher thinks about the development of knowledge; the philosophy associated with the research paradigm influences the way knowledge is studied and interpreted. It is the choice of paradigm that sets and regulates the inquiry, by providing frames and processes through which the investigation is accomplished (Bogdan & Biklen, 2003; Mertens, 2005; Weaver & Olson, 2006).

In social science, the research paradigm suggests a set of assumptions about the social world and what constitutes appropriate and proper techniques and topics for the inquiry (Punch, 2005). Creswell (2014) advises that researchers need to think through the worldview assumptions they bring to a study, the strategy of inquiry related to this worldview, and the specific methods or procedures of research that translate the research approach into practice.

According to Lincoln et al., (2011) the researcher should consider paradigm issues critical to their inquiry, and not proceed without being clear about what paradigm informs or guides their approach. Lincoln et al., (2011) believe a research inquiry should be based on the concepts of ontology (the way the researcher defines the truth and reality), epistemology (the process by which the researcher comes to know the truth and reality) and methodology (the method used in conducting the investigation). To this end, Lincoln et al., (2011) recommend the researcher asks three questions to define a research paradigm:

1. The ontological question: What is the form and nature of reality and, therefore, what is there that can be known about it? ‘Ontology’ is the nature of reality.
2. The epistemological question: What is the nature of the relationship between the knower or would-be knower and what can be known? ‘Epistemology’ is the philosophy of how we can know that reality.
3. The methodological question: How can the inquirer go about finding out whatever he or she believes can be known? ‘Methodology’ is the practice of how we come to know that reality.

According to Lincoln et al., (2011), the answers to these questions provide an interpretative framework that guides the research process, including strategies, methods and analysis. These questions were used to reflect on the ontological and epistemological considerations for this study.

Scotland (2012) points out that each research paradigm naturally contains differing ontological and epistemological viewpoints. Hence, they have differing views of the reality and knowledge that provide the foundation of their particular research approach, and this is reflected in the methodology and methods applied in the research. The selection of the research paradigm sets the intent and expectations for the research. Without nomination of a paradigm as the first step, there is no basis for subsequent choices regarding methodology, methods, literature or research design (Mackenzie & Knipe, 2006). Therefore, to clarify the researcher’s line of inquiry and methodological choices, an explanation of the paradigm adopted for this study and the methodologies utilised are presented in the following sections.

In social science research, the position taken by the researcher relates to their understanding of reality (ontological standpoint) and the nature of knowledge (epistemological standpoint) (O’Leary, 2010). The two research paradigms most commonly utilised in contemporary social, organisational and management research are positivistic and interpretivist or naturalistic (Neuman, 2011; O’Leary, 2010). The key features of these paradigms, including the worldview, the nature of knowledge pursued, and the means by which knowledge is produced within each paradigm, are discussed and summarised next.
3.2.1 Positivism

Positivism, commonly known as the scientific method, is based on the rationalistic, empiricist philosophy originating from the works of Aristotle, Francis Bacon and Emmanuel Kant (Creswell, 2014). The positivist epistemology is objectivism, where the assumption is that the researcher is capable of studying the object without influence on it or being influenced, and if rigorous procedures are followed, values and biases are prevented from influencing the outcomes (Lincoln et al., 2011).

Research that applies the positivistic paradigm tends to predominantly use quantitative approaches for data collection and analysis (Punch, 2005; Weaver & Olson, 2006). Positivistic philosophy is based on a highly structured methodology to enable quantifiable observations and evaluate results using statistical methods. Positivists attempt to identify causes that influence outcomes, going into the world impartially and discovering absolute knowledge about an objective reality (Creswell, 2014). The researcher and the researched are independent entities; the positivist methodology is directed at explaining relationships and testing hypotheses.

3.2.2 Interpretivist

The interpretivist paradigm arose from Edmund Husserl’s philosophy of phenomenology and Wilhelm Dilthey’s study of interpretive understanding, called hermeneutics (Mertens, 2005). The interpretivist paradigm has as its philosophical foundation that there are numerous truths and several realities; it is associated with research approaches that provide an opportunity for the voice of research participants to be heard (Weaver & Olson, 2006).

The basic tenet of this paradigm is that reality is socially constructed. Interpretivists seek to appreciate an individual’s subjective understanding of the world
as it is from the experience of the individual. The interpretivist ontological position is one of relativism—that reality is subjective, with intangible mental constructs that differ from person to person (Lincoln et al., 2011).

The interpretivist epistemology is one of subjectivism based on real-world phenomena and the assumption that knowledge is generated through interaction between the researcher and study participant (Lincoln et al., 2011). Interpretivist research is guided by the researcher’s set of beliefs and feelings about the world and how it should be understood and studied (Denzin & Lincoln, 2005). In the interpretive paradigm, ‘knowledge is relative to particular circumstances—historical, temporal, cultural, subjective—and exists in multiple forms as representations of reality (interpretations by individuals)’ (Levers, 2013, p. 3).

The interpretivist paradigm operates using predominantly qualitative methods (Punch, 2005; Weaver & Olson, 2006). Unlike positivists, interpretivists commonly do not begin with a theory; through the research process, they ‘generate or inductively develop a theory or pattern of meanings’ (Creswell, 2014). Interpretive methodology is directed at understanding a phenomenon from an individual’s perspective, investigating interaction among individuals as well as the historical and cultural contexts that people inhabit (Creswell, 2014). Antwi and Hamza (2015) argue that ‘the premise of interpretive researchers is that access to reality (whether given or socially constructed) is only through social constructions such as language, consciousness and shared meanings’ (p. 218). The interpretivist researcher interacts with the environment and seeks to make sense of it through their interpretation of events and the meaning that they draw from these (Antwi & Hamza, 2015).
3.2.3 Paradigm for this study

The relationship between the philosophical/methodical framework and all aspects of the research process is critical, and the philosophical position taken by the researcher has implications for the way the research questions are formulated, how data are gathered and how those data are analysed (Fleming, Gaidys, & Robb 2003; Koch, 1995; Marshall & Rossman, 1999; Sanders & Munford, 2003). Koch (1995) believes the methodological approach must be congruent with the philosophical basis, and therefore advises at the starting point of an inquiry that the researcher examine the philosophical assumptions underlying a method and determine if those assumptions are consistent with their own view.

Utilising a positivist approach for this study would not allow for the humanist element associated with the experience of the phenomenon to be fully explored; it was deemed unlikely that the information necessary to deeply understand the experience of the phenomenon in question would be obtained. Conversely, an interpretivist approach was seen as most suited to meeting the objectives of this study, because of the researcher’s view that multiple realities exist, that elements of reality can be shared, and that the researcher and the phenomenon are linked through experience.

With an aim to develop understanding rather than test hypotheses, it was determined that this study would be undertaken using a qualitative rather than a quantitative approach. The study is underpinned by an interpretive perspective. The interpretive paradigm is the most suitable in which to locate this study to achieve the objective of this study—to explore, interpret and develop an understanding of SDNs’ lived experience of a SDS model and their transition to the SDN role.
3.3 Research Design

In determining the research approach, the researcher must consider selecting an approach that offers the ‘best fit’ (Maxwell, 2005, p. 17) for the study. According to Morse (1994), research strategies are only tools and it is the researcher’s responsibility: to understand the variety available and the different purposes of each strategy, to appreciate in advance the ramifications of selecting one method over another, and to become astute in the selection of one method over another. (p. 62)

Qualitative and quantitative approaches can be viewed as different ends of a continuum, with a study tending to be more qualitative than quantitative or vice versa (Creswell, 2014). Mixed methods research incorporates elements of both qualitative and quantitative approaches and sits in the middle of the continuum. There are distinct differences between qualitative and quantitative approaches. Creswell (2014) suggests a ‘more complete way to view the gradations of differences between them’ (p. 3) is to view the philosophical assumptions the researcher brings to the study, the research strategy used in the research overall and the methods used to deploy the research strategy. According to Creswell (2014), research design involves the ‘intersection’ of philosophy, strategies of inquiry and specific methods.

A qualitative inquiry is considered a useful approach to explore and understand how people make sense of their lives, experiences and their structures of the world (Creswell, 2013; O’Leary, 2010). Merriam (2009) describes several key characteristics of qualitative research: the purpose of qualitative research is to understand the meaning that people construct in response to a phenomenon, the researcher is the primary instrument for data collection and analysis, qualitative research is an inductive process to build abstractions, concepts, hypotheses or theories (rather than deductively testing
existing theory), and qualitative research provides highly descriptive data in the form of words and pictures to convey what the researcher has learned about a phenomenon.

Janesick (1998) offers a list of strategies for qualitative inquiry, describing 11 characteristics of qualitative research that should be considered in deciding the study design. According to Janesick (1998, p. 42), qualitative design:

- is holistic and looks at the big picture, which starts with a search for understanding the whole
- looks at relationships within a system or culture
- is personal, face to face and immediate
- focuses on understanding a given social setting, not necessarily on making predictions about that setting
- demands that the researcher stay in the setting over time
- demands that time in analysis equals time in the field
- demands that the researcher develop a model of what occurred in the setting
- requires the researcher to become the research instrument and have an ability to observe behaviour
- incorporates informed consent and is responsive to ethical considerations
- incorporates room for description of the researcher’s own role, biases and ideological preferences
- requires ongoing analysis of the data.

Janesick (1998) offers three common rules researchers should consider when conducting qualitative research: 1) look for the meaning and perspectives of the participants in the study, 2) look for relationships regarding the structure, occurrence and distribution of events over time, and 3) recognise ‘points of tension’ or conflict, things that do not fit (p. 43).
I decided it was appropriate to use qualitative methods for this study, as I planned to conduct the study in naturalistic settings and held an interest in uncovering and understanding actual lived experiences of the SDNs and the personally constructed meanings as described by the SDNs about their lived experiences.

The literature related to qualitative, interpretive research methods was reviewed to compare and consider possible approaches to my study, including the use of case study, grounded theory and phenomenology (Creswell, 2013, 2014; Finlay, 2009; O’Leary, 2010; Punch, 2005; Struebert & Carpenter, 2011). Each of these approaches addresses questions of meaning and understanding, and when considered as research methods, differences emerge with respect to how the researcher frames the research question, sample participants and collected data (Starks & Trinidad, 2007).

The case study design is useful for testing whether scientific theories and models actually work in real-world situations and should be considered when the focus of the study is to answer ‘how’ and ‘why’ questions to gain a rich understanding of context and processes (Shuttleworth, 2008; Yin, 2003). Grounded theory studies are generally focused on social processes that deal with an articulated problem. The researcher asks about what happens and how people interact to discover social–psychological processes with a purpose to generate a theory that describes and explains the phenomenon under study (Creswell, 2013; Strauss & Corbin, 1990). Phenomenological studies describe the participants’ lived experience of a concept or phenomenon and the meaning of that experience from their perspective (Creswell, 2013). Within the phenomenological approach, the focus is on describing what all participants have in common as they experience a phenomenon, with the purpose to develop a description that presents the universal essence of the phenomenon for all the individuals (van Manen, 1990).
The objectives of this study did not encompass generating theories or models of the phenomenon being studied; therefore, the use of a case study or grounded theory approach was discounted in favour of employing a phenomenological approach. The phenomenological approach was selected as the most suitable approach for this study, in which it is important to understand the individuals’ experiences of the phenomena explored (Creswell, 2013). To support this study’s objectives, the selection of this approach is further reinforced by Crotty (1996), who describes the aim of phenomenology as to ‘describe the experience as it is lived by the people (p. 5)’, to gain an understanding of experience from an individual’s perspective, point of view or frame of reference, with the task of a phenomenology study being to identify subjective experience, describe it and then to understand it.

### 3.3.1 Phenomenology

Phenomenology is described as both a philosophy and an inquiry method, with the purpose of describing particular phenomena or the appearance of things, as lived experience. Moustakas (1994) describes phenomenology as the foundation of human science and the basis of knowledge. Phenomenology seeks to describe and understand the essence of experiences related to a particular phenomenon, where the experience or phenomenon become the central focus of the study. Van Manen (1990) describes phenomenology as the systematic attempt to uncover and describe the internal meaning of structures of the lived experience.

The underpinnings of phenomenology are complex, and different philosophers have different interpretations of phenomenology as both a philosophy and method of inquiry (Converse, 2012; Earle, 2010; Finlay, 2009; Laverty, 2003). Phenomenology has many different strands, interpretations and followers, and the opposing ideas of how to do phenomenology arise from different philosophical values, theoretical preferences
and methodological procedures (Earle, 2010; Tuohy, Cooney, Dowling, Murphy, & Sixsmith, 2013). Finlay (2009) suggests that phenomenological approaches are dynamic and undergo constant development, as different forms are demanded according to the type of phenomenon under investigation and the kind of knowledge the researcher seeks. Streubert and Carpenter (2011) advise researchers embarking on a phenomenological inquiry to return to the original works of the philosophers to ensure a solid and in-depth understanding of the philosophy behind the method and accept that there is no simplistic step-by-step approach to phenomenological inquiry.

3.3.2 Origins and focus of phenomenological inquiry

Historically, the phenomenological method of philosophical enquiry was developed by Edmund Husserl (1859–1938), modified by Martin Heidegger (1889–1976), and reinterpreted in France by Marcel, Ricœur, Sartre and Merleau-Ponty (Streubert & Carpenter, 2011). Husserl was inspired by the writings of philosophers Kant, Hegel and Brentano to develop the concept of phenomenology as a means of studying human experiences, and is acknowledged as introducing the study of ‘lived experience’ or experiences within the ‘life-world’ (Finlay, 2009; Matua & Van Der Wal, 2015; McConnell-Henry, Chapman, & Francis, 2009). Through the years, there has been a transition of the phenomenological movement led by Heidegger, Gadamer and Ricoeur, which has seen the emphasis shift from only description, as prescribed by Husserl, to focusing on the interpretation of experience (Matua & Van Der Wal, 2015).

Essentially, there are two schools of phenomenology: transcendental phenomenology (known as descriptive phenomenology), based on the original work of Husserl, and hermeneutic phenomenology (known as interpretive phenomenology), espoused by Martin Heidegger, Husserl’s student (McConnell-Henry et al., 2009). Although the descriptive and interpretive approaches share the epistemological
foundation laid by Husserl, there are methodological differences between the approaches (Matua & Van Der Wal, 2015).

Transcendental phenomenology or descriptive phenomenology is focused on the description of the participant’s experiences rather than the interpretation of the researcher (Creswell, 2013). The researcher attempts to uncover what it is like to experience a particular phenomenon, focusing on describing accurately the first-hand experience under investigation, in order that others are able to see and feel it (Matua & Van Der Wal, 2015). According to Wojnar and Swanson (2007), if the true structure of the phenomenon is identified, anyone who has experienced the phenomenon should be able to identify their own experience in the description. Factors such as religious or cultural thoughts and beliefs can influence how phenomena are understood, so to describe the true essence of the ‘lived experience’, it is first necessary for any preconceived ideas to be cast aside (Converse, 2012; McConnell-Henry et al., 2009; Tuohy et al., 2013). Phenomenological epoché, or ‘bracketing’, is a method used by researchers to achieve a state of subjectivity to understand the experience in its purest form (Wertz, 2005; Wojnar & Swanson, 2007). The aim of descriptive phenomenology is to describe a phenomenon’s general characteristics rather than the individual’s experiences, to determine the meaning or essence of the phenomenon (Touhy et al., 2013). Descriptive phenomenology methods attempt to ensure that pre-understandings the researcher may have do not slip into the study’s findings and that the knowledge generated reflects the phenomenon as experienced by participants first-hand (Finlay, 2008; McConnell-Henry et al., 2009).

Hermeneutic phenomenology or interpretive phenomenology is seen as an interpretive process as well as a description where the researcher makes an interpretation, and it is through explanation of the experience that meaning is discovered.
According to Seaton (2005), ‘the purpose of Hermeneutic Phenomenology is to achieve understanding of phenomena through interpretation’ (pp. 204–205) and the ultimate purpose of interpretation is to uncover or reveal meanings that otherwise remain hidden (Seaton, 2005). For understanding the ‘lived experience’ of SDNs’ transition to their role and use of the SDS model, this study was guided by hermeneutic phenomenology, which provided participants the opportunity to describe their perceptions of their own experiences.

### 3.3.3 Hermeneutic phenomenology

Martin Heidegger is considered the founder of interpretive hermeneutic phenomenology, which has a focus on the meaning of ‘being with others’ within the world (Sjostrom & Dahlgren, 2002). Heidegger viewed humans as inseparable from the existing world and considered humans constantly engaged in Dasein or ‘being in the world’, which involves adapting to the environment, resulting in the meaning of one’s experience also changing. Heidegger proposed that humans are always attempting to find meaning in their lived experiences and considered understanding as more important than merely describing experiences (Maggs-Rapport, 2001; Sjostrom & Dahlgren, 2002). Hermeneutic phenomenology examines the life-world or human experience as it is lived. With a focus on revealing details and seemingly inconsequential features within experience that may be taken for granted in our lives, the goal of hermeneutic phenomenology is to create meaning and a sense of understanding (Laverty, 2003).

Van Manen (1990) views hermeneutic phenomenology as research orientated towards lived experience (phenomenology) and interpreting the ‘texts’ of life (hermeneutics). Using a hermeneutic approach, the researcher is required to apply the skill of reading the text of transcripts – spoken accounts of personal experience – and isolating themes which in turn can be viewed as written interpretations of lived
experience (van Manen, 1990). The application of hermeneutic phenomenology is to examine the text and reflect on the content to discover something ‘telling’, something ‘meaningful’, something ‘thematic’ (van Manen, 1990). On identifying the phenomenal themes, the researcher rewrites the theme while interpreting the meaning of the phenomenon or lived experience.

Van Manen (1990) describes phenomenological research as the interplay among six research activities. Researchers first turn to the nature of lived experience, an ‘abiding concern’ (Creswell, 2013), investigating the experience as it is lived, then reflecting on essential themes, describing the phenomenon through writing and rewriting while maintaining a strong and orientated relation to lived experience and balancing the research context by considering parts and the whole (Creswell, 2013, Van Manen, 1990).

With the intent of the researcher to include her own perspective as a hospital nurse educator to glean meaning from the experiences of others, the hermeneutic approach was considered best suited to this study. Laverty (2003) advises that the researcher use a hermeneutic approach to engage in a process of self-reflection to reach quite a different end than that of descriptive phenomenology. In particular, the hermeneutic researcher’s biases and assumptions are not set aside or bracketed but are embedded and considered essential to the interpretive process. Considered an ongoing process, the researcher using a hermeneutic approach should give deep thought to their own experiences and explicitly state their position or how their experience relates to the issues being researched (Laverty, 2003). Keeping a reflective journal can support the researcher in the process of reflection and interpretation (Laverty, 2003).

Heidegger believed the interpretive process is circular, moving back-and-forth between the whole and its parts and between the researcher’s pre-understanding and
what was learned through the investigation (Wojnar & Swanson, 2007). Heidegger referred to this process as ‘the hermeneutic circle of understanding that reveals a blending of meanings as articulated by the researcher and the participants’ (Wojnar & Swanson, 2007, p. 175). In hermeneutic phenomenology, data analysis is achieved by applying the hermeneutic circle, where the process of understanding moves from parts of a whole to a global understanding of the whole and back to individual parts in an iterative manner. The aim of this process is to increase the depth of engagement with and understanding of texts, and to allow for the development of a complex whole of shared meanings between the researcher and the participants (Laverty, 2003). It is seen as a circular process as neither the whole text nor any individual part can be understood without reference to one another. The goal of hermeneutic inquiry is to identify the participant’s meanings from the blend of the researcher’s understanding of the phenomenon, participant-generated data and data obtained from other relevant sources (Wojnar & Swanson, 2007). Hermeneutic phenomenology is suitable for answering ‘what’ and ‘how’ questions, and while it does not assist in prediction, it can develop understanding of the significance of an event or topic to the person or group and provide understanding of issues and concerns and therefore assist in anticipating events in future (Whitehead, 2004).

The phenomenon being investigated in my study was the lived experience of SDNs transitioning from a clinical role to the role of SDN within a SDS (described in Chapter 3) situated in a hospital setting.
3.4 Research Methods

While there is no set method or step-by-step formula to follow for data collection and analysis using a phenomenological approach (Finlay, 2009), the methods used for this study need to be congruent with the philosophical position of hermeneutic phenomenology. For procedures in undertaking a phenomenological inquiry, Creswell (2013) proposed the following process:

- The researcher needs to understand the philosophical perspectives behind the approach (see previous section).
- The investigator writes research questions that explore the meaning of that experience for individuals, and asks individuals to describe their everyday lived experience (see Participant Recruitment).
- The investigator collects data from individuals who have experienced the phenomenon under investigation; typically, this is collected through interviews (see Collecting Data).
- In phenomenological data analysis, statements are transformed into clusters of meaning and tied together to make a general description of the experience that includes a textural description (what is experienced) and a structural description (how it is experienced) (see Data Analysis).

3.4.1 Participant recruitment

For phenomenological studies, to understand the phenomenon more deeply, there must be adequate exposure to those experiencing the phenomenon. In terms of selecting participants, Moustakas (1994) regards it as essential that the research participant has experienced the phenomenon and is willing to participate in the various methods required to gather data.
The aim of the selection strategy for this study was to select participants who had lived experience of transitioning to the SDN role at the hospital, were willing to talk about their experience of the SDS model, and were diverse enough to increase possibilities of rich and unique stories of their experiences (O’Leary, 2010). In this study, the term participant is used to describe a SDN who met the inclusion criteria of the study, including having lived experience of the phenomenon, so they could provide information that would address the research objectives.

Purposive sampling was considered appropriate for this study in line with Streubert and Carpenter (2011), who advise that purposive sampling allows the researcher to select interviewees whose qualities and/or experience permit an understanding of the phenomenon in question. In sampling purposefully for this study, it was important to consider individuals who would provide a number of perspectives, and importantly, an opportunity to learn about the lived experience of the phenomenon by the participant SDN population (Stake, 1994). To this end, the researcher searched for participants who had lived the experience being studied. This sampling method is consistent with the interpretive paradigm research design for this study (Punch, 2005; Streubert & Carpenter, 2011).

3.4.2 Inclusion criteria

The inclusion criteria for this study included being a registered nurse acting or holding a permanent SDN position role during the participant recruitment phase of the study, with a minimum of six months’ experience in the SDN role to ensure an adequate length of time to live and hear of this experience from a variety of perspectives. It was anticipated that participants with six or more months’ experience would have experienced the model and the transition to the role. Nurses who had less than six
months’ SDN experience and nurses who were not employed as an SDN or acting SDN by the hospital at the recruitment phase were excluded from the study.

For qualitative work, the quality of the information gained is of importance; if the participant size is too large, there is a risk that detailed analysis cannot take place (Patton, 2002; Sandelowski, 2011). The number of participants can depend on the shape and form of the data collected (Neuman, 2011); Creswell (2013) advises a participant size range of five–25 as adequate for a phenomenological study. Streubert and Carpenter (2011), however, believe it is ‘impossible’ to predetermine the number of participants required for a given study, and recommend data collection continues ‘until the researcher believes saturation has been achieved and saturation is when no new themes or essences have emerged from the participants and the data are repeating’ (p. 95). O’Leary (2010) writes of saturation as a technique to ensure thoroughness during data collection and a strategy to achieve credibility in qualitative research.

For this study, the number of participants was guided by the principles of saturation. It was projected that 10–12 participants would be adequate to uncover multiple realities and effectively address the research objectives. As the study progressed, the sample size was determined at 10 participants when no new data emerged from the interviews.

An invitation to participate letter (see Appendix 1) was emailed to 34 registered nurses occupying SDN positions, with an Information Sheet (see Appendix 2) included as an attachment. The invitation to participate was issued initially by the researcher via the SDS group email. All nurses occupying SDN positions had a subscription to this service in this hospital. Potential participants who were interested in the study then contacted the researcher by email, who followed up with a phone call to the respondents to discuss the study further. A small number of respondents expressed an interest and
consented to participate in the study. A repeat invitation with the same information was issued, again via the SDS group email, resulting in more respondents consenting to join the study.

3.4.3 Consent

On expressing interest to participate, participants were contacted by the researcher to arrange a meeting time. During this call, the researcher provided information on how confidentiality, anonymity and privacy regarding their identity and input into the data would be maintained. Each participant in this study was made aware, in writing, of the intent of this research. Participation in the study was voluntary and prior to data collection, a plan language statement and consent form (see Appendix 3) were provided to participants to obtain written consent to participate in the study and for interviews to be tape recorded and transcribed. Participants signed their consent at the first interview and were made aware of the option of withdrawing if they wished to discontinue. In promoting and maintaining respect for the participants, I arranged interviews at their convenience for time and meeting place and maintained a respectful attitude during interviews.

3.4.4 Ethical considerations

Prior to beginning the study, it was necessary to obtain approval and permission to conduct this study from separate authorities. The first of these was approval from the University of Notre Dame Australia Human Research Ethics Committee via an Application for Low Risk Review of a Project Involving Humans and the School of Business Research Committee, which needed to be satisfied both with the academic potential of my research proposal and with its ethical acceptability (see Appendix 4). Approval to conduct the study at the hospital was then sought and granted by the Area Health Nursing Research Review Committee (see Appendix 5) as per their approval
With approval granted by the Area Health Nursing Research Review Committee, permission to contact the SDN group and recruit participants to the study was requested from and granted by the Hospital Executive Director of Nursing (see Appendix 6).

### 3.4.5 Data collection

Phenomenological research studies typically consist of data being collected via in-depth interviews and multiple interviews with participants (Creswell, 2013; Merriam, 2009). The interview is a form of discourse between two or more people where the questions and responses are contextually grounded and jointly constructed by those involved in the interview; a qualitative interview can be regarded as a conversation with a purpose, and the goal of phenomenological-based interviewing is for study participants to reconstruct their experience (Creswell, 2013; O’Leary, 2010). Turner (2010) cautions that many researchers view unstructured conversation interviews as unreliable because of the inconsistency in the interview questions, which can make it difficult to code the data. Green and Thorogood (2004) note an interview can be seen as a directed conversation, more or less, towards the researcher’s particular needs for data, with semi-structured interviews sitting in the middle of a spectrum from completely structured to completely unstructured (Newton, 2010).

Data collection and the analysis took place over a period of four years. The data collection for this study consisted of semi-structured, face-to-face interviews and re-interviews of approximately one hour in length. Whiting (2008) advises that interviews should ideally be held in a quiet, private room with participants given the choice of venue. Therefore, with the aim to ensure comfort, the participants were asked to nominate a place for the interview to be conducted and a time convenient to them. All participants chose to be interviewed within the hospital: seven elected to be interviewed
in their own office space and three participants who did not have an office of their own met with me in a private meeting room within the hospital. Prior to commencement of interviews, participants were asked to sign the consent form.

Semi-structured interviews are suitable to explore perceptions and opinions of participants and enable probing and clarification of answers (Barriball & While, 1994). Within the semi-structured interview, participants are encouraged to describe experiences and viewpoints that are meaningful to them from their own perspective (Kvale, 2007). Kvale (2007) describes semi-structured interviews as focused on particular themes, with questions seeking to focus on the topic of research, yet at the same time, providing an openness and allowing for changes in sequence and form of the questions to follow up on the answers and stories provided by the participants.

Semi-structured interviews can provide an opportunity for the use of probes. For example, to assist some SDNs recall their experience transitioning to the role of SDN, I provided probes such as:

Researcher: What were some of the things that made it easy for you? Were there things that happened or strategies that you used to make it easier, or that you used to make that transition?

Researcher: When you first started as the SDN, day one or week one or two weeks into it, what did you find was your experience of that? What was it like for you?

Researcher: When you were talking about when you first started, you said something like ‘scoping it out’. What assisted you to scope out the job, or what needed to be done?

Probes can assist respondents to recall information for questions involving memory, extract valuable and complete information, clarify issues raised by the respondents and provide the opportunity to explore sensitive issues (Barriball & While, 1994). Probing can also maximise the interactive opportunities between the respondent...
and interviewer, assisting in establishing rapport and decreasing the risk of socially desirable answers (Barriball & While, 1994).

During data analysis and the generation of themes, I re-interviewed four participants to check my interpretation of the texts. These interviews ranged from 30 minutes to one hour with a focus on discussing the themes I had identified and clarified information that the participants had provided.

3.4.6 Guided questions

The interview questions provided opportunities for information to emerge and an opportunity for participants to describe their lived experiences (Creswell, 2013). I anticipated utilising the concept of the ‘hermeneutic circle’ to achieve understanding of their lived experience.

An interview guide (see Appendix 7) was designed with key questions, to be used for reference and as prompts, if necessary. An interview guide can provide a set of instructions for the interviewer and a structure for the interview while maintaining a degree of flexibility, and can provide reliable, comparable qualitative data (Cohen & Crabtree, 2006; Turner, 2010). To understand the phenomena surrounding the SDNs, the following guiding questions were developed:

1. What has been your experience making the transition from bedside nurse to the SDN role at the hospital?
2. Can you describe any barriers to the transition to the role?
3. Can you describe any facilitators to the transition to the role?
4. What strategies did you use?
5. What has been your experience of using the SDS model?
6. Can you describe for me a typical day in the life of an SDN?
The interview guide provided conversation-starters that I used in the interview. While the guide did not provide a script for directing the interview, the interview guide supported the strategy of asking follow-up or probing questions based on the participant’s responses to pre-constructed questions:

Researcher: Were there factors that might have been barriers for you when you first started? Things that have made it harder for you to make a transition into that role?

Researcher: So, you just mentioned the structure; when you talk about the hospital structure, what is it you notice about that? What’s your experience of that?

For the face-to-face interviews, I elected not to take notes during the interviews to focus my attention on the participant. With the participants’ consent, the interviews were taped with a digital recorder and began with guiding, open-ended questions. I listened and observed the participants, noted their body language and tone of voice and gave prompts when the flow of conversation slowed or I needed to encourage more detail.

Hermeneutic phenomenology acknowledges the potential effect of the researcher’s personal characteristics on the data collection and analysis; an essential component of hermeneutic phenomenology is the researcher’s ability to be self-aware in describing and interpreting their experience of the research process (Lincoln et al., 2011). During this study, I made use of memos and field notes (see Figure 3.1) to record events and note content and process of interactions during data collection and analysis to promote my self-awareness.
3.4.7 Data analysis

The goal of qualitative phenomenological research is to describe a ‘lived experience’ of a phenomenon. Creswell (2013) states that phenomenological data analysis proceeds through the methodology of reduction, the analysis of specific statements and themes, and a search for all possible meanings.

The phenomenological approach uses the analysis of significant statements, generation of ‘meaning units’ and the development of an ‘essence description’ of the situation/phenomenon being studied (Creswell, 2014, p. 184). Van Manen (1990) wrote that phenomenological research analysis is mainly a writing exercise, and through a process of writing and rewriting, the researcher distils meaning. The researcher uses the writing process to construct a story capturing the important elements of the lived experience and the reader, by the end of that story, should feel that they have vicariously experienced the phenomenon under study and be able to make similar conclusions about what it means (Starks & Trinidad, 2007).
Starks and Trinidad (2007) explain analytic methods for phenomenology by identifying descriptions of the phenomenon through examination of individual experiences, clustering these into discrete categories, which, taken together, describe the ‘essence’ or core commonality and structure of the experience. Researchers using an interpretive orientation treat social action and human activity as text where human action is viewed as ‘a collection of symbols expressing layers of meaning’ (Berg, 2001, p. 239). Through this lens, interviews and observational data can be transcribed into written text for analysis with the interpretation of the text dependent on the theoretical orientation taken by the researcher (Berg, 2001). According to Berg (2001), interviews and field notes are not necessarily ‘amenable for analysis until the information they convey has been condensed and made systematically comparable’ (p. 238); Berg (2011) advises this can be accomplished through a process known as content analysis.

Content analysis uses a coding and categorising approach to explore textual information. The purpose is to construct a model, conceptual system, conceptual map or categories (Elo & Kynga, 2008; Hsieh & Shannon, 2005). Content analysis ‘entails a systematic reading of a body of texts, images, and symbolic matter, not necessary from an author’s or user’s perspective’ (Krippendorff, 1980, p. 10). It is a method used for the subjective interpretation of text data and achieved through the systematic process of coding and identifying themes or patterns (Hsieh & Shannon, 2005). Content analysis requires defining the categories to be applied, outlining the coding process, implementing the coding process and analysing the results of the coding process.

Content analysis may be used in an inductive or deductive way; Elo and Kynga (2008) suggest the inductive approach is appropriate when there is not enough knowledge about the phenomenon or if this knowledge is fragmented. In inductive content analysis, the researcher refrains from using preconceived categories, thus
allowing the categories and names for categories to flow from the data—this is described as inductive category development (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). When formulating categories, the researcher makes the decision, through interpretation, as to which items go into the same category (Elo & Kyngäs, 2008). In the coding process, the researcher creates or develops a coding scheme to guide their decisions in the analysis of content; according to Hsieh and Shannon (2005), the success of a content analysis depends on the coding process. During content analysis, the coding of transcripts is essential to reduce the quantity of data and facilitate a thorough analysis (Brewer, 2003; Dey, 1993). Using the process of coding, the researcher examines and analyses the text language to identify patterns and themes (Elo & Kyngäs, 2008). The themes found in the text or developed through analysis are then categorised, with the purpose of providing the means of describing the phenomenon (see Figure 3.2), and thus increasing understanding and the generation of knowledge (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005).

Figure 3.2. Generating categories.

Miles, Huberman and Saldaña (2014) consider qualitative data analysis as having concurrent activities: data reduction, data display and drawing conclusions.
According to Miles, Huberman and Saldaña (2014), these components are interwoven during the analysis and involve three main operations: coding, memoing and developing propositions.

Creswell (2013) presents a strategy for qualitative data analysis, suggesting steps involving multiple levels of analysis. The levels are emphasised in the steps of organising and preparing the data, reading all data, using a coding process, generating categories or themes for analysis, representing the themes or description in a narrative form and interpreting the data. For this study, I deployed the strategy advocated by Creswell (2013) to organise and analyse the data.

3.4.8 Organising the data

Several writers refer to the practice by researchers of keeping field notes, a research journal or other forms of recording personal observations as research proceeds (Mulhall, 2003; Sanders & Munford, 2003; Streubert & Carpenter, 2011). I organised my field notes by type: transcript file, interview note and research journal. The
transcript file contained the transcripts of interviews in a central column, with coding and themes noted in appropriately wide margins (see Figures 3.3 and Figure 3.4).

![Figure 3.4. Transcript with green pen reflecting the latest codes.](image)

Each transcript was labelled with the code name of the SDN and filed in a binder in chronological order. Interview notes were handwritten on A4 paper, and contained my thoughts and observations immediately after each interview (see Figure 3.5). I used these to capture my thoughts about the circumstances of the data collection, including details of the setting, participants and my impressions, attaching the note to the respective transcript.
My research journal was a series of A4 journals (or A4 pages) I maintained over the course of the study. I utilised the research journal to reflect on my experiences in nursing education and why I had embarked on this study, to explore personal reflections of my experience grappling with understanding the phenomenological approach (see Figure 3.6) and to capture my reflections as I read the transcripts: recording preliminary propositions and ideas, discussing emerging concepts with my supervisor and strategies to proceed with higher levels of analysis. I recorded ideas on links between ideas suggested by my reading of interviews, discussion with my supervisor and at a later stage started to draw diagrams to aid my analysis.
Figure 3.6. Researcher’s study journal.

3.4.9 Coding process and generating categories and themes for analysis

Researchers need an efficient way to sort, store and locate qualitative data. Several authors provide advice on the various techniques to assist researchers to code, organise and sort information (Bouma & Ling, 2004; Creswell, 2014; O’Leary, 2011; Punch, 2005). All interviews were transcribed in their entirety as it was important that all participants voices were heard (Bird, 2005; Morse & Field, 1995). Once an interview was finished, I arranged transcription of the digital recording, transferred the digital recording of the interview to a password-protected computer and reviewed the recording against the transcript to check for accuracy.

Following the transcription check, a transcript was first read fully. At this point, no analysis was attempted, with only initial ideas noted in the margin of the transcript. The transcribed interviews were re-read by the researcher and each transcript was
summarised, including my initial impression and search for preliminary codes, patterns and themes occurring across the participant interview transcripts. These initial impressions were later compared with the in-depth interpretation of the detail within the text, which assisted in the subsequent analysis. As the number of transcripts increased, these summary sheets served a valuable purpose in allowing my thinking to be refreshed without needing to re-read every transcript right through.

According to Ryan and Bernard (2003), themes emerge from data (an inductive approach) and our prior theoretical understanding of whatever phenomenon is being studied (an a priori or deductive approach); the act of discovering themes is what classic content analysts call qualitative analysis. Ryan and Bernard (2003) advise that there are multiple methods for arriving at a preliminary set of themes, pointing out the primary goal is to discover as many themes as possible. They describe eight techniques to assess the texts and four techniques to process the texts. Ryan and Bernard (2003) suggest the cutting-and-sorting method is the most versatile technique for identifying themes; this begins with ‘pawing’ (p. 94) through texts and cutting and sorting expressions into piles of things that go together. These authors advise that this method can lead to identification of major themes and subthemes, and although the analysis of these kind of data is enhanced by computational methods, much of it can be done without using a computer program. I considered use of qualitative computer software program Nvivo (Nvivo 9) to manage the data for my study, however, found the procedure of hand coding to be efficient and manageable compared with learning a new software system within the constraints of the timeframe for this project.

When all interviews were completed, I commenced another round of reading the transcripts. This time, I was seeking to also identify similarities and differences as each interview was re-read in-depth and coded for themes. Subthemes and categories were
identified by attaching codes or multiple codes to segments of text across the entire transcript, with codes (see Figure 3.7) drawn from the participant’s words when possible or synonyms where appropriate (Dey, 1993; Miles, Huberman & Saldaña, 2014; Morse & Field, 1995; Polit & Beck, 2017).

Figure 3.7. Attaching codes to text.

Following coding, I wrote a detailed summary of the interview transcript describing its contents, added my thoughts on the data as a memo and attached the summary sheet to the respective participant transcript file. After each interview had been coded and summarised, previous transcripts were re-read to determine whether new codes were also present within these.
Where needed, codes were subdivided or merged to ensure they remained relevant, inclusive, mutually exclusive and exhaustive regarding the data collected (Dey, 1993). According to Dey (1993), codes that are exclusive relate in some way to an overarching category or underlying concept; consideration of the relationships between these can allow for similar codes to be clustered together, thus creating a smaller number of broader subcategories and categories (Miles, Huberman & Saldaña, 2014; Ritchie & Lewis, 2003) (see Figure 3.8).

Figure 3.8. Generating categories.

Figure 3.9. Researcher’s journal identifying emerging themes.
The subthemes and overall text were re-examined to identify patterns and emerging issues or larger themes (see Figure 3.9). The identification of themes continued until no new themes were found in the interviews; through this process of reading, re-reading and writing, categories were grouped where appropriate, allowing a larger picture of the lived experience of SDNs to gradually emerge from the data. Commonalities were identified across the transcripts and gathered into themes, and text passages with similar themes from different interviews were extracted and compared to identify evidence and quotations to support the major theme (see Figure 3.10). During this process, I would write paragraphs about each category and theme, utilising as far as possible participants’ words and information from my field notes.

Figure 3.10. Researcher’s journal identifying evidence to support themes.

The identification of common themes across the transcripts took considerable time, involving thinking, hand coding, re-reading, and questioning the text and myself about why I chose particular themes. Checking my interpretations of the text was
critical, and these were discussed during second interviews with participants (see Figure 3.11). Second interviews with four participants did not result in any changes, and they confirmed the categories.

Figure 3.11. Researcher’s journal pictorial of SDN lived experience.
As suggested by Silverman (2006) and Dey (1993), an opinion was also sought from my academic supervisor on the codes, categories and themes that emerged (see Figure 3.12). Several transcripts were provided for my supervisor, who validated the initial common themes and overarching theme as they emerged from the interpretive and writing process; this demonstrated consistency between the codes, categories and themes.
The following metaphor resonated with me and clarified my thinking about data analysis as a process:

How do we do jigsaws? There are some pieces of puzzle which are so unique that we can see straight away their place in the picture. These exceptions apart, classification is the key to the process. Before I can fit a piece into the puzzle, I have to assess its characteristics and assign it to some category or another. This bit is a corner, that’s an edge, this blue bit is sky, that brown bit is earth, and so on. The categories we use are organizing tools which allow us to sort out the heap of bits according to relevant characteristics. Gradually, all the blue bits together may make the sky, the brown bits the earth, the green bits a forest, and so on until we have built up a complete picture. The categories through which I initially organize the bits—flat-edged, blue, brown and green—lead on towards a new classification—sky, earth, forest—in terms of which I can finally describe the picture. (Dey, 1993, p. 41)

During the second round of re-reading, the preliminary themes generated in the first stage of analysis were taken back to the original transcripts and further refined. Themes were derived by either identifying a subcategory and using it as a theme under which categories were grouped, or creating a more abstract theme to describe groups of categories, all of which demonstrated particular features of the puzzle.
As with the codes, the subcategories, categories and themes were inclusive, exclusive and exhaustive of the data (Dey, 1993; Silverman, 2006). Consequently, codes became categories and themes as a deeper understanding of the SDN lived experience was developed and themes emerged from the data (see Figure 3.14). The multiple reading of transcripts enabled participants’ experiences to be noticed and a greater understanding to be achieved, which allowed for intuitive connections to be made between the data and its interpretation (Moustakas, 1994; Seidel, 1998). Reading and rewriting activity continued during the analysis, resulting in the final thesis. The categories and themes are further discussed in the presentation of the findings (see Chapter 5).
Figure 3.15. Researcher’s journal weaving the analysis.

The data were summarised by describing emerging themes and links across categories, weaving the resulting analysis together (Polit & Beck, 2017) to present an abstract picture of the lived experience of SDNs (Ritchie & Lewis, 2003) (see Figure 3.15). The themes are graphically represented in Chapter 5. Graphic representation is an especially appropriate method for qualitative analysis (Miles, Huberman & Saldaña, 2014), as it provides an effective way of coping with complex interactions, indicating the key concepts employed and their inter-relation. According to Dey (1993), pictures provide a powerful tool for capturing or conveying meaning. Irrespective of how
researchers present the voices of participants, confidentiality is an important factor: more so for studies that involve a small number of participants who provide identifying personal information and are drawn from a small population (Punch, 1994).

3.5 Confidentiality

Punch (1994) advises that safeguards should protect the privacy and identity of research subjects, and researchers must ensure participants cannot be easily identified by the research findings. Liamputtong and Ezzy (2005) suggest researchers may adopt different ways to protect the true identity of their participants; for example, giving a fictitious name to the research site, and when using participants’ verbatim explanations, using pseudonyms rather than their real names.

Because of the small sample size and the participants of this study being employed at the same hospital, careful measures were taken to maintain privacy and confidentiality. Demographic data collected included length of service, professional qualifications, current designation, appointment status and previous work experience: relevant demographic characteristics are described in Chapter 5. Pseudonyms were used in place of real names and confidentiality was maintained throughout the study by participants making contact directly with me as the researcher through emails, telephone calls and private meetings for interviews. The identity of each participant was recorded on a cross-referenced list with a participant number and pseudonym and stored securely with an electronic password; paper copies were locked in a filing cabinet.

Each interview tape and transcript was marked with this participant number and the date of the interview to preserve anonymity. Data were collected on a password-protected digital recorder and transmitted electronically to a contracted transcriber. The contractor was briefed on the requirement for confidentiality and signed a confidentiality agreement (see Appendix 8) prior to commencing transcription.
Transcripts were subsequently de-identified by the researcher and pseudonyms assigned to the participants were attached to data at the point of storage. Care was taken to minimise breaches of confidentiality. Names of individuals and locations mentioned by participants were anonymised within the thesis, with place names recorded simply as ward or area and third parties referred to by their role. All data were stored securely on a password-protected computer and all hard copy data were stored in a locked cabinet. The audio recordings and hard documentation, including interview transcripts, will be maintained securely for five years, as per the UNDA guideline *Monitoring of research data*.

### 3.6 Conflict of Interest and Risk

Through my substantive position at the hospital as the DSD, a number of the participants were known to me; because of this professional relationship with the SDNs, there could be a perception of coercion to participate. The SDN position was not a direct line report to the director position and our operational paths rarely crossed because on a day-to-day basis SDNs were stationed in various locations across the hospital site. Despite minimal contact with the SDN workforce, care was taken to not use coercion or obligation to solicit participation. As a strategy to diminish any perceived role conflict, an arrangement was made with the hospital Director of Nursing Research to oversee the recruitment of participants: initiating the invitation to participate and providing information on the study to interested respondents prior to contact with the researcher. However, prior to commencing participant recruitment and continuing on through the data collection period, I was seconded to a position at another institution. The recruitment phase was, therefore, conducted without the need of assistance from the Director of Nursing Research.
I considered the potential psychological risk to participants arising from the research activity to be low. Participants were provided information about their local occupational counselling service in the event their participation provoked undesirable feelings about their work.

3.7 Rigour of the Research

Lincoln et al., (2011) advise the trustworthiness of a research study is important to evaluating its worth, and that trustworthiness involves establishing credibility (confidence in the ‘truth’ of the findings), transferability (showing that the findings have applicability in other contexts), dependability (showing that the findings are consistent and could be repeated) and confirmability (a degree of neutrality or the extent to which the findings of a study are shaped by the respondents and not researcher bias, motivation or interest). Within these four aspects, Lincoln et al., (2011) recommend specific methodological strategies be used to attain trustworthiness, such as peer debriefing, prolonged engagement and persistent observation, audit trails and member checks Lincoln et al., (2011). Following Lincoln et al., (2011) advice, I employed the following strategies to promote trustworthiness in my study.

3.7.1 Credibility

A study is credible if the data are believable, the reader has confidence in the truth of the findings and credibility is established by providing authentic descriptions and interpretations of the participants’ experiences (Beck, 2009). I maintained credibility in several ways:

- recruiting nurses who had experience of the staff development model of the hospital and who were employed as SDNs at the hospital
- spending time in the field developing relationships and rapport with participants experiencing the phenomenon
• conducting interviews until saturation confirmed the findings and similarities between participant experiences and enabled a comprehensive description of SDN lived experience
• describing categories and themes using direct quotes
• drawing on my depth of knowledge and experience of staff development in hospital settings gained through 20 years of immersion in the field, and hence bringing extensive practical knowledge and professional craft knowledge
• discussing with my academic supervisor during planning, conducting and analysis stages, and regularly debriefing with my supervisor to uncover biases, perspectives and assumptions
• reviewing data extracts with another researcher experienced in qualitative methods to promote and understand multiple ways of seeing the data
• engaging with the hermeneutic circle of writing, rewriting interpretations, allowing new code words to be identified within previously collected data and enabling redundant codes to be removed, thus allowing emergent categories to be discussed with participants in later interviews
• conducting member checks through repeat interviews, testing analytic categories, interpretations and conclusions with participants, providing the opportunity to assess preliminary results and confirming interpretations of the data and emerging themes.

3.7.2 Dependability

Dependability refers to the stability of data collected over time and differing conditions, and is reliant on credibility (Holloway & Wheeler, 1996; Lincoln et al., 2011). Lincoln et al., (2011) suggest an audit trail as a method for showing dependability, which involves maintaining adequate records such that another
researcher might arrive at the same or similar conclusions. In promoting dependability, I maintained an audit trail throughout this study, including:

- my field notes (transcript file, interview notes and research journal) and notes from debriefing sessions with my research supervisor
- consent forms, information letter to participants and interview guide, to contribute to making explicit the information provided to participants
- audiotapes of the interviews, as the verbatim transcripts were analysed in light of new information; this approach ensured findings were representative of SDNs lived experience of the staff development model.

3.7.3 Transferability

Transferability in qualitative research refers to the extent to which findings might be relevant to other situations; it occurs when the original context has been ‘described adequately so that a judgement of transferability can be made by readers’ (Koch, 2006, p. 92). Lincoln et al., (2011) describe using thick description as a way of achieving a type of external validity; by describing a phenomenon in sufficient detail, one can begin to evaluate the extent to which the conclusions drawn are transferable to other times, settings, situations and people. A thick description provides the specific information a reader needs to know to understand the findings (Lincoln et al., 2011). The concepts that evolved from this study may be applicable in other contexts; I promoted transferability by providing a thick description of the context (see Chapter 4) and environment of the participants while maintaining the confidentiality.

3.7.4 Confirmability

Confirmability relates to the degree to which the research findings can be confirmed or validated by others. Thus, confirmability involves ensuring data can be traced to its originator and that its interpretation and conclusions are logical, with the
findings a result of the research rather than the researcher’s prior assumptions
(Holloway & Wheeler, 1996). To promote confirmability, I:

- made use of field notes to monitor and question my observations and actions at each stage of the research process
- made comparisons of my analysis of the transcripts with that of my research supervisor
- conducted member checking with second interviews
- archived all collected data in a well-organised, retrievable form so they can be made available if the findings are challenged.

3.8 Limitations

The following limitations are noted as inherent in the research design:

- The main data collection technique is interview, which may lead to misinterpretation of data by the researcher.
- The study was conducted in only one hospital
- The small convenience sample of nurse educators does not allow findings to be transferred to the larger population of nurse educators, as only one model was tested.

3.9 Chapter Summary

The purpose of this study was to understand the phenomenon of the SDN lived experience of transition to the SDN role in a teaching hospital in Perth, WA, through their individual experiences and reflections.

This chapter has examined the methodological basis of the research and the rationale for a phenomenological approach. The research method has been considered and ethical considerations addressed. The research design has been described and justified with reference to theoretical perspectives, and this has provided a basis for the
research procedures adopted and the data analysis process. The trustworthiness of the research has been considered with references to the procedures followed.

The following chapter presents the context and settings for this study.
Chapter 4: Context

4.1 Introduction

The previous chapters provided a background to this study, an overview of continuing education and SDS models and a description of the role of nurse educators in hospitals. Chapter 3 outlined the study methodology and the rationale for a phenomenological approach.

The purpose of this chapter is to provide the context and setting in which the study was conducted. In phenomenological studies, the context is very important as the lived experience is context specific.

4.2 Setting for this Study

As hospitals expanded into multifaceted health care organisations, the focus of staff development departments changed to become a corporate department serving all clinical health care personnel, though nursing personnel remained the largest supported group (Blocker, 1992). This was also the experience at the hospital that is subject of this study. The School of Nursing within this hospital reconfigured in the 1990s to become the SDS. It continued to be organisationally positioned within the nursing structure, and predominantly, its function was nursing education as well as providing some elements of corporate education, for example, hospital induction, to all staff.

This hospital was established in the 1800s (see Figure 4.1). The original hospital was built by convict labour in 1856 and was housed in a two-story residence. It became a public hospital in January 1897, when it opened with 52 beds.
In the years that followed, further additions were built, with a multistory ward wing opening in 1976. By 2009, the hospital had evolved to become a 450-bed metropolitan public teaching health service providing tertiary clinical services, including obstetrics and mental health, with approximately 3,000 staff inclusive of a full-time equivalent (FTE) 1,500 nursing workforce (see Figure 4.2).

The hospital’s SDS organisational model transitioned over the years from its origins based in the School of Nursing. Historically, the School of Nursing provided professional development to qualified nurses and the training of registered nurses via the hospital-based Diploma of Nursing into the 1970s and 1980s. Following cessation of
hospital-based training of registered nurses in the mid-1980s, the hospital School of Nursing reconfigured into a staff development unit charged with providing staff development to the hospital’s qualified nursing staff, with a component for corporate education available for all staff. Providing staff development support involved identifying and responding to continuing training and development needs and providing a variety of education programs that responded to the changing health care system and accounted for the professional needs of staff. These programs included orientation, mandatory training, continuing education programs, formal and informal in-services, coaching and consulting. The SDS had the following assigned positions within the service:

- DSD, the strategic leader to provide leadership and direction for the operation of the SDS, with eligibility for nurse registration as a requirement for the position
- Corporate Trainer (CT), providing nonclinical training and education consultancy tailored to organisational needs
- SDE, a registered nurse responsible for staff development and education programs at the organisational level
- SDN, responsible for staff development and clinical education at the ward/unit level.

In this structure, the SDEs and CT were aligned with clusters of programs across the service and reported to the DSD. SDNs were assigned to and situated in specific clinical areas and reported centrally to the DSD (see Figure 4.3).
Figure 4.3. Organisational chart reflecting SDN reporting to DSD.

The SDS structure is a model of centralisation and with a dual-track structure. Gundluch (1994) describes ‘dual-track structuring’, in which Track One refers to education interventions that are routine where there are activities that meet learning needs on a continuous basis, maintain functional competency and schedule in-service, and Track Two refers to non-routine interventions that address intermittent learning needs, support learning needs associated with organisational change and short-term event scheduling.

4.3 Researcher Profile

My interest in this research began with my own experience and journey from being a novice SDN, and increased through subsequent positions in hospital-based nursing education. In this section of the thesis, I describe my story, as this has influenced my views about beginning SDNs.

As a registered nurse, I had experience working in intensive care units (ICU) within tertiary hospitals. After working in this field for several years, I completed a postgraduate qualification in critical care. With my new-found knowledge, I became an enthusiastic mentor and preceptor for novice intensive care nurses. Clinical teaching was an enjoyable challenge for me. I was comfortable sharing my knowledge, and with
other senior clinical nurses, organised regular in-services for ICU staff. Eventually, a colleague suggested that I should think about applying for an acting SDN role in the adjacent coronary care unit and acute medical unit, and I thought ‘Why not?’ Much to my surprise, I found I had no idea what the job entailed or what was expected of me; quite the opposite of my experience as clinical nurse in the ICU. The transition to ward-based SDN was disconcerting and I was totally unprepared for the role, which resulted in a sense of isolation. I recall feeling bemusement that I was in a state of not being sure what to do next, and that somehow, I should know what to do as an SDN. It was with some irony that I observed that the SDN was responsible for the orientation of new clinical staff, yet I did not receive an orientation or instruction to the SDN role or coaching from the staff development department. Consequently, I muddled my way through the secondment period and returned to the ICU.

A couple of years later, my continuing interest in staff development led me to be appointed as a SDN at another hospital for their hospital-based postgraduate program. My experience of the transition to this SDN role was in stark contrast to my previous venture. In the postgraduate nursing education unit, I received orientation, instruction and mentoring from an experienced and skilful educator and was immediately introduced to and integrated into a group of supportive colleagues who were generous with sharing tips, materials and answers to questions. I was responsible for clinical teaching by the bedside as well as delivering lectures to postgraduate students. I really enjoyed this role and derived much satisfaction from interactions with learners and learning from my education colleagues. I had an interested and engaged nurse educator mentor who assisted me to develop my skills in nurse education and curriculum development. This position seemed to have more structure to the role than my experience as the SDN in the coronary care unit. I was able to quickly establish a work
routine in line with the responsibilities of following up with students and delivering lectures on a program with a curriculum over 12 months. My mentor actively supported my career trajectory by encouraging me to pursue secondments to senior education roles. This led to a promotional appointment to a SDE position in the hospital-wide education service (external to the postgraduate nursing education unit), where I was responsible for provision of professional development opportunities for hospital-based nurses. The work involved developing and delivering education sessions focused on clinical and professional content in a decentralised education service. As a new SDE, I experienced a lack of orientation and role support, and it took personal resilience and my own ‘can do’ attitude to find my feet. I held this position for several years and while I experienced satisfactory outcomes in projects, programs and working relationships, I experienced the following:

- It took time and energy to influence everybody for anything.
- The hospital SDNs were a disparate group, separated by operational services that did not always encourage working across organisational boundaries and held tightly the ‘ownership’ of the SDN role.
- Role support for new and substantive SDNs and nurse educators was ad hoc and dependent on being driven by interested individuals who in turn needed to do so from a position of influence rather than line management.
- There was a lack of cohesion across the organisation in planning and sometimes a resistance to working together to manage differing ideas, resulting in duplication of effort with people working in silos.
- There was no organisational-wide agreed governance or processes to manage training and development, so recordkeeping and use of resources was not well organised or cohesive.
My observations and experience prompted a long-term interest in staff development and how people learn and stimulated my ambition to achieve a nurse education leadership role. To turn those thoughts into reality, I pursued higher education degrees in training and development, leadership and management and non-tertiary studies in transactional analysis and neurolinguistic programming. During this period, I completed a Master of Nursing, with a research project *Exploring the structural and social environment of the nursing preceptor in an acute care hospital environment.* Without a doubt, these studies influenced my thinking on education in the workplace.

Eventually, I was offered an opportunity as acting Nurse Director Staff Development at yet another hospital. This was my first role as the senior lead in nurse education, sitting at the nursing executive table. At this hospital, the education service was a decentralised model, and I felt that I was still operating within my comfort zone: continuing to function in an influential rather than a directive way to deploy education initiatives and programs. I had similar observations from my previous experience regarding the SDNs; however, I was on a fixed term secondment and an inexperienced Nurse Director, so it wasn’t the time to challenge the status quo!

Some months later, I was appointed to the position of DSD at a large tertiary hospital with a centralised SDS. I had responsibility for strategic and operational matters relevant to the functioning and provision of nursing and midwifery education for nurses and midwives within my organisation. At first, it was quite daunting—all eyes looked to me for leadership and direction of the education service. My days of getting things done by influence alone were in the past and I had to step up quickly. What struck me was the lack of role orientation and education mentors at that level. However, I was fortunate to have a supportive Director of Nursing, who as a knowledgeable other, provided guidance, developed my business skills and was someone I could discuss ideas and
confide in when I lacked self-confidence. At this point, I was truly appreciative of my years of postgraduate study and began to draw on my body of knowledge to develop the SDS and people in it. My experience as a nurse educator helped to shape this study. For example, because I had received encouragement and guidance from peers and mentors, as I interviewed the study participants, I listened for examples of support they might have received and the types of relationships that they had established. My own experience in nursing education, preceptor research and similar experiences I had heard from other nurse educators prompted me to ask the study participants about their transitions from clinical nurse to the role of SDN. Thus, in reference to the literature review, my personal perspective and beliefs comprise the frames of interpretation that I brought to the study.

The literature review highlighted for me that although there is a considerable volume of research on transition experience of nurses to higher education in general, there is a distinct lack of research on the experiences of nurses making the transition to a HBNE role. Therefore, I perceived a gap in the body of nursing research about novice HBNEs and determined that a study such as this would allow a better understanding of their experiences. This information will be of value to those concerned with hiring and supporting HBNEs.

4.4 Review of the Staff Development Service

As the newly appointed DSD in the hospital, I set out to gain a better understanding of the organisation and the issues and concerns the SDS employees had. I undertook a review of the service, inviting feedback from staff and stakeholders. The purpose of the review was threefold: a means to gain insight into the business processes and issues for the service, to provide a forum for staff ideas and feedback, and to gather information for the development of a departmental strategic plan. The methodology
used during the review involved appraisal of education programs, stakeholders and customer forums and meetings, and focus groups with the SDS staff for their input concerning the service. The focus groups involved groupings of staff (SDNs, SDEs and CTs); each group was invited to a workshop to respond to questions. The collection of answers and ideas was achieved through a combination of group brainstorming and using a modified nominal group technique for collecting individual contributions. From analysis of the information gathered, the following observations were made.

Staff reflected that they considered that there was a positive benefit of having a central leader with educational expertise; support from the central bureau assisted in the reduction of the silo effect and they could share resources – people, equipment and ideas. All groups described the culture of the service as ‘friendly’, ‘good relationships’, and a ‘positive atmosphere’. Staff identified specialist knowledge as present within the service and perceived that the service was effective in event management, delivering education programs, determining learning needs and maintaining the hospital-wide mandatory education and assessment program. Generally, stakeholders, internal customers and staff development employees conveyed that they were satisfied with service delivery and the centralised SDS structure.

During the focus groups, staff development employees were asked to consider what concerned them as an issue or needed improvement. The SDNs expressed that they experienced a lack of understanding of role expectations, did not feel prepared for the role and felt that Clinical Managers also did not understand the SDN role. It was apparent from the SDN feedback that they had little idea what was expected of them in their role, reporting that they had taken the role based on experience, professional qualifications and a desire to be committed to such an important task. Overall, it appeared that most SDNs experienced a haphazard introduction to the role.
The SDEs also identified that there was lack of preparation and training of the SDNs for the role and expressed a desire to line manage SDNs to improve support for them. There were recruitment and retention issues around the SDN position – 40% of the 35 FTE staff were either providing relief cover or were newly employed in the role. The SDE group raised the supervision required for inexperienced SDNs as a workload issue. The SDE group recommended professional development for the SDNs, as in previous years the SDS had provided a Certificate IV in Training and Assessment to SDNs. However, with staff turnover, there was not a critical mass of SDNs with staff development knowledge and expertise.

From this review as the DSD, I concluded there were three main themes that needed attention: SDN role understanding and role support, training and development needs of the SDS employees and workload issues. In the first instance, the SDNs’ lack of understanding of and preparation for their role, coupled with their perception that Clinical Managers did not understand the SDN role, was an issue I considered critical in determining the way forward for the service. Underpinning this was my belief that people felt challenged in fulfilling job requirements if they did not understand the expectations of their job role.

4.5 Responding to the Review

As a new DSD, I looked to texts on nursing staff development to assist me in responding to the review. I thought that Bille’s (1982) systems approach to nursing staff development could offer a practical blueprint for redefining the hospital’s SDS structure and function. Bille (1982) describes the systems approach as a means of looking at all parts and structures in an organisation and the way they relate to organisational outcomes or goals. Bille (1982) advised that staff development provides professional development opportunities via:
• induction education
• remedial education to fill gaps left by the nursing education program and to allow re-entry to practice
• in-service education to increase competence in specific areas of practice
• continuing education to enhance the professional knowledge base.

I perceived that this approach would provide the means to articulate a model of staff development with the capability to outline SDE and SDN job roles, expectations and key performance indicators. Deciding to explore the model further with the senior education team, the SDEs, the objective was set to re-engineer work design and develop an organisational model to depict the SDS structure and role functions. The purpose of a model was to provide a staff development framework to develop and articulate operational plans, arrange resources and provide a guide for SDS staff in work planning and outcome measurements.

4.6 Developing the Staff Development Service Model

Bille’s (1982) concept of a staff development approach that provided learning opportunities through induction, remedial education, in-service and continuing education was readily adopted by the SDEs. In considering Bille’s concept, the SDEs decided to reframe and rename one of the parts—remedial education—to ‘Competency Management’. From that point, Bille’s framework with the adapted terminology and associated acronym (ICIC) was adopted by the SDS to articulate a staff development framework for staff development:

• I – induction and orientation
• C – competency management
• I – in-service education
• C – continuing education.
It was determined that the new ICIC Staff Development Framework for the SDS needed to be supported by defined structural and operational arrangements, staff were to be provided training and support from their line managers, and that the training would include the ICIC Staff Development Framework that depicted the function of the SDS. Once a blueprint was crafted for the new SDS model (see Figure 4.4), the model was presented to the Nursing Executive Council for endorsement and authorisation to implement in the hospital. The proposal presented to the Nursing Executive Council described the findings of the review, outlined revised structures and presented the revised SDS model incorporating the new ICIC Staff Development Framework.

Figure 4.4. Graphic depicting the revised SDS model.

4.6.1 Service model implementation

The setting and structure of an organisation are important elements in a systems approach to operationalising an effective staff development program; as Bille (1982) proposes, ‘The administrative setting and climate within an organisation will determine not only whether staff development exists at all, but also how effectively staff development can carry out its given responsibilities’ (p. 23). Staff development departments can be organised in different ways; models used to illustrate or
communicate staff development structures have been described as centralised and
decentralised or a combination of both (Bille, 1982, Horner, 1995; Kelly-Thomas,
1998). Considering culture, organisational characteristics, staff qualifications,
organisational shortcomings and cost effectiveness, it was determined the SDs would
continue with a centralised structure. The operational arrangements for the SDS, such as
staff recruitment and retention, role and responsibilities, line management arrangements,
department policies and standard operating procedures, underpinned the SDS capability
to deliver a staff development program. Departmental policies and procedures were in
place and made available to SDS staff in a shared drive on the organisation’s computer
network.

4.6.2 ICIC Staff Development Framework

The hospital’s staff development program was based on a systems approach to
staff development with a conceptual framework that utilised the components of
Induction, Competency management, In-service education and Continuing education to
identify needs, plan, organise and direct education and training resources. The ICIC
Staff Development Framework had four main elements, described below.

4.6.2.1 Induction and orientation

Induction was a centralised program designed to introduce new staff members to
the hospital culture and organisation. Orientation was decentralised to hospital units,
where the SDN was responsible for assisting new employees to assimilate to a new
environment, duties and responsibilities.

4.6.2.2 Competency maintenance and skill development

Coordinated and facilitated opportunities were provided to enable staff to
achieve and maintain competency in clinical performance, area-specific competencies
and hospital mandatory competencies.
4.6.2.3 *In-service that is coordinated and synchronised*

Instruction or training provided in the work setting was designed to increase competence in specific areas of practice; for example, this training related to such things as specific deficiencies, new products and change in practice.

4.6.2.4 *Continuing education for ongoing professional development*

Continuing education programs were designed to promote the development of knowledge, skills and attitudes for the enhancement of practice.

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**ICIC Staff Development Framework**

- **Induction**: Assimilation to the environment, duties & responsibilities.
- **Competency**: Coordinated, facilitated opportunity to achieve/maintain area specific/organisation competencies.
- **In-service**: Just in time instruction/training in work setting to increase competence in specific areas of practice.
- **Cont. edu**: Programs designed to promote development of knowledge, skills & attitudes for enhancement of practice.

*Figure 4.5. ICIC Staff Development Framework.*

The SDS staff used the ICIC Staff Development Framework (see Figure 4.5) to distinguish training needs, prioritise use of resources, monitor program performance indicators, organise work activities and identify role expectations. Designed for people whose training is in technical fields but are called on to take up a staff development role, the aim of the ICIC Staff Development Framework is to provide managers, workplace trainers and new SDNs with a conceptual model for providing a SDS to a workplace. The ICIC Staff Development Framework articulated what SDS employees at the hospital functionally did to deliver a staff development program: it was utilised as a
guide to identify activities and resources required to operationalise the staff
development program (see Figure 4.6) in alignment with the hospital’s organisational
goals.

![Staff Development Program Goals]

**Induction**
1. Introduce *Critical Aspects Unit Orientation Checklist* for nursing staff
2. Publish induction program on intranet with ability to complete sections online
3. Publish induction handbook for orientees
4. Publish performance appraisal and development tool for managers
5. Develop Orientation checklist for manager use
6. Attendance at Hospital Induction

**Competency Management**
1. Increase availability of mandatory training online
2. Publish *Managers Guide to Mandatory Competency*
3. Introduce *Safety Skills Day for Nsg* to meet demand and specific training required
4. Manual Handling Program tools and guidelines to be published
5. MOAT Program to adopt best practice model and prioritisation of training to risk
6. Continue MET training with ACE, ISBAR, A-E Assessment system incorporated
7. Mandatory training requirements reviewed to meet changing needs
8. Percentage of staff completed mandatory training/competency assessment in manual handling, infection control, MOA, life support, emergency procedures relevant to practice

**In-Service Education**
1. In-service coordinated & synchronised
2. Monthly In-service Calendar of Events publish interprofessional in-service and widen scope of advertisement
3. Introduction of *Clinical Classics* monthly forums for clinicians
4. Introduction of *Classics For All* monthly forums for all staff
5. Continue Manager Moments in-service for managers
6. Number of in-services conducted annually
7. Number of cancelled in-services

**Continuing Education**
1. Course Booklet to be provided in 2 editions Jan-June and July to Dec versions
2. E learning priority determined with subsequent resources developed and made available
3. Staff Development Service Intranet page to be restructured for easier navigation and more resources available
4. Introduction of a professional development framework and roll out of professional development programs for all staff: Endeavour, Explorer, Discovery and Voyager
5. Staff attendance numbers at staff development programs
6. Number of staff granted study leave to attend programs and attending in own time
7. Number of initiatives/programs delivered
8. Staff satisfaction through participant evaluation
9. Number of Graduates
10. Number of Undergraduates
11. Number of staff completing Professional Development Programs

*Figure 4.6. Example of ICIC Staff Development Framework to plan organisational goals.*
4.6.2.5 Role support for Staff Development Nurses

The review demonstrated that while a centralised staff development structure was in place at the hospital, it did not necessarily support SDNs themselves or the learning needs of novice SDNs when they first entered the realm of staff development. Nurses in clinical teaching roles require role support and development of their teaching skills; support needs to come from managers and educators in terms of recognition for their work, along with feedback and communication with senior educators (Speers, Strzyzewski, & Ziolkowski, 2004). Provision of leadership and line management to SDNs and SDEs so they felt encouraged and knew what was expected of them was essential. Ideally, the line manager has education expertise and, if not, looks for a mentor who does have this expertise. Defining the role, articulating expectations of staff and determining performance indicators (e.g., 80% staff compliant with mandatory training, orientation program in place) are essential components for SDS staff to factor when providing role support. SDNs worked on the ward with clinical staff as a supernumerary educational resource and in the office worked to maintain training records and prepared orientation and education material. The ratio of 70% clinical work to 30% office work was identified as a guiding principle for SDEs and SDNs to determine where SDN workload energy should be directed.

Team structure and function were considered regarding line management, and while the DSD maintained overall accountability for the department operations, SDEs were made responsible for direct line management of their SDN team (see Figure 4.7). Responsibilities for team meetings and staff management were determined to ensure staff had opportunity up and down the line to receive directions, organisational information and feedback and flag concerns or issues.
4.6.2.6 Training support for Staff Development Nurses

The impact of the shortage of experienced nurses in the workforce was presenting a challenge for the recruitment and retention of experienced staff to SDN roles. It is imperative to adequately prepare nurse educators with a well-grounded, user-friendly and sound orientation program and the means to clearly articulate the responsibilities and duties of the job. An induction list with essential learning for new/inexperienced SDNs was designed and implemented as a checklist for SDEs to identify new SDNs’ learning needs and schedule these into training; for example, content included presentation skills, computer training, train the trainer for life support drills and skills, manual handling and performance management.

A two-day event titled Staff Development Matters was provided by the DSD on an annual basis. Designed to assist new SDNs, the content was specific to the SDN role and included practical tips, concepts of staff development, a systems approach to staff development, clinical teaching methods, providing performance feedback and theory.
and application of learning strategies. During the Staff Development Matters program, the Bille (1982) systems approach to staff development was presented and the ICIC Staff Development Framework was explained, with examples of how to apply the framework to everyday work in the life of an SDN. All staff development employees had an opportunity to attend this event. The ‘DSD In-service’ was another ongoing event offered, with the DSD conducting monthly 45-minute in-service sessions on staff development subjects for all SDNs. Topics centred on the themes of leadership, education and interpersonal skills and complemented material in the Staff Development Matters program. A Staff Development Matters Handbook was made available to all staff, and included the elements of the study day plus templates and articles relevant to staff development.

4.7 Post Implementation

A 12-month review of the implementation of the revised service model indicated positive responses to the strategies put in place. Encouraging anecdotal feedback was received from hospital nursing directors, managers and staff. The SDE group reported back to the DSD the effect of the changes during the year through group and individual meetings and the SDN group provided their feedback in a focus group conducted by the DSD.

The introduction of the ICIC Framework was considered successful in practical terms. The acronym ICIC became common terminology, and with its associated elements, was used to orientate new staff development employees to the service. The ICIC Staff Development Framework was understood by Nursing Directors and Clinical Nurse Managers when the DSD and SDEs articulated the work of the SDS. SDEs reported using it to negotiate the priority of service requests with clinical areas in times of SDN unavailability to determine what service could be delivered or the service that
needed to go on hold or be decreased until the SDN FTE was achieved. The Nursing Executive Council included the ICIC Staff Development Framework in its strategic plan for nursing to communicate its expectations for staff development activities.

All SDS employees were engaged in professional development. The Staff Development Matters study day was presented again, with five other metropolitan hospitals enrolling their SDN workforce to also attend. The SDEs requested Staff Development Matters be provided on an annual basis and reported evidence of the material being actively applied in the practice of the SDNs. The ‘DSD In-service’ proved to be popular, with 40–50 attendees at each session. SDEs commented that the human resource management processes for SDN team management had become more streamlined and efficient. The greatest amount of positive affirmation came from the SDE group regarding the delegated authority to holistically manage their teams. The SDEs reported that they experienced an increase in autonomy and a high satisfaction level with the degree of flexibility they now had to manage their team and themselves to meet service outcomes.

The DSD held a forum with the SDN group, for which the majority of attendees had participated in the focus group 12 months earlier during the service review. The group appeared to have a positive morale and appreciated the professional development made available. Overall, the results were interpreted as a positive affirmation, with the ICIC Staff Development Framework perceived by the staff as useful. However, most of the feedback information gathered was anecdotal in nature or elicited by informal means, and I identified that a gap remained in understanding the factors that facilitated or impeded transition for those nurses transitioning to the SDN role.
4.8 Chapter Summary

The intention of this chapter was to explain the context and experience of a SDS implementing a SDS model to address issues it had identified that needed attention, such as SDN role understanding and role support, training and development needs of the SDS employees and their workload issues.

In adapting Bille’s (1982) schema to develop a model for SDS, anecdotally it appeared there was a positive outcome. However, I was left questioning how, or even did, the adoption of the ICIC Staff Development Framework actually make a difference to SDNs and that this needed further exploration using a more scientific approach. I was curious to find out if there were facilitators or barriers for an SDN to transition to the role and what role support would be of assistance. Identifying these factors could make an impact organisationally as well as for the individual embarking on this work-role transition. With this in mind, I determined one way to assess this would be to explore the SDN lived experience of the SDS and ICIC Staff Development Framework, and thus, chose to embark on this phenomenological study, with the assistance and supervision of an experienced scholar.
Chapter 5: Findings

5.1 Introduction

Chapter 1 provided the background to and purpose of the study and introduced the research questions. Chapter 3 described the research paradigm and methodology deployed to undertake a phenomenological study. The context of the study was described in Chapter 4.

This chapter reports the findings of the study to explore SDNs’ lived experiences of an SDS model in a hospital setting. The purpose of the study was to explore and describe the participants’ lived experiences of the factors that facilitated or impeded transition to the SDN role, role orientation and role support for SDNs within the context of the staff development model. Understanding was sought in the participants’ stories to identify themes and dimensions that transcended this lived experience of transitioning to the role of SDN.

Data collection and the analysis took place over a period of four years. As described previously (see Chapter 3), data analysis began during the initial interview and continued until all participants had been interviewed or were re-interviewed. Following the interviews, a protracted period of analysis of transcripts, memos and journal notes was undertaken. The findings reported in this chapter began to take shape after that initial interview, evolving into categories and themes as data collection and analysis continued, until a clear picture of the SDN lived experience of transitioning to the role of SDN in the SDS model emerged.

This chapter provides background information on the participants, presents emerging themes and provides a descriptive interpretation of the phenomenon and a summary of the overarching theme.
5.2 Participant Characteristics

The experiences of individuals can only be understood if the context in which participants find themselves is understood (Dey, 1993; Holloway & Wheeler, 1996); therefore, it is critical to describe participants’ demographic details as these may affect interpretations derived from data analysis (Fine, Weis, Weseen, & Wong, 2003).

Participants for the study were drawn from the SDN population at a public teaching tertiary hospital with participants having a mixture of work experience and length of SDN experience, which was characteristic of the total population of SDNs at the hospital during the period of recruitment.

Ten SDNs participated in this study. Their nursing backgrounds varied, as did their years of experience in the profession and experience as an SDN. All the participants were female (no male SDNs responded to the invitation to participate), and all were employed full time in the role of SDN. Eight SDNs were employed in the role post implementation of the ICIC Staff Development Framework, one in the year of implementation (2011) and one sometime before implementation. Participants have been given pseudonyms for the purposes of this study. The following paragraphs provide a description and background of the individual participants.

Linda (28 years old) had seven years’ experience as a registered nurse. Her experience since graduation had been in the one teaching hospital in Perth. Linda has a postgraduate certificate in a nursing specialty. Linda had been acting SDN for 18 months at the time of the first interview.

Nancy (44 years old) had six years’ experience as a registered nurse, and her experience since graduation had been in the one teaching hospital in Perth. Previously, Nancy had been employed in non-health-related jobs. Nancy had no postgraduate qualifications. Nancy had been an SDN for two years at the time of the first interview.
Beth (28 years old) had seven years’ experience as a registered nurse, and her experience since graduation had been in the one teaching hospital in Perth. Beth has a postgraduate certificate in a nursing specialty. Beth had been an SDN for 12 months at the time of the first interview.

Shannon (45 years old) had nine years’ experience as a registered nurse. Before this, Shannon had been an Enrolled Nurse for 17 years. Shannon had a wide range of experience, including working in rural settings and as a clinical tutor for a university. Shannon has a Masters in Nursing. Shannon had been an SDN for two years at the time of the first interview.

Simone (38 years old) had 12 years’ experience as a registered nurse in different specialties across two hospitals, and previous experience as an SDN at another hospital. Simone had no postgraduate qualifications and had been an SDN for three years at the time of the first interview.

Ronda (35 years old) had 15 years’ experience in nursing and midwifery practice, mostly part time and casual. Ronda’s experience was varied across medical, surgical and midwifery settings, in both metropolitan and rural contexts. Ronda has a postgraduate certificate in a nursing specialty. Ronda had been SDN for 18 months at the time of the first interview.

Sonya (43 years old) had 21 years’ experience as a registered nurse working internationally and with experience in different specialties. Sonya had no postgraduate qualifications. Sonya had been an SDN for two and a half years at the time of the first interview.

Jessie (33 years old) had 12 years experience as a registered nurse in different specialties across hospitals, including interstate. Jessie had experience as an SDN at
another hospital interstate and a postgraduate certificate in a nursing specialty. Jessie had been an SDN for 18 months at the time of the first interview.

Tara (32 years old) had 10 years’ experience as a registered nurse working in different specialties, including internationally. Tara has a postgraduate diploma in a nursing specialty and had been an SDN for 17 months at the time of interview.

Jenna (52 years old) had over 20 years’ experience as a registered nurse working in a variety of different specialties, including internationally. Jenna has a postgraduate certificate in a nursing specialty. Jenna had been an SDN for 12 years at the time of interview and had commenced the role prior to implementation of the ICIC Staff Development Framework.

Table 1

<table>
<thead>
<tr>
<th>Name</th>
<th>Age</th>
<th>Years nursing practice</th>
<th>In role pre or post ICIC implementation</th>
<th>SDN experience</th>
</tr>
</thead>
<tbody>
<tr>
<td>Linda</td>
<td>28</td>
<td>7</td>
<td>Post</td>
<td>18 months</td>
</tr>
<tr>
<td>Nancy</td>
<td>44</td>
<td>6</td>
<td>Post</td>
<td>2 years</td>
</tr>
<tr>
<td>Beth</td>
<td>28</td>
<td>7</td>
<td>Post</td>
<td>12 months</td>
</tr>
<tr>
<td>Shannon</td>
<td>45</td>
<td>9</td>
<td>Post</td>
<td>2 years</td>
</tr>
<tr>
<td>Simone</td>
<td>38</td>
<td>12</td>
<td>Post</td>
<td>3 years</td>
</tr>
<tr>
<td>Ronda</td>
<td>35</td>
<td>15</td>
<td>Post</td>
<td>18 months</td>
</tr>
<tr>
<td>Sonya</td>
<td>43</td>
<td>21</td>
<td>Post</td>
<td>2.5 years</td>
</tr>
<tr>
<td>Jessie</td>
<td>33</td>
<td>12</td>
<td>Post</td>
<td>18 months</td>
</tr>
<tr>
<td>Tara</td>
<td>32</td>
<td>10</td>
<td>Post</td>
<td>18 months</td>
</tr>
<tr>
<td>Jenna</td>
<td>52</td>
<td>20</td>
<td>Pre</td>
<td>12 years</td>
</tr>
</tbody>
</table>

Despite the differences in age and range of experience as a nurse, common themes representing the SDNs’ lived experience of transitioning to the SDN role in the service model emerged through the process of data analysis. Coding and categorising of
interview transcripts was undertaken (as described in Chapter 3) to determine significant statements and categories of data that represented the lived experience of the participants. Common themes were derived from the interviews; combining these into categories enabled inter-related commonalities between experiences to be noticed (Seidel, 1998), which allowed a picture of the phenomenon to emerge.

According to Van Manen (1990), the purpose of phenomenological reflection is to grasp the meaning of an experience as a whole, and the understanding of an experience is arrived at through the analysis of the themes. Each emergent theme is a statement of a concept or category and provides structure for a fuller description of the larger phenomenological dimension of the lived experience (Van Manen, 1990). Coffey and Atkinson (1996) describe the phenomenological dimension as that which goes beyond the data.

Through the process of data analysis, it became clear that each participant was talking about identifiable dimensions of the experience of transition to the SDN role. There were dimensions that were common to all participants. For some participants, one or two of these dimensions was predominant; for others, a range of aspects of experience was discussed. In analysing the data, themes emerged suggesting the SDNs’ lived experience of the SDS model involved going through a process of not knowing what the job entailed, becoming aware of the ways to get organised to get the job done and then finally using the tools and systems to achieve a state of ‘being on track’.

5.3 Presentation of Themes

The process of the SDN lived experience of the SDS model is described and illustrated, using descriptions from the original transcripts where appropriate, and with reference to the field notes. The process conveys the common structures of the lived experience of an SDN using the SDS model and acknowledges the dynamic nature of
the experience. In this study, three themes (see Figure 5.1) emerged from the data: *stumbling in the dark, becoming aware of the scaffolding, and using the scaffold.*

![Diagram showing themes: Stumbling in the dark, Becoming aware of the scaffolding, Using the scaffold.]

*Figure 5.1. Pictorial presentation of themes.*

Each theme is presented with descriptive expressions directly from the participants to portray the lived experience of SDNs in this study. While full transcripts were used to analyse interviews, in presenting the findings, some quotes were edited for ethical reasons (de-identifying work areas to maintain participant confidentiality) and to improve their readability (Arksey & Knight, 1999; Kvale, 1996; Poland, 2003). Where this has occurred, the convention [ ] indicates changes to the text and (…) that words have been removed.

### 5.3.1 Stumbling in the dark

This theme comprises the factors experienced by SDNs in their initial period of the role, which they described as a time of adjustment and unsettledness. For some SDNs, it took some time to ‘figure out’ what the role was—they came into the job with little understanding of what working as an SDN entailed, and as Shannon observed, they experienced a period of ‘stumbling’ along, struggling to find the structure and what it was they were required to do in the job:

I always knew education was important, but I didn’t understand how it all came together. So, there was probably, for a long period of time, about three months, a lot of stumbling along in the dark, making things up as I went along (Shannon).
To *stumble* is to go unsteadily or act in a hesitant way (“Stumble”, n.d.) and was reflected in the SDNs’ lack of comfort and confidence during their period of adjustment:

It took about three months, to be able to feel confident in what I was doing day to day and that I had things planned and to sort of get a bit of momentum up (Jessie).

It took me over a half year to figure out what my job was as a staff development nurse. And I grew more comfortable in that role just because of the length of time that I was in it (Beth).

The idiom *being in the dark* describes being uninformed or ignorant about something (“In the dark”, n.d.) and signifies the period during which SDNs are trying to figure out what the job is but cannot yet see a meaningful shape or structure:

In that first month I really had no idea what I was supposed to be doing. I think in the very beginning, that’s what I struggled with. I was like, I’m not really sure what is supposed to be going on (Linda).

In the beginning I was spending a lot of time sitting at my desk thinking, “I’m sure I’m supposed to be doing something, but I’m not really sure what that is.” (laughs) It would have taken me probably another three or four months to really get into it (Nancy).

In analysing SDNs going through the process of not knowing what the job entails, *stumbling in the dark* (see Figure 5.2) emerged as a concept to describe this theme. In the context of this theme, stumbling in the dark means not being able to see clearly or having any idea where you are going. The key subthemes of stumbling in the dark are not knowing the role and blurred expectations.
Figure 5.2. Theme of stumbling in the dark.

5.3.1.1 Not knowing the role

Although participants were experienced nurses, the majority mentioned that when they were a nurse on the floor, they did not have an understanding of the role of an SDN, and expressed not knowing what they had ‘got themselves into’. In this sense, they were entering an unknown space in the dark. They were not long into the job when they experienced not knowing or understanding the job or what the job entailed:

First of all, you don’t really know what your got yourself in for. When you’re a nurse on the floor, you really think that’s [SDN] a very easy role. You really have got no understanding of the [SDN] role at all. (Nancy)

To begin with I wasn’t really sure what the role of SDN was, I wasn’t really sure of what the position entailed (Linda).

For some, moving into the new role of SDN from a direct patient care role was more of a change than they had anticipated. Their role as a clinical nurse on the floor had been characterised by structure, policies and procedures, whereas in the new role, participants were surprised by the loose structure, describing an initial period of transition when they were seeking to understand the role expectations. This is evidenced by the quotes below:

Suddenly you've gone from a position where you come to work, you have your set work and you break it down and design your day, but
you have tasks and they're all individual little tasks to achieve patient care, so you understand your role with good clarity and what you need to achieve in a day (Tara).

Ward nursing is task orientated, so when it’s 10 o’clock, it’s time for doing the [observations] … everybody knows that that’s what happens at that time. And that’s what I struggled with the most in the role at first. I’m sure I should be doing something, but I’m not sure exactly what it is. And if it’s important, I wish someone would come here and tell me, exactly what it is I should be doing (Linda).

I like to be really organised, so when I first came to the staff development role in those early days, maybe there was a routine, but I didn’t understand it. I didn’t really understand how staff development worked in the big scheme of things, I think that’s because I didn’t understand the processes (Shannon).

Descriptions of orientation processes varied significantly, and the inconsistency of a structured orientation was evident for some SDNs. A lack of or delayed orientation was detrimental to their progress in understanding the role, and was conveyed by participants as:

I never really got an orientation and I think, in some ways made it [transitioning to role] more difficult (Shannon).

I had some orientation six or eight weeks after I started … I think it could have been more beneficial if it had been at the beginning and I’d had a better understanding of what I was supposed to be doing (Linda).

Orientation to the job was a factor which, for some, affected their ability to get the job done or prolonged the time to understand the job. The quality of the orientation was influenced by factors such as absent senior nurse educators, leadership turnover or lack of structured program or process in place to orientate new SDNs. This gap in the orientation, along with no preparation for the role, led to a state of not knowing the role or what it actually entailed, which resulted in blurred expectations of the role. Once they were in the role a few months, they started getting an idea of what the expectations were but were still not completely aware of these.
5.3.1.2 Blurred expectations

For nursing staff, successful job performance depends on a clear and full understanding of workplace expectations and guidelines; for example, knowing the ward routine and demonstrating clinical skills required for specialist areas. In this subtheme, SDNs commented on expectations for their new role that were very different from what they were used to as a nurse on the floor. At this point, SDNs were moving from a state of not knowing to a state of beginning to know what the role was: it was as if they could see expectations appearing as shapes in the dark that were unfamiliar and unformed as yet. SDNs were discovering there were expectations, albeit unknown to them, from other nursing staff and the SDS. SDNs did not see these expectations clearly at first; however, they had a sense that people expected them to fulfil a role but were unsure what those expectations were. Merriam-Webster’s dictionary defines the term “blurred” as something vaguely or indistinctly perceived (“Blurred”, n.d.); these blurred expectations related to their own expectations and managing expectations of others during the transition to the role:

I found the transition very difficult to move into that SDN role because of the expectations, which were my own … what was staff development and what was different from my clinical role (Beth).

My real challenge was trying to separate myself as a clinician to then an educator, and I found that really difficult, trying to gauge the expectations that I had for myself as well as what the staff had of me (Tara).

Participants questioned their readiness for the role; not knowing the role caused them to have blurred expectations of themselves, and of what others expected of them while trying to figure out what actually was expected of them in the role. This caused the SDNs to experience a period of stumbling along in the role, trying to find their way. SDNs observed that transitioning to the role and subsuming an expert persona could be challenging, along with the internal pressure to be considered expert:
I didn’t think I could do it [role of SDN] or what to expect. I thought, well, okay, maybe I should just dive in the deep end and just see (Ronda).

I did lots of clinical reading, because I thought that was more what I had to know (Jessie).

When I first came into staff development, I didn’t think I was ready. I had my own expectations of what I thought I needed to be … your expectations as a clinician and that you’re expected to know all these things now because you hold an SDN position (Shannon).

[Ward Staff] started by treating me quite gently, but as the questions became more complex, I started thinking how am I going to manage all this time that I need to teach other people and teach myself things that I need to know to actually teach them? So that was a bit of a challenge to start with (Simone).

… you’re coming from a team environment and then you’re by yourself. I’d say it’s a confidence thing. It really comes down to having a lot of confidence. You really need to build on that … Everyone just thinks you should know it all … but we don’t know it all. We can’t know all the policies and procedures. There’s no need. Look it up. And that’s the thing (Nancy).

It was not only their own expectations, participants observed, but also suddenly being thrust into the role resulted in a perception that ward staff had expectations of the role; the challenge for the SDNs was to ensure others did not have mistaken expectations:

There’s this assumption [by ward staff] that the minute that you step off the floor, all (of) the sudden you’re not [NAME] who was a clinical nurse, you’re an SDN so you’re supposed to know it all, and you’re supposed to have all the answers. I found that a little bit off-putting (Shannon).

Look, I think clinically you always have barriers because of the perception of the [SDN] role … there’s an expectation from the floor that you’re an extra and if it’s busy you should be out there helping (Jessie).

Sometimes other staff members were either supportive or a little bit negative of the fact that you had gone into the role … they might have been more senior people who had hung around in the hospital longer but … also the type of people who never stepped into those roles, the type … first to criticise but … last to help. So that was a bit interesting,
but you get difficult personalities everywhere and I just let it go (Tara).

SDNs discovered that the SDS also had expectations of the role:

You come into staff development and you have these ideas of what you think might be wanted from you. I wasn’t aware of the other aspects, like, having to help out with [hospital-based programs] induction sometimes, or on the safety skills day being rostered in to do either a talk or assessment, something like that. (Nancy)

There’s lots of fine print … you’re not too sure about until you’ve … talked it through with your educator … because when you talk about being a SDN, you don’t necessarily think outside of your own … area. You think I’m going to be staff development nurse for [CLINICAL AREA] and it’s not just about that area. You realise it’s about the hospital as a whole … I will go to other wards to do in-services and I’ll get roped in to go help on the xyz course or, as I did the other day, a whole day of safety skills. The medication talk three times in a row. They didn’t tell me about that when I started. They didn’t tell me that at all (laughs) (Sonya).

Stumbling in the dark was the initial phase of transition to the role. SDNs described a lived experience of first not knowing what the role entailed or was, dealing with expectations and searching for a way to make sense in understanding their role. As SDNs adapted to their new job, they appreciated it was about understanding the job, dealing with expectations, and learning about processes and business systems. For the SDNs, as they became increasingly aware of their new world of staff development, they also become aware of the scaffolding to support them in their role.

5.3.2 Becoming aware of the scaffolding

In a learning context, scaffolding describes a strategy where learning and performance is actively supported by a ‘knowledgeable other’ or additional resources that enable people to perform while they are still learning (Smith & Sadler-Smith, 2006). Scaffolding uses a combination of questions, prompts, cues, direct explanations and modelling to guide learning and build understanding (Valentine & Edmondson, 2015) and refers to processes, structures and tools used to help people ‘solve a problem,
carry out a task, or achieve a goal which would be beyond their unassisted efforts’ (Wood et al., 1976, p. 89 cited in Valentine & Edmondson, 2015).

Scaffolding does not make the learner learn, but rather, makes it easier for the learner to learn; an important aspect of scaffolding is the support that an expert provides to the learner until the learner can perform independently (Lajoie, 2005; Lepper, Drake, & O’Donnell-Johnson, 1997). Thus, scaffolding as a concept supports the theme of becoming aware of the scaffolding (see Figure 5.3)—the phase where SDNs described their lived experience of the organisational scaffolds: support from managers and peers and the conceptual and technical organisation of the SDS.

SDNs described learning on the job and developing strategies to assist them in the role. The following quotes are examples that describe this category:

The biggest thing that I had to learn was not just organising things, but also learning how to deal with people, different personalities, sometimes on the ward there are conflicts and people try not to get involved and if it’s me I’ll sort of hide from those, whereas as SDN, you can’t (Beth).

I keep a notebook as I re-encounter the same issues again … I record what I did last time and … try to do the same thing or … somehow improve (Linda).

I was writing down everything … I did, and I still do, so I can look back and go … I have done a fair amount this week … I have … been … effective in what I’m doing, have spoken to so-and-so … have caught up on this (Sonya).

Following the initial period of adjustment and uncertainty, SDNs entered a stage of seeking to find their way on what to do in the job. At this point, SDNs observed that they were learning on the job, ‘finding their way’ and starting to make the job their own in their own way:

I don't think that you can have all the skills that you need for this role initially. I think it's a gradual process as you start to learn the job, like with any job (Jessie).

When I went into the role I tried to follow them [other SDNs] around and see how they structured their days, but I found after being in the...
role longer, you actually have to make it your own and have your own way of dealing with things (Tara).

When I started, [WARD SDN NAME] had already gone. So, you’ve got to try and find your own way. I did struggle sometimes with the computer things, where to find things. You do have to try to find your own way, and the more you do it, the better you get at it, if you get support (Nancy).

During this phase, SDNs were finding the supportive mechanisms within and the organisational structure of the SDS, through orientation when their attention was directed to it or by self-discovery through exploration: they were becoming aware of the scaffolding in place to support them in their role as SDN.

I was happy with my support and what was happening in staff development … I had what I needed … someone to ring … manuals … information was there to be found … I found it. I had support of my unit manager and educator. I think that’s really important. Particularly someone coming in as green as I was (Ronda).

I read a lot. I also spoke to nurses that had held the role previously. I had a really good one-to-one orientation with the SDN that was outgoing, so I sort of understood their process or what their goals were (Jessie).

Two subthemes supported the premise of becoming aware of the scaffold: finding the support and receiving instruction. Both these themes were required for the SDN to become aware of the scaffolding.
**Figure 5.3.** Theme of becoming aware of the scaffold.

### 5.3.2.1 Finding the support

For nurses commencing work in a new work place, common practice during induction is provided by a preceptor, a colleague who works side by side, acting as a guide to acclimatisate the new staff member to how things are done and introduce them to colleagues in the team. In this respect, the new nurse is introduced to a vertical structure of support (line management and the leadership structure) and a horizontal structure of support (peer support within the team).

SDNs described a vertical and horizontal structure of support in their new world of staff development. The information that was available and the presence of a role model influenced the time it took for SDNs to progress their understanding of what was required of them in their new role. For some, it was not so evident, in that they were not provided with an introduction as to who was available to assist them in acclimatising to the role; as Simone describes her search for support:

I was using the Staff Development Enquiry email to ask questions initially … I used it like a help desk, because I didn’t quite understand what it was about. If I had a question about staff development … I
thought that email address was … someone from the office being able to answer questions or re-route questions that I didn’t have the answer to … I was asking about who would be the best person to contact for such-and-such … and the [Administration] staff were really helpful … they would pass the question on to somebody, an SDE or another SDN, and they’d get back to me … But eventually they said don’t do it like that (laughs), ask your SDE as the email address was for hospital staff to make enquiries about staff development courses (Simone).

Linda also found it could take a while to learn who was available:

… when I first came here, I didn’t know who anyone was … there’s a whole list of names and phone numbers next to my phone … I thought who do I ring? Who’s my person … after a while you learn where everyone fits (Linda).

More than half the SDNs found human resources were readily available and observed that there were ‘helpful’ guides and people showing them the way, or the way to find what they were searching for:

Since I’ve been here, I can see there is a structure to it. You can see you’ve got your SDNs, you’ve got your SDEs, and … Head of Department. If your SDE isn’t here, someone else is always there who you can go to (Sonya).

… for me it’s like a hierarchy … not in a bad sense … It’s a leadership model. And so, there’s me and then there’s the educator, [NAME]. So if I’ve any issues or anything, she’s guiding me … I’ll refer to her. If it’s anything graduate related I’ll go to [NAME], and other individuals if it’s more specific. And then there’s [NAME] the Director Staff Development … so that’s how I think is the education leadership structure (Beth).

For the participants, the vertical scaffolding of support are those people immediately available to them, the Clinical Nurse Manager (CNM) of the area to whom the SDN is allocated and to whom the SDN has a professional accountability, and the SDE who is the SDN’s operational direct line manager.

5.3.2.1.1 Vertical scaffolding by manager

With the SDN position located within the clinical area, the CNM has the SDN in line of sight daily. Achieving staff development outcomes in clinical-based education
requires that the SDN and CNM work together collaboratively and agree on staff training plans. The nature of this relationship could make it easier or harder for the nurse in the SDN role; some SDNs described how the relationship with the CNM affected their work when they felt or did not feel supported by the CNM. The ease with which the SDN progressed in the role was dependent on the relationship with the ward CNM and the degree of engagement and communication they experienced. Linda observed that her ward CNM identified that she was unsure what to do at first and responded with prompts and gave her direction at the start:

My CNM of [ward area], is very supportive of me. I think she knew in the beginning I wasn’t really sure what was going on … she was …. prompting me, “have you thought about this?” or “could you do this instead?” She pushed me in the right direction, so I could go and find the answer for myself (Linda).

Simone had experience as an SDN in other hospitals and reflected on her experiences regarding the relationship with the CNM. For Simone, having a good relationship with the CNM made it easier to work together to achieve beneficial outcomes:

I found it a lot easier when I was working with a manager I had a good relationship with, that we could make plans together, that had certain ideas of how the ward (would run), what would benefit the patients and the staff in their competencies and their skills (Simone).

Beth also observed the difference a relationship with the CNM made to her experience and the impact of having a positive role model was a motivator to do her best:

The previous CNM, was much more closed off … it’s hard when you’ve got somebody that’s closed off … you try and speak to them but it’s like a different dynamic. But if you have somebody more open like my CNM now, it changes things … she’s full of knowledge, I think that leadership inspires you (to) just want to do the best job that you can … and that’s somebody that you aspire to be as well (Beth).
On the other hand, Nancy spoke of coming into the job with no handover and having trouble in the relationship with the CNM, which affected her confidence:

When I came on [WARD], [WARD SDN] had already gone. So, no one to teach me … give me a proper handover … It was messy for me to start off with. I was the acting staff development in [WARD] … that was a difficult experience for me … because of problems I experienced with the nurse manager. In that respect, I didn’t find that I got enough support … I really could not have done anything better … because of what happened with that nurse manager, I felt like I was looked upon as the difficult one and lost my confidence. That was the really hard thing, losing my confidence to do the job (Nancy).

Ronda observed her own behaviour also affected her relationship with the CNM, inferring personality differences influenced working style and that was a factor that needed to be taken in to account:

I had a different experience when I moved from [WARD] to [WARD] and the manager there is absolutely brilliant. We can talk to one another … that has really shown me too, that hang on … maybe I was a bit too anxious, right? But everyone works differently and that has to be accepted, as long as you really want to do the right thing by the staff (Ronda).

SDNs in the context of this study were embedded in the clinical areas and not in the line of sight of the SDE daily; therefore, the relationship between SDN and SDE was dependent on engagement through check ins or meetings. The role of the SDE was to provide line management and guidance to SDNs; they were responsible for assisting them to gain confidence and competence in the role. The SDE was observed as a pivotal source of support for SDNs. This is described below:

My SDE was fabulous and very supportive. And even the other SDEs (Ronda).

… when my SDE is away for different things, she would always say, “Here’s a pager number, ring.” If I ever rung whoever it was, they were always really good and would point me in the right direction and talk me through whatever I needed. That was fantastic. (Sonya).

The SDE was observed to be an essential go to person in the first instance for all the SDNs and the experience and organisational knowledge of the SDE was a critical
factor in assisting the SDN to progress in the role. Linda detected that her SDE was also
in a transitional phase of her own, which resulted in Linda searching for information
and relying on finding alternative vertical support (as mentioned previously) in an
understanding CNM:

My SDE was quite new at the time … in a transitional phase as well. She didn’t really know, same as me, wasn’t sure what she was
supposed to be doing … I found I was going to her to ask questions
and she didn’t know the answers to them … I had to either find them
for myself or seek somebody else [CNM] who would (Linda).

The support from an available, knowledgeable and experienced line manager
meant an SDN felt supported and encouraged:

The SDEs were really supportive, which was definitely important
going into that role, because you do come up against some interesting
barriers and … because they knew the staff development framework
as well … that helped a lot. Yeah (Tara).

Conversely limited access to and availability of an SDE made a difference for
two of the SDNs:

… meeting with my SDE for orientation time was six or eight weeks
after I started … could have been a bit more beneficial if it had been
at the beginning … I’d had a better understanding of what I was
supposed to be doing (Linda).

Unfortunately, our staff development educator, was often away so you
couldn’t really rely on her a lot … I really relied on the other SDNs
… because I really didn’t know what to do about the situation
[relationship with CNM] anymore (Nancy).

While the relationship with the ward CNM was viewed as important by SDNs,
the vertical line management from the SDE provided direction and structure:

I feel supported by my SDE and the department. It feels directed …
they encourage you to be more self-directed, I guess … you check in
once a month with the SDE and … you’re working towards your goals
… you can check in for yourself or check in with them (laughs)
(Simone).

… having educators [SDE] above you, they guided you to make sure
elements were being achieved … You kept your competencies
monitoring up-to-date and managed your training in-service to be up-to-date (Jessie).

The SDN relationships with these two line managers affected how the SDNs felt about their job and their capability to execute their duties; while these relationships were important, the relationship with peers provided another supporting mechanism.

Just as the vertical relationships with line managers were important, the horizontal relationship with peers was equally important for the SDNs in becoming aware of the scaffold.

5.3.2.1.2 Horizontal scaffolding by peers

The horizontal scaffold of support for the SDNs was provided by their peers, some of whom could meet them immediately and some of whom could not. All participants highlighted that the relationship with peers had the greatest impact on their experience in the role:

One of the SDNs that I work with now inspired me to get into staff development in the first place … I think a mentor is important, but also is having access to other SDNs once you’re in the role … I found that was vital (Jessie).

I found the best support were my SDN colleagues … a lot of it is you’ve got to ask questions to find your way (Ronda).

SDNs, on joining the SDS, were allocated a peer as a buddy. This strategy by the organisation provided the SDN with someone identified as the person to count on for support, a go to person who could answer questions in the first instance:

… support of my buddy SDNs … that was the best support … having other SDNs around who I could go to was great. I would ask them questions and things like that (Tara).

… because we’re in SDN groups, we know who to go to first. It’s a buddy system. It’s just knowing there’s other people to ask questions off. Even the non-SDN admin staff are there too, ask questions of them and be a support as well (Simone).
Some SDNs were co-located and sharing office space; this provided an opportunity to have a buddy in close proximity and someone to work with alongside, which enabled learning from each other:

… sharing an office … helps … if you’ve got a problem, you chat with your fellow SDN in the office … odds are they’ve done the same thing or something similar … you can learn from each other (Sonya). It’s one of those things about having a sidekick in the office. You’ll be sitting there and say, “how do you do this?” and they reply back “You do A, B and C” (Ronda).

When I first worked as an SDN, we were all in one office so other SDNs were just an excellent resource … picking their brains and asking where is this and how do you do this and sharing resources with other SDNs (Tara).

Three of the SDNs who were not co-located with their peers observed the importance of networking with them instead, which countered feelings of isolation:

I sort of get a little bit isolated up in my office … good to regroup with other SDNs … see that some of the struggles that I was having, it’s the same as other SDNs (Linda).

… to know that they’re [other SDNs] there for you … you don’t feel so alone … if we have a tough day we’ll catch up and debrief. Because sometimes you’re in the middle. You’re aren’t part of the ward … if you have something frustrating, you can’t comment on it to the ward staff, so you and the SDNs from the other floors sit around and debrief, and then just get on with things … it’s good because you can maintain a professional boundary with your ward staff … not to let things get to you (Beth).

Shannon described the benefits of networking beyond the buddy when the SDS held its monthly meeting of all staff:

There is a sense of community within staff development … the combined meetings [monthly service meeting] helps with that … it makes each of us as individual staff development nurses more accessible to each other … if I need to know something about chemotherapy, being able to put a name to a face and know who I’m speaking to helps (Shannon).

Mentoring and ongoing support of new staff is fundamental for successful transitions. The provision of information and guidance to the SDNs was pivotal to their
understanding of their new role; the need for mentoring and orientation support is
evidenced in the comments below:

… having those tools is really important, but also having that initial
really good orientation as to what those job expectations are, and I had
a good orientation, I had everything written out within the orientation
that I needed to do my job (Jessie).

… (from) the orientation I was given, I knew where to find
information. So, I didn’t feel like I didn’t have the information. I
always had the information available to do the job (Sonya).

I had an easier transition given [ward area] has two SDN, so whilst I
was learning the role there was [someone] there who knew the role
and was available … I found learning systems, databases and the
actual work of an SDN a lot easier because I did have those resources
there (Tara).

I had a good role model to set me up, because at that time there wasn’t
a system in place for my orientation to that role. Like I said, it took
me over a half year to feel like I was getting my head around the role,
and I think, looking back, it’s probably because there wasn’t the
structure there that I know there is now that helped me develop those
skills (Beth).

Jenna had been in SDN service the longest period and was in the role well
before the introduction of the ICIC model; she made the following observation that
supports the need for an organised orientation to the role:

When I look at the SDNs that I have worked with the last few years,
they have been better prepared, I think than I was. They [attend] skills
training and [train the trainer] to teach them to be assessors, and for
me that sort of training was watch one, do one, teach one … the
[SDNs] coming through now, they have the rationale behind what we
do … and I think that is evidenced as they actually do it well, whereas
I'm not sure how my standards were at first (laughs). I'm sure I got
better (laughs) (Jenna).

A defined vertical and horizontal scaffold of support provided a mechanism for
SDNs to progress in the role of SDN. The key factors that positively influenced their
experience in this regard were a harmonious relationship with the CNM, an available
and knowledgeable SDE who could provide orientation, direction and structure in how
to do the job and the opportunity to network and learn on the job from peers. Another
factor that influenced the SDNs’ lived experience of transitioning to the role was
knowing what to do to be organised.

5.3.2.2 Receiving instruction

Nurses commencing work in a new workplace are generally orientated to the
environment, people and processes through specialist training and instructional
templates or guides, such as organisational forms, policies and procedural guidelines.
The purpose of providing training and templates is to expedite assimilation to the team
in a new clinical area or, in some cases, specialty. Like the clinical areas, the SDS
provided professional development opportunities and templates: departmental
information, forms, documents and checklists. During induction to the department,
SDNs were introduced to these and became informed on how the business was
organised. In this way, they became organised and could see what needed to be done:

… when you first come into the job you learn about the model and it's
like okay, I have learned this model, and then you become
comfortable enough to have more head and time space to do things …
Because you know that your KPIs are being met, you know that your
job role requirements are being met in a foundation level and you can
build on that (Jessie).

… the structure is important because of so many demands that pull
you in and out of what you're actually supposed to do, and that was
my role and that was what I had to do and focus on (Linda).

I very much enjoy having the time to focus on education rather than
rushing around. You still have a lot to do … but working in the scope
[of the SDN role] I find that it’s a job that you have things that you
have to do (Tara).

Because it is a business you’ve got to be sure of time. So I’ll be on the
ward, sort things out … then I’ll do the office work, preparing in-
services, planning, doing the appraisals (Beth).

SDNs coming into the role became aware, through orientation or self-discovery,
that the SDS had in place an instructional structure with organisational templates and
training for their benefit.
5.3.2.2.1 Templates

Ready-made education resources, departmental policies, a staff development handbook and ‘how to’ instructions (see Figure 5.4) on using the filing systems and databases were the ‘templates’ available for SDNs to use as guiding documents to go about their work. For example, in the shared drive, there was a directory with an index system for staff to be able to locate the SDS forms (see Figure 5.5) and policies they were to use daily to organise their work or know how to do a certain task.

Figure 5.4. Screenshot of shared drive how to instructions.
Sonya and Tara spoke of how they explored their way through the SDS electronic filing system, where they were able to find these templates and resources ready-made for them to access and use:

I spent all my spare time going through that W-drive [shared drive] … going into everything to have a look what was there. It is a matter of going through the staff development database … asking the questions. It was just trial and error and spending the time sifting through and studying the records for myself (Tara).

Figure 5.5. Screenshot of shared drive forms.

Figure 5.6. Screenshot of shared drive templated resources.
I like things like W-drive [shared drive] … I know where to find things now … most of the time I can flick straight in … find the information I want … I don’t have to keep umpteen copies of the letter for safety skills day because it’s on here [W-drive] … I just print it off when I need it. I know what I’m printing is the most up-to-date … SDLPs [learning resources] … I don’t keep any printed out. I just go straight into here and do it. It saves paperwork, it saves time … I think it’s really a valuable thing (Sonya).

The SDNs discussed a staff development handbook provided to them, called Staff Development Matters, during their induction to the SDS. Apart from the resources available to SDNs on the shared drive, this hardcopy handbook provided instruction and templates that SDNs found invaluable. The handbook included a description of the ICIC Staff Development Framework, the role of nurse educators, material on learning styles and articles on training and education. The information in the handbook provided the means to understand the workings of staff development, for them to become organised.

As Sonya and Ronda observed:

It’s a booklet given to new SDNs explaining staff development and how it works and explained the ICIC … I found it quite good because it did help give me a bit of a rudder as to where I needed to go (Sonya).

I didn’t have a very good understanding of it [SDN role] initially, I opened the handbook and did a bit of reading and thought hmm … it gives a very clear picture of staff development and how I can organise myself … it made it easier for organising – orientation, in-services, having a look at the staff, where their training needs were and how to train them, and the [training] needs of the hospital as well (Ronda).

For the SDNs who transitioned to the role with little role preparation or training and performance development knowledge, the guidebook offered a reference tool where they could find answers to their questions. The guidebook supported the development of their theoretical knowledge of staff development:

I found it handy to have. I’ve still got it because occasionally I think of something … pull it down because it will have it in there. The answer will be there somewhere. So yeah, I found it quite a good little book to have from the start (Sonya).
The handbook came sometime in the first six months. I picked up the handbook and went oh! … there’s lots of things in here. As I saw a little bit more of the picture, the handbook became a lot more helpful. There were articles … explaining why we do these things … it was very handy to have … it was very helpful (Nancy).

It gave insight into the dynamics of teaching adult learners … when you are an adult learner, you don't really acknowledge the difference in it because it's the transition from high school to Uni and then post-grad. It happens that you're not aware that there has been this huge change in how you're learning. So that information was helpful (Simone)

The handbook (see Figure 5.7) provided SDNs with a handy resource and this was supported further when instructions in the handbook were also provided face to face in a structured professional development program.
5.3.2.2.2 Training

The SDS provided SDNs training for their role via a professional development day, specific to the role of a SDN, titled *Staff Development Matters* (SDM). All SDNs
remarked that attending this training was a turning point for them in understanding the role and their focus. The content of the SDM professional development days included an overview of the role of SDNs, instruction on the ICIC Staff Development Framework and staff development model and instruction on teaching and coaching on the run. SDNs observed that the SDM professional development day had a positive impact on their confidence, teamwork and understanding of the ICIC Staff Development Framework and staff development model:

Staff Development Matters [professional development day] … changes your whole outlook … it gives you the tools to be able to plan your day and deliver education … coming into staff development you suddenly become a lot more autonomous and you have to respond (Beth).

The timing of attending the SDM professional development day made a difference to a couple of the SDNs, who remarked that attending sooner than later would have been advantageous:

I wish I had had access to staff development-specific study days earlier than I did … the Staff Development Matters [professional development day] changed my understanding quite a bit (Shannon).

… Staff Development Matters day … I found that really helpful … I wish I’d had it earlier as well (Linda).

Jessie observed that the impact of attending SDM professional development day resulted in her peer team of SDNs finding common goals in their work and improving their teamwork:

… for everyone that attended that day, we then had a common language and a common goal … prior to that, you have your own experience and idea of what the role to be … go to that [SDM] day you see you're working under one framework and it makes it a lot easier. I was working in a team with three SDNs and we were all very new … trying to do our best, but then having that structure and framework, you then know what's expected of you. You work better as a team … you get the tools and the framework … so we were just better able to organise ourselves. We were able to specify our roles … the organisation of our work changed. It became more structured and
more efficient as opposed to just being quite reactive as it was in those first couple of months.

SDNs already with some experience in the role commented that the impact of SDM professional development day was significant for their confidence. For a couple of SDNs, this day resulted in a defining moment regarding their role and how they thought of their work:

… I grew as a staff development nurse when I was able to attend SDM [study day] and get those concepts of staff development (Simone).

I just got a lot more confident. I felt like I knew what the expectations were … that's because I had experience being in the role and had the tools and framework. For me it was like yep, okay, a confirmation this is the structure, this is what I'm working towards (Beth).

… I would have gone to one of the earlier ones of those (SDM study day) … I'd been in staff development a few years … SDM [study day], was great because I suppose it defined me as an educator … I could see a more organised approach that seemed so sensible to me, I figured out what my role was … helped me with a format to follow … clarified what my job was and clarified a little about the skills that I needed to do a good job, which before I was doing an all right job, I'm sure (laughs) but hadn't thought about it in any concrete way (Jenna).

For Jenna, who had been an SDN for a number of years, attending the SDM professional development day sparked an interest in furthering her own development as an educator:

I hadn't particularly thought about developing myself as an educator … I thought if I want to stay in education, then these are the basic tools that I need and then where do I go from here? So I went off and did my post-grad cert in education. SDM [study day] was a springboard for me to go off and study at Uni (Jenna).

SDNs discovered supporting mechanisms for their role through professional development and instructional support. The aspect that further enabled them to understand the role was the introduction to the SDS framework, which promoted an organisational shared mental model for SDNs. According to Green (2011), a company’s mental model can eliminate internal confusion. The mental model is a framework that
simplifies complicated strategy, allowing everyone in the organisation to internalise the strategy and be guided by it.

5.3.2.2.3 Staff Development Framework

The SDS had introduced a staff development framework (ICIC Staff Development Framework) as an organisational mental model to guide staff development activities and outcomes in the organisation/ward. This ICIC Staff Development Framework described the staff development elements (the elements being Induction, Competency, In-service, and Continuing education (ICIC); see Chapter 4) to be activated when providing a staff development program within an organisation or at ward level. The ICIC Staff Development Framework was utilised by the SDS to orientate new SDNs to the concept and elements of staff development and how to accomplish it within a service model. When participants were asked about the acronym ICIC or if they were aware of the ICIC Staff Development Framework, all participants reported being aware of the framework, and with the exception of Jenna, the framework had been implemented prior to their commencement of employment as SDNs. The SDNs were introduced to the ICIC Staff Development Framework as a concept during their role orientation and the SDM professional development day. All SDNs had attended an SDM professional development day, when formal instruction about the ICIC Staff Development Framework was provided. Their attendance to SDM post start as an SDN ranged from 1–12 months, with the exception of Jenna, who had been an SDN for seven years before attending the first SDM professional development day, held by the SDS in November 2009. For SDNs, the instruction and comprehension of the ICIC Staff Development Framework was pivotal for their understanding of their role and of staff development as a concept:

… in the beginning I didn’t understand staff development … as I’ve gone on in the role, and especially after a study day [Staff
Development Matters] where I learned about the ICIC, I understand better what it’s [staff development] purpose is (Linda, attended SDM post 10 month start).

I didn't realise it [staff development] existed in that format until Staff Development Matters study day kind of enlightened me to that (Tara, attended SDM post 5 months start).

I hadn’t experienced staff development anywhere else … the ICIC thing made staff development easy to understand because there’s a framework. I thought it was very easy, very logical (Ronda, attended SDM post 1 month start).

The ICIC Staff Development Framework was a structure that they became aware of after being in the job for some time or following attendance at the SDM professional development day. Understanding of the framework enabled these SDNs to make sense of their role and the expectations that the organisation held of them. The ICIC Staff Development Framework provided instructional structure for the direction of their work and ability to determine their role boundaries:

… I think its a good framework for providing direction for what you should be doing as a staff development nurse (Shannon, attended SDM post 12 month start).

What I found beneficial was the ICIC model because you knew exactly what the elements were of your role … it gave me an idea, especially in an early phase, of what I needed to do within the role (Jessie, attended SDM post 3 months start).

… it [ICIC Staff Development Framework] describes an expectation of Staff Development so I know what is expected of me and what’s in my role … helps me remember what I should be doing and what I shouldn’t be doing (Beth).

SDNs describe how the framework provided them with a guide to make plans and where to focus their attention and work effort:

… it [ICIC Staff Development Framework] helps me better plan what I’m doing, make sure I’m doing what’s important for my role (Linda).

… its [ICIC Staff Development Framework] really good … it’s stuck on my [office] wall, it reminds me of what my priorities are. Interviewer: What’s on your wall?
It’s an ICIC poster. I didn’t stick it up there … someone else did … It’s next to all the important dates and things I have to go to, and it just sort of keeps me on track (Ronda).

Simone, Jenna and Tracy made additional observations regarding the ICIC Staff Development Framework. Simone had previous experience as an SDN at another hospital and joined the department during the year the ICIC Staff Development Framework was implemented. When asked if the implementation of the ICIC Staff Development Framework made any difference to her, Simone did not specify any change for her, and her comments reflect that the framework introduction created a sense of teamwork:

… I was absorbing [role of SDN], so I didn’t notice the changes [implementation of ICIC Staff Development Framework] as somebody who might have been in longer … I was knowing that there is that ICIC structure, I didn’t hear about it straightaway, but fairly soon. Knowing that there was sort of an umbrella of staff development … you weren’t isolated, which had been [my] previous experience at [Other Hospital]. Here you weren’t just ward-focused, you were … hospital focused. I enjoyed that comparison. It’s nice to know that this is what all of staff development is focusing on (Simone).

Simone observed that the ICIC Staff Development Framework mainly assisted her in orientating her peers. As for other SDNs, Simone commented that the framework provided a mechanism to determine the focus for both her role and role of the department. For Simone, the most beneficial use of the framework was orientating colleagues and using the framework in explaining the SDN job role to others, which previously had been a somewhat difficult thing for her to do:

I have orientated other SDNs and job-shared … I talk through it [ICIC Staff Development Framework] with them … my folder for … new SDNs is set up in that format [ICIC] and then I divide my handover into those sections. I find it handy to describe our main focus … so um, yes, it helps them focus at first (Simone).

Other than that [orientation of other SDNs], I guess I don’t use it [ICIC Staff Development Framework] except to explain my job to other people when they ask what the staff development nurses do, if it’s
patients or other staff. I use that [ICIC Staff Development Framework] to describe the job, which I always found a little bit difficult before (Simone).

Jenna had been employed as an SDN for a substantive period (seven years) prior to implementation of the ICIC Staff Development Framework. For Jenna, the implementation of the ICIC Staff Development Framework had a significant impact on her work and her outlook on staff development. Jenna’s turning point was attending the SDM and being instructed formally on the ICIC Staff Development Framework (see page 131 for Jenna’s comments on SDM). During this interview, Jenna was noticeably animated and excited to speak when the ICIC Staff Development Framework was discussed, with her comments reflecting her personal journey to understanding staff development and her role in the organisation:

It [ICIC Staff Development Framework] gave me a structure … as a staff development nurse you're pulled at from different people … you're not actually sure where your boundaries are … to have that structure was really useful (Jenna).

The way Jenna described her experience during the interview was as if she had had an epiphany during the SDM professional development day. After being in a role of SDN for several years, there was a sudden new understanding of staff development, her role and the SDS and now aspects of these ‘made sense’:

And then, when I was talking about my job, I had something that I could structure my thoughts around … it was more business like. I hadn't thought about it before … that we were delivering a service … a service to the whole of the hospital … before I'd always felt we were … in isolation … a silo of nursing education. I liked that we were a service. It made sense (Jenna).

When Jenna was asked about her experience of the ICIC Staff Development Framework implementation, she observed the change on a personal and organisational level and saw the change in her thinking as well as the change in the department:

Yes, yes, I did [excited] … it was the way I thought about my job, and the way I structured my job and the way I reported on my job … and
it wasn't just within our [CLINICAL AREA] group, it was consistent throughout the service … we were all talking the same language (Jenna).

As the only SDN in position before implementation of the ICIC Staff Development Framework, Jenna was asked if the implementation made any difference to her experience as an SDN. Jenna was excited to explain that with the introduction of a structure, her internal frame of reference changed:

There was a definite advantage with having a structure that I recognised rather than one that I was creating in my own head (laughs) … that's the first time in my career, I've been aware of [staff development] structure like that. That's the difference that it made to me (Jenna).

Recognising and responding to a new structure enabled Jenna to shift away from some inefficiencies in her ways of working; as she observed:

There were definitely inefficiencies in the way I was doing it [SDN role] before as to the way we were doing it once we had the (ICIC Staff Development Framework) structure. That structure feeds down into what happens on the floor and the way we think … organise … manage competence and, that impacts upon education that you see on the floor … I don't recollect having that sense of that structure before. It always felt a bit knee-jerky, responding to crisis and then the next crisis … having a structure like ICIC and a plan allows you to respond to crises because the normal workload's covered … it's easier to respond when things crop up … which they do in education. So yes, I like it … and yeah, it did make a difference (Jenna).

Tara, conversely, who commenced as an SDN two and half years after the ICIC Staff Development Framework implementation, suggested that she already had an awareness of the ICIC Staff Development Framework coming into the role:

… I knew what had to be achieved, I understood the systems that were around … I didn't understand the whole framework existed as one. It was connecting the dots … I was already in that framework and implementing it, but I didn't understand that that was how it had been designed to be (Tara).

Tara spoke of how she had a ‘light bulb’ moment during the SDM professional development day (attending SDM five months post start in role), when she recognised
the ICIC Staff Development Framework was something she had experienced in action as a nurse on the floor:

… the framework was what I was already used to … I had been exposed to those elements [ICIC] as a nurse on the floor, not consciously thinking how they were aligned … that's how I came into the hospital. I had orientation … attended in-services … tested on my competencies. Reflecting on my own experiences at Staff Development Matters [is] where that light bulb moment came from … [recognising] I've actually been through this system and I didn't even realise that … I know that it got me to where I was (Tara).

Tara considered staff in the ward area were also cognisant at some level of the framework but not necessarily at the same level of awareness she experienced since being an SDN:

I think everyone in [WARD] could tell you … development of a nurse and what stages they're meant to be achieving in terms of [learning] … because they've all gone through that system [ICIC] … I don't think any of them realise how deliberately planned that was, following a framework like [ICIC] … I don't think they would know that (Tara).

With experience of the model as a nurse on the floor, combined with experience using and receiving instruction on the ICIC Staff Development Framework as the SDN, Tara came to an understanding of the logic of the ICIC Staff Development Framework and her part in ‘keeping it going’:

… when you think about it … obviously somebody had planned it to be like this, and here I am keeping it going as the SDN … it made a lot of sense in the way that it [ICIC Framework] was designed to get people moving along the education ladder and getting their understanding of the [AREA of clinical specialty] (Tara).

Becoming aware of the scaffold is the phase when SDNs found the scaffolding structures of the department and become aware of the ways to get organised to get the job done, which leads them to become organised. From here, SDNs started Using the scaffold to stay on track.
5.3.3 Using the scaffold

The world of staff development, like the world of nursing, has its own language, task, routines and processes, which, when combined, lead to outputs—in this case, organisational and professional development and learning by the users of the SDS.

It was evident within this study that SDNs entered the world of staff development with relationships and systems that, for them, were at first unfamiliar; gradually, they came to understand themselves as part of that world. Eventually, it become a shared world of skills and practices acquired through being-in-the-world of staff development:

… if you’ve got the right networks, what you really come to understand is that it’s about knowing your resources, not knowing everything. I would say that to junior SDNs, making sure that you take help when it’s offered and look for help when you need it, that sort of thing, which I think is set up really well here (Tara).

In the final stage of the process to being on track, SDNs used their familiarity with the SDS model to focus their efforts and collaborate with others to achieve their goals of seeing the big picture of staff development and making a difference to patient outcomes by supporting nurses educationally to perform their best:

It was like they knew what needed to be done now, if they stayed on track and covered the bases, they had room to explore and be creative (Researcher Memo).

The two subcategories that compose the theme using the scaffold (see Figure 5.8) are explained below.
5.3.3.1 Seeing the big picture

The Farlex dictionary of idioms describes the “Big picture” (n.d.) as the complete perspective of an issue or a situation. In other words, to see the big picture means the ability to see everything at once, take it all in and understand how everything works. To this end, once SDNs had travelled through the phases of *stumbling in the dark* and *becoming aware of the scaffold*, they shifted to a state of seeing the big picture of staff development and their role in it. At this point, SDNs understood why the SDS existed and what its purpose was. The SDNs identified staying focused, organised, in touch and on task as key elements of their role in contributing to the organisation as a staff developer.

SDNs were aware of the need to be focused on delivering priorities, despite the competing demands; as observed by Linda:

> you have many competing demands as an educator … often [you are] seen as an extra person … [I've] got to make sure that I've done what I need to do before I can even think about being the extra person on the floor (Linda).
SDNs could sometimes lose their focus or *big picture thinking*, and this prompted them to use the scaffold as a supporting tool to assist them to get back on track:

Sometimes you become focused on the wrong things … I have that model [ICIC Staff Development Framework] in my office and it tells you what are your priorities. I refer to that a lot … and then you’re like okay, let me get back to just why I’m here … so I have that [ICIC Staff Development Framework] as my focus on what I need to get done … work with people and try to get them [to be] better clinicians … make sure they’re safe (Beth).

For Shannon, *using the scaffold* resulted in making it work for her, being able to determine her workload and giving her a sense of enjoyment in going about her work with a degree of autonomy:

I like being able to work hard within that framework without necessarily having total autonomy. I like being able to say – this is our workload and this is how we’re going to make it work for us. I enjoy that (Shannon).

Another SDN observed thinking about their work goals in a strategic way and recognising this was dependent on themselves to be organised in a conscious way:

… it’s only you that can organise this stuff, it’s not the ward. So you’re working alongside with them [nursing staff], also meeting priorities of staff development – you have to think about what your goals are at least every month, rather than just floating through and ticking the boxes that have to be done (Nancy).

Having an understanding of how things worked enabled SDNs to stay organised and on track with a sense of responsibility. In this regard, *using the scaffold* enabled SDNs to stay organised to accomplish tasks that, earlier in their experience, had not necessarily been easy or possible to manage:

I never used to be as organised as this, but I found out I have to be … delivering x-number of in-services a month … responsible for ABC in teaching … mandatory training … I’ve certainly had to be a lot more organised. I can’t say I’m as organised at home, but when I’m here I like to be … I don’t like to let people down (Sonya).
SDNs discovered by staying organised and taking care of the core business, they could extend the range of their work:

You've got your key things … that's your ICIC structure … as long as those things are taken care of and organised, you can start to do other things outside that … working on little projects or spend more time on the floor. It's [ICIC Staff Development Framework] just that little quick reference to know that things are in check and progressing (Jessie).

You need to focus on getting the grads through, getting the new staff through, getting them settled. So induction, making sure everybody gets their mandatory competencies, and their in-service and the continuing ed stuff is what you fit in, in between (Nancy).

For SDNs, staying in touch with each other further promoted their ability to understand how everything worked as a whole. The SDNs appeared to have a shared understanding of what the purpose of their work and service was, and this was illustrated by their use and understanding of the ICIC Staff Development Framework. Working together in teams and sharing ideas and information resulted in SDNs having a sense of achievement, with access to ‘powerful’ tools to assist them executing their plans:

Our whole [AREA] program’s actually set up around ICIC … definitely helped focus our orientation for instance … It takes a lot of pressure off us as staff development nurses for ensuring we actually hit all the right notes during our orientation. The fact there’s a formalised process that’s an incredibly powerful tool in terms of protecting the institution and protecting staff development nurses … before this was formalised, there was always “no one told me that.” The PDP [performance development pathway] around the ICIC, I think, is great (Shannon).

Once you started working as a (SDN) team across [ward areas] … there was information sharing … mentorship happened … development of relationships between units … deficits in areas across [ward areas] that we're able to address together as a team with that cohesion … I think that's quite powerful in an education sense but also in a networking sense between the units that work very closely together (Jessie).
Working with each other assisted SDNs to structure their work and better manage their workloads. Their ways of working as a team using a framework with mutual understanding promoted this:

Our meetings were structured around ICIC so we could decide what we were going to do … what our priorities were, not just for that week but for the month and year ahead. We would plan what to achieve, and do it around that model and we would report. We'd report the things we've achieved and things we'd like to do … we'd use that model to do that. So it structured our business … It was just a better way of thinking about the job that we did (Jenna).

I like the ICIC. This is your focus … teamwork is important as we join forces, the surgical SDNs plan stuff together … so we’re sharing the load (Linda).

… it's [ICIC Staff Development Framework] a leveller that allows me to compare with another SDN as well, because you're measuring against the same framework (Jessie).

With their view of the big picture, SDNs used the scaffold to ensure they were staying on task. SDNs could determine they were staying on task by being able to measure their effectiveness; SDNs used data to monitor their progress and report their outcomes. This provided a means for SDNs to see the impact of their work and appreciate their effectiveness. Being able to measure their efficacy was a motivational factor for the SDNs:

… sometimes education is quite thankless … it's really hard to show the difference you make, having this model you can really show your numbers … you can get that with the data systems we have here … you can easily pull that data and you can motivate yourself along to achieve that. Just as a strategic direction, it's good (Sonya).

… you're able to report on the things that you're actually doing … using ICIC to communicate to your line management, to see how effective you are in your position (Linda).

Jessie observed the value of being able to measure the impact of her work on the organisation and individuals. Through analysing measurement data against tasks
performed and their outcomes, Jessie could see a return on the investment of the effort she was employing in her role:

You've got measures that come with that [ICIC Staff Development Framework] … in-services you do, inductees you have … compliance to competencies … progression of staff through the department. Our staff that got to promotional positions, all of that comes back to the work of staff development and the support that it provides … good thing about having this model is you can directly measure the impact because you have something to measure, something quantitative that you can measure against (Jessie).

In seeing the big picture, SDNs were able to notice the impact of their work through measurement, and consequently, they began to see how they were making a difference to others and how the job was making a difference to them.

5.3.3.2 Making a difference

Making a difference means to have an impact or to cause a change (“Make a difference”, n.d.) and following a period using the scaffold, made up of vertical and horizontal support, and receiving instructions, SDNs noticed their experience and actions made a difference to themselves and to staff with whom they worked. SDNs observed learning on the job, their experience with people and the responsibility of the job made a positive impact on their own personal growth and development of their personal attributes:

I’ve learned a lot in this role, a hell of a lot, definitely communication-wise. I never thought I would like speaking in front of a big group and I really enjoy it. I know, it’s weird, isn’t it? I remember my first talk I had cotton in my mouth, I was a mess [laughs] (Nancy).

… it [role as SDN] made me grow up as a person … I’ve gotten better at reading people as well, so now I feel so better able to deal with people. I’ve gained that confidence (Linda).

… it [role as SDN] made me grow as a person, definitely. I think I’m a better people person. Because you can’t shy away from things … if you see something’s wrong, you can’t shy away (Beth).
With understanding and becoming confident in their role, SDNs could see the SDN role offered them the opportunity to grow and be innovative. Being confident in using the scaffold enabled SDNs to ensure the basics of the job were covered, and this led to them being able to explore the possibilities for their role as well as experiencing satisfaction in the job:

I certainly do feel comfortable within the structure … it gives you the confidence to try other things … if you know that you've got the basics right … you can say can I have a go at this, is that all right to explore something else? I think if the structure's really sound and strong, then innovation is encouraged (Beth).

I actually really love staff development … I think some days are more challenging than others, but that’s why it’s called work (Simone).

Feeling their efforts were worthwhile and appreciated was a motivation for SDNs to persevere. Feedback, direct or indirect, was an important aspect to be able to see the impact of their work on the staff around them:

I’ve had lots of positive feedback from people I work with, they really do notice that I’m here and they appreciate what I try and provide for them and to do for them (Nancy).

… sometimes you feel a bit like it’s a bit of a battleground, trying to constantly motivate people … I was helping an Enrolled Nurse who hadn’t studied for, she said 30 years … she did an Enrolled Nurse emergency course. I spent a lot of time really helping her, then she got a credit, which was like amazing. It made it worthwhile for me … she came to me and said, “Thank you so much for all of your help, I couldn’t have passed without you.” That makes me want to get up in the morning and come and help people instead of thinking nobody wants to go to in-service. It makes it worthwhile (Linda).

You can see you’re making a difference when you give them [nursing staff] that knowledge and they’ve made that good call in clinical judgement … it gives you that warm, fuzzy feeling. That’s a good day (Jenna).

This view was further expanded to see also how the service support was making a difference to new SDNs coming into the service. Reflecting on and comparing their own experiences, it appeared obvious to SDNs that new SDNs coming into the service
were being introduced to a scaffold. They observed this resulted in new SDNs assimilating into the service at a more rapid rate than they had:

they come in and are efficient within such a short time … because the structure is laid out … they quickly build upon it because they know what the structure is. The clear pathway of support in their educational development does make a difference (Shannon).

… all the people that have come into it [staff development] have been motivated and keen to be there. So people have always been driven to do a good job … I think ICIC helps them because they quickly know what direction they're pushing in (Sonya).

… they amazed me by how quickly they adapted to it [role of SDN] and how they could put their new ideas quickly into action … maybe that's because they thought of it more as a business, whereas I hadn't (Jenna).

At this point, SDNs were using the scaffold: they felt appreciated, could see they were making a difference to others, observing the model in new SDNs and experiencing a difference in themselves, such as satisfaction in achieving a degree of competency in the job.

Three themes (see Figure 5.9) emerged to depict the transition process from clinical nurse to SDN: stumbling in the dark, becoming aware of the scaffolding, and using the scaffold.

*Figure 5.9 Flow chart of the three emergent themes depicting transition.*
A summary of the transition and themes is presented below.

5.4 Chapter Summary

The overarching theme that emerged was the concept of the participants being on a journey to understanding the business of staff development work and their role. Participants in this study identified several barriers that impeded on their transition to the SDN role:

- having little or no understanding of the requirements of the role
- that going from a clinical nurse role to SDN role was more of a change than they had anticipated
- having an inconsistent or delayed orientation to the role affected their ability to get the job done or prolonged the time to understand the job
- the need to manage the expectations of self and others.

Participants also identified facilitators that assisted their transition to the SDN role:

- provision of structured orientation to the role and expectations of the role
- introduction and allocation of a supportive peer mentor and opportunity to network within a community of practice
- access to departmental information and instruction on using departmental documents and systems
- having a good relationship with the clinical manager
- having an available and supportive line manager knowledgeable in staff development
- access to ready-made education resources and a handbook with ‘how to’ instructions
- receiving training and professional development specific to the role of a SDN
• a framework that provided a shared mental model of staff development and the expectations that the organisation held of them.

As an SDN, the nurses underwent a transition in three distinct stages (stumbling in the dark, becoming aware of the scaffold, and using the scaffold). The analysis of interview transcripts identified several themes shared by all participants during these stages. The clusters of shared themes were of relevance to the SDNs’ lived experience of the staff development model at the hospital. These themes were subsumed under an overarching theme of ‘being on track’, (see Figure 5.10) and is explained in the next chapter.

![Flow chart of transition under the overarching theme](image)

*Figure 5.10 Flow chart of transition under the overarching theme*
Chapter 6: Discussion of Findings

6.1 Introduction

This chapter briefly reviews the study purpose, research design and summary of the overarching theme to emerge from this study. The overall findings are discussed in relation to the literature and the theoretical context. This study sought to explore the lived experience of hospital-based SDNs’ transition from a ward-based role to the role of the SDN.

A qualitative approach was selected, using a purposive sample of 10 SDNs who had begun their careers in a variety of clinical settings. With the exception of one SDN, who had had more than 10 years’ experience in the role, participants had between one and three 3 years’ experience in the role of SDN. During the study, SDNs described their lived experience of their transition to the role of SDN in a hospital nurse education service; this study identified strategies that SDNs utilised to facilitate their journey. The hermeneutic phenomenology methodology was used to address the central research question.

The study’s methodology involved conducting face-to-face interviews, which were recorded and transcribed verbatim. The narratives from the participant interviews served as the means by which the lived experience of the SDNs was revealed. Using the data analysis strategy advocated by Creswell (2013), the researcher engaged with the data to generate themes and interpret the data. From the collective experience of the participants, three themes and six subthemes emerged, resulting in an overarching theme that provided insight into the central research question.

This chapter is organised into three areas of focus: the first provides a summary of the overarching theme arising from the study findings relative to the research
question, the second discusses the findings related to the literature, and the third offers a comparison of the findings to existing theoretical frameworks.

6.2 Being on Track – The Overarching Theme

The study findings indicate that the SDNs’ lived experience of the transition to their role using the SDS model involved them going through a process of not knowing what the job entails, becoming aware of the ways to get organised to get the job done and finally using the tools and systems to achieve a state of ‘being on track’.

Three themes depict the transition process from clinical nurse to SDN: *stumbling in the dark, becoming aware of the scaffolding*, and *using the scaffold*, culminating in the overarching theme—*being on track*.

6.2.1 Stumbling in the dark

On entering the role, SDNs realised they did not know or understand the job role. Several expectations became apparent to them as they progressed in the job. The start of their transition to the role, stumbling in the dark, is depicted in Figure 6.1, with the SDN standing at the start of a broad road with three wide avenues. The road is broad at first because at this point, SDNs can experience a wide open space of ‘not knowing’, creating for some SDNs a feeling of overwhelm and confusion as they try to work out what their new role is. They have left their old world, in which they had a clear and full understanding of workplace expectations, knew work routines and felt confident in using clinical skills required for their specialist areas. Not knowing the new role caused them to have blurred expectations of their own, and of others’ expectations of them, while trying to figure out what actually was expected of them in the role.
Figure 6.1. Illustration representing transition from nurse to SDN role.
The three wide avenues in Figure 6.1 represent the expectations that SDNs identify: expectations of self, from the clinical staff around them and those that the department has of them. It takes some time for the SDN to figure out what is expected of them in their new role. *Stumbling in the dark* is SDNs’ lived experience of dealing with expectations and searching for a way to make sense of their role. As they move to a state of beginning to understand the role, they became increasingly aware of their new world of staff development. From dealing with expectations, receiving orientation and connecting with others, the road takes a right turn, signalling the SDN is heading in the direction to where they become aware of the organisational scaffolding to support them in their role.

### 6.2.2 Becoming aware of the scaffolding

This constitutes the period where SDNs discover or are shown organisational support mechanisms: the role support from line managers or peer support and receive additional instructions and training. Figure 6.1 now demonstrates the road tapering, as the SDNs develop a deeper understanding of the role by receiving instructions and support from knowledgeable line managers and peers. The road tapering signals that the SDN is no longer experiencing the wide open space of not knowing: the tapering represents the SDN gaining a focus and solid understanding of what constitutes the role. There are no longer twists or turns in the road as their understanding is gained through peer learning, training and instruction on the SDS model and ICIC Staff Development Framework.

### 6.2.3 Using the scaffold

SDNs realise they are making a difference and start to see the big picture: understanding the concept of a SDS and their role in it. Figure 6.1 shows the road merging to become one avenue, much like a highway. The SDNs move along the
highway and they know now how to be on track regarding expectations and have the capability to meet their key performance indicators set by the SDS for their role.

Being on track is when participants reach the point in their transition process where they understand the role adequately to be able to achieve the job description requirements autonomously:

I think the [ICIC] Framework provides you a little autonomy in what you do over here [ward area], which I like (Shannon).

… it's [ICIC Staff Development Framework] a quick way to refer to what is expected in the role … a way to understand the KPIs [key performance indicators] for SDNs, where I'm strategically going to focus my attention to make sure that I'm achieving what I need to as an SDN (Sonya).

This transition to the SDN role was linear in nature and the time it took for each SDN to transition to the point of being on track was variable and particular to each individual. Figure 6.1 illustrates the transition process as linear, using arrows to demonstrate the process is one way. The transition time was dependent on the provision of orientation to the job, availability of role support, instruction and training:

… since that model has come in, I can see that SDNs who are new to it have a notion of what their core business is. They seem to have assimilated and got their heads around being a staff development nurse quicker than I did (Linda).

Being on track constitutes the elements the SDNs reported experiencing when they reached a level of understanding and autonomy in the role, such as being able to identify priorities, staying focused and meet KPIs set by the service:

I have that model [ICIC Staff Development Framework] and it tells you your priorities … I have that as my focus on what I need to get done. I use it to remind me of the bigger picture, why I’m here (Beth).

… because it is business and you’ve got to be focused. I'll be on the ward…and then I’ll do the office work…preparing, planning, doing the appraisals…sort things out…fit it all in, work with people. You can see you’re making a difference (Jenna).
SDNs like to receive feedback … you can get that with the data systems we have here … you can pull data and you can motivate yourself along to achieve (Jessie).

The good thing about this model is you can directly measure impact because you have something to measure, something quantitative you can measure against (Linda).

Being on track also includes teamwork, utilising networks and being proactive in planning as well as dealing with just-in-time demands:

… if you’ve got the right networks what you come to understand is that it's about knowing your resources, not knowing everything (Tara).

I have job-shared [as SDN] and I talk through it [ICIC Staff Development Framework] with them [job share SDN] for planning and getting organised … I find it handy to describe our main focus (Simone).

We offer ourselves to the other SDNs, not in the way of [doing] their business. Give us a call if you want us to do something for you … It’s a team environment generally (Shannon).

You still have a lot to do, working the scope of the SDN role in that [ward area] setting…it’s a job that you have things you have to do, but other bits are flexible, like the continuing ed focuses (Ronda)

Other elements include realising their potential, getting creative and finding time for experimenting:

I like that we’re given opportunity … I feel there’s an encouragement to expand your role but that’s also down to you, your own personal motivation (Sonya).

I’m thoroughly enjoying the experience of being an SDN … even though I’ve been an SDN here doing XYZ, I’m offered and given the chance to go and be an SDN somewhere else (Beth).

You’ve got key things you need to do and that's your ICIC structure … if those things are taken care of, then you can start to do other things outside that (Jessie).

Last, also important are feeling appreciated, loving the job and seeing how they were making a difference:
… it has made me grow as a person. I feel comfortable. I think I’m a better people person (Simone).

I do love it. I think I’ve had lots of positive feedback from people I work with (Linda).

The basis of this thesis is that the transition of a nurse to the role of an SDN is experienced as a linear process that results in achieving a state of ‘being on track’. For the participants in this study, the journey to get to the point of ‘being on track’ was supported by a combination of orientation, organisational support and training. The time to transition to the stage of being on track can be affected by these factors being provided in a timely fashion relative to the commencement of the nurse to the SDN role. The findings revealed that once on track, they were sustained by an organisational scaffold that provided a framework that they could use to plan, organise and monitor their outputs against KPIs:

… the [ICIC] model gives you a structured approach to being a clinical nurse educator … it [ICIC Staff Development Framework] doesn't teach you how to teach … it makes you more effective in what you do because you've got something to guide you (Tara).

The findings of this study are now compared with the related literature published on nurse transition to nurse educator roles to identify the similarities and differences between the findings and the literature.

6.3 Comparison with the Literature

When an organisation orchestrates the provision of adequate orientation, organisational support and training on early entry to the SDN role, the transition and assimilation period is more rapid than if the SDN is not provided guidance, as observed by an experienced SDN:

… they [new SDNs] come in and are efficient within such a short time … because the structure is already laid out … they quickly build upon it because they know what the structure is. The clear pathway of support in their educational development does make a difference (Shannon).
The findings of this study correlated to previous research findings with regards to the role transition from clinical nurse to educator roles. While the transition of clinical nurse to educator is not a new phenomenon, there is a dearth of literature that documents the transition experience of a bedside nurse to the role of a hospital-based clinical educator within a nurse education service situated in the hospital setting.

Predominately the literature focused on transition from practice to academic settings, with most of the published literature, when referring to nurse educators, focused on the roles and functions of nurse educators in higher education institutions (Thornton, 2018). In higher education institutions, nurse educators, commonly referred to in the literature as faculty nurse educator, are primarily responsible for the formal education of undergraduate and postgraduate nursing students, whereas nurse educators within the hospital setting are responsible for the provision of continuing professional development for hospital-based nurses (Thornton, 2018).

6.3.1 The importance of orientation and managing expectations

In this study, SDNs experienced the process of initially not knowing what the role entailed, finding human and organisational resources that were available to them, receiving instructions and progressing onto gaining an understanding of their role in the SDS. When participants in this study transitioned into their new role, they found that it took some time to figure out what the job was. They came into the job with no previous idea of what the job of the SDN entailed, and in this sense, they were entering an unknown space. Moving from a clinical nurse role, highly structured by policy and procedures, to one that was somewhat looser in structure caught them by surprise. The transition to the SDN role was much more of change in role than they had expected and resulted in a period seeking to understand the role and the expectations. The period of not knowing the role was influenced by the timing of orientation and expectations.
This finding resonates with the nursing literature, which speaks of the transition to faculty nurse educator as being challenging: lack of preparation, having unrealistic expectations of the role and limited or no opportunities for orientation. Several studies found that the initial transition to the faculty educator role can be difficult, with novice staff feeling overwhelmed, confused and uncertain (Dattilo, Brewer, & Streit, 2009; Duffy, 2013; Schriner, 2007). The transition from nursing service to education faculty can result in stress and anxiety related to lack of knowledge, incongruence with expectations and limited support (Duphily, 2011; Forbes, Hickey, & White, 2010; Schriner, 2007).

The participants in this study reported during the first phase of their transition that they did not really understand the role expectations, nor could they at first see the structure of their new work role, which resulted in feelings of uncertainty and a lack of self-confidence. These finding are consistent with previous qualitative studies regarding faculty nurse educators (Anderson, 2006; Dempsey, 2007; McArthur-Rouse, 2008; McDonald, 2004; Shapiro, 2018; Siler & Kleiner, 2001; Young & Diekelman, 2002). Parslow (2008) found that participants in her study of the lived experience of clinical educators (faculty) reported feeling unprepared and ill equipped for the role and did not understand the expectations of the role because of a lack of orientation to the responsibilities of role.

Participants in this study identified being surprised by expectations for their new role during the time they were moving from a state of not knowing to a state of knowing the role. First, they found the role very different from the clinical nurse role, and were surprised by an internal expectation to now be considered the expert. They also did not expect to find that their colleagues had expectations of them when they moved into a different role even though they remained in the same clinical area.
The literature documents a consistent lack of mentoring and formal orientation to the academic setting (Grassley & Lambe, 2015), and while the literature reports models for orienting and preparing nurse clinicians as faculty nurse educators, there is little consensus to support a single approach (Reid, Hinderer, Jarosinski, Mister, & Seldomridge, 2013). Orientation programs, either formal or informal, were found to be essential in the findings of several studies, with a suggestion to include practical orientation resources; for instance, a handbook (Forbes et al., 2010; McArthur-Rouse, 2008; McDonald, 2004; Parslow, 2008). Elder, Svoboda, Ryan and Fitzgerald (2016) found typical institutional policies, schedules and teaching responsibilities may not be fully understood and argued that this is time-sensitive, important information that should be understood as soon as possible after hiring.

Several SDNs in this study described how orientation to the job and having a helpful mentor or buddy affected their ability and the time it took to understand the job. For the participants, a gap in their orientation process, along with no preparation for the role, led to a state of not knowing the expectations of the role or what the role entailed. For the SDNs who reported receiving an adequate orientation to the role, the period of not knowing appeared to be short-lived in comparison with the SDNs who considered they had experienced an inadequate induction. The quality of the orientation was influenced by aspects such as absent or inexperienced senior nurse educators and lack of a structured program or process to orientate new SDNs. This experience is reflected in the literature by Tucker (2016), who noted from her study, orientation and having a mentor were both facilitators and hindering factors, dependent on both the amount and quality of the experience.
6.3.2 The importance of support and instruction

The literature acknowledges the transition from nurse to faculty educator is one of difficulty, noting the shock, needs and difficulties that nurses experience during the transition (Anibas, Brenner, & Zorn, 2009; Dempsey, 2007; McArthur-Rouse, 2007; Siler & Kleiner, 2001). Many authors describe the phenomenon of not being prepared for the transition and move to the solution of mentoring to solve this problem (Anderson, 2009; Block, Claffey, Korow, & McCaffrey, 2005; Gardner, 2014; Grassley & Lambe, 2015; Zambroski & Freeman, 2004). According to McLaughlin (2010), there are two types of mentoring relationships: formal and informal. Informal relationships are those that develop on their own between partners, such as a source of information or a friend providing socioemotional support. Formal mentoring refers to assigned relationships, more often associated with organisational mentoring programs.

Schoening (2009) observed that to overcome obstacles such as identity issues and uncertain role expectations, new faculty nurse educators sought out mentors ‘among their peers based on shared interests, perceived knowledge, and experience. They sought the knowledge necessary to perform their job through formal and informal, self-directed processes’ (p. 82). SDNs in this study described managing similar obstacles by seeking support through formal and informal structures that they were directed to during orientation, or found through self-discovery. The presence of role models and helpful peers as mentors, coupled with a positive relationship with their line manager, influenced the time it took for SDNs to progress their understanding of what was required of them in their new role. These were seen by participants as pivotal factors for successful transition to their role.

Mentorship in several studies was highlighted as an important supportive strategy, as a facilitator of the transition to the faculty nurse educator role (Bailey, 2012;
According to Bailey (2012), a way to ease transition and professional development for new faculty is to implement a buddy or mentor program. Cash, Doyle, von Tettenborn, Daines and Faria (2011) reported sharing the knowledge, wisdom, and ‘corporate memory of experienced nurse educators’ (p. 263) can assist newer colleagues in coming to an understanding of their new environments. Grassley and Lambe (2015) advise that intentional mentoring is needed to ease the transition from clinician to nurse educator. Sheets (2008) in her study found that mentoring is one of the most desirable scaffolds that supports new faculty nurse educators in adjusting to their new role, with peer mentoring gaining the most support from new faculty. Duphily (2011) further acknowledges mentorship can be the single most influential way to assist the successful development of novice faculty nurse educators, observing that new faculty should have careful and deliberate pairing with an invested, positive mentor in an atmosphere conducive to sharing concerns and asking questions. Grassley and Lambe (2015) suggested a mentoring program would mitigate the challenges of transition for new educators and identified three key components that supported a successful transition: formal preparation for teaching, guidance navigating the academic culture and a structured mentoring program.  

These observations of faculty nurse educators identified in the literature are evident in this study, where SDNs reported that having an allocated peer mentor and an available network of ‘buddies’ had the greatest impact on their experience in the role. Having an identified ‘go to’ person provided opportunity for the SDNs to ask questions and learn from each other and someone they could count on for support. Through their peer support network, the SDNs reported that they quickly became familiar with organisational processes and how to ‘get things done’ to meet organisational demands.
and expectations. The participants stated how their peer mentors helped them with practical information as well as providing emotional support, and for several participants, their peer group was their best source of support.

Sheets (2008) investigated faculty nurse educators learning the role during their first year following an emergency-hire into that position. Sheets (2008) defined the emergency-hire as a faculty nurse educator hired immediately prior to a semester commencement, which typically occurred with a shortage of experienced faculty. In these instances, working nurses would ‘fill in’ for the semester and accept the ‘emergency-hire’ position (Sheets, 2008, p. 2). According to Sheets (2008), many novice emergency-hires start out as clinical educators and rarely have an academic teaching background. Although they may be expert clinicians, with little or no time for preparation through orientation, the new emergency-hires often lacked the skills necessary for their role as educator. The literature indicates that most clinical nurse educators are prepared and socialised for experiences in advanced nursing practice rather than teaching (Sheets, 2008), and nurses often receive very little formal training in how to teach in their new role as clinical nurse educators (Duffy, 2013). Siler and Kleiner (2001), investigating experiences of new faculty nurse educators, found that ‘much of the practice of these new teachers was based on doing what they thought was best and learning from the consequences of those actions’ (p. 402), and therefore, supported the idea that some type of formal education was necessary to prepare faculty nurse educators to teach. For nurse educators to be successful, they require knowledge of and commitment to learning and teaching processes, adult education principles to inform their practice and critical thinking and communication skills (Conway & Elwin, 2007; Sayers et al., 2011).
McDonald’s (2004) study examining new faculty experiences found the participants had difficulty understanding and defining their role as faculty and that policies and procedures were unclear for them to function comfortably in their new roles. McDonald’s (2004) participants reported learning on the job, which was deemed a disappointment by the participants, who were ‘unhappy and surprised at the degree to which they were left to learn on their own’ (p. 214). This is in contrast to the experience described by participants of this study. SDNs described learning on the job, however did not express any discord in this situation or any disappointment in needing to do so; rather, they observed that they thought this was to be expected when learning a new role.

According to Bailey (2012), the primary challenge faced by novice nurse educators is the feeling of isolation, alienation, exclusion or belonging; hence, formal education and professional training are necessary for a ‘smooth flow of transition from practitioner to educator’ (p. 121). Bailey (2012) notes that expert clinicians require a program of professional development to become more proficient in their academic skills and that individuals with access to resources and opportunities can accomplish the tasks required to achieve organisation goals.

Participants in this study entered the role with little or no notice, or preparation, and typically lacked formal teaching and training skills. SDNs described learning on the job and developing strategies to assist them, such as using the learning resources provided or that they found through self-discovery. The study participants’ ability to become organised and grow in confidence was supported by the availability of ready-made teaching resources and templates, an instructional handbook and attending professional development activities. This finding was reflected in studies that found when there was lack of orientation and mentoring, novice faculty nurse educators found...
self-directed information seeking and participation in professional development activities helpful during their early transition to the role (Anderson, 2009; Bailey, 2012; Tucker, 2016).

The literature supports the observations in this study that all SDNs remarked that receiving training specific to their role and instruction on education theory and training strategies was a turning point for them in understanding their role and focus. The provision of focused instruction and training had a positive impact on SDNs’ confidence, ability to work in a team and understanding of the operations of a SDS model. SDNs reported this was a defining point in how they thought of their role, enabling SDNs to make sense of their role and the expectations that the organisation held of them. Several SDNs described having ‘light bulb’ moments on experiencing the combination of orientation, working with a mentor/buddy and receiving explicit training and instruction on how to do the job.

6.3.3 The importance of an organisational scaffold of support

The success of new faculty nurse educators depends on their own interests and initiative, and the support they receive from academic leaders and colleagues in learning about and adapting to a new and unfamiliar culture such as the academic enterprise (Bellack, 2016). Challenges in transition to the educator role decreases with time (Penn et al., 2008) and novice educators begin to be more comfortable when they have the opportunity to repeat content teaching didactic courses or are in their second or third year (Anderson, 2009; Tucker, 2016). Tucker (2016) identified in her study that the participants, on gaining comfort and confidence, experienced a ‘satisfaction that brought feelings of success and a sense they were impacting the next generation of nurse’ (p. 181). This finding was reflected in this study, where the participants also noted, on
becoming comfortable in the role, they experienced satisfaction with achieving a level of competency, felt appreciated and could see they were making a difference to others.

Gazza and Shellenbarger (2005) argue that having access to basic information may decrease the amount of time new faculty spend seeking information and may allow them to be more productive, and that support programs must ‘facilitate successful enculturation, including learning how to think, behave, and develop, to function effectively in the new work environment’ (p. 251). According to Sheets (2008), knowing what supports learning the new role of a faculty nurse educator can allow Schools of Nursing to design appropriate scaffolding to support the emergency-hire nurse instructor; further, novice teachers should be provided with ‘explicit directions and instructions’ (p. 175). This resonates with the support scaffolding provided to the SDNs in this study by their department. The SDS provided new SDNs’ induction, an allocated mentor/buddy, instructional templates and a training day with a focus on role of SDNs, instruction on teaching theory and coaching on the run and, further to these, explicit instruction on the staff development model and expectations the organisation had of the role against the ICIC Staff Development Framework.

To function effectively in the workplace, Gazza and Shellenbarger (2005) identified that new faculty needed to learn the rules and policies that pertain to students and faculty, connect with people and build relationships and function efficiently. With the multiple demands of the nurse educator role, newly hired faculty may have difficulty managing the competing demands for time and feel pulled in competing directions, and therefore, need guidance on learning how to streamline activities (Gazza & Shellenbarger, 2005).

In contrast to the literature, participants in this study did not express feeling unsupported or disappointed in the support they were provided during their transition
and beyond to the point of being on track. All participants reported that being instructed and directed to follow the ICIC Staff Development Framework enabled them to see the big picture of staff development and their role in a hospital-based nurse education service, which resulted in them gaining an understanding of what was expected of them. This result is most likely generated from the study participants’ context—a centralised service model can provide a greater degree of support compared with a decentralised service model (Keane, 2016). In her investigation of hospital-based nurse education service models across Australia, Keane (2016) demonstrated a centralised nurse education service model gives educators a better organisational view, makes educators feel less isolated and is more supportive of junior educators. In a centralised model, nurses transitioning to the educator role benefit from close collegial relationships with other educators, which can assist to build their identity as an education specialist (Keane, 2016).

As seen in the literature, the findings in this study demonstrated that SDNs enter the world of staff development where relationships and systems are at first unfamiliar, and gradually come to understand themselves as part of that world. Once SDNs understood the scaffolding structures of the department and were orientated to the service model, they became aware of the ways to get the job done, which resulted in them reaching a state of being organised. From the point of experiencing being organised, the SDNs then described using the scaffold to stay on track. SDNs in this study reported a point in their journey when they were consciously using the staff development model they had been instructed on: staying focused, organised, in touch, and on task to achieve their goals of staff development and supporting nurses educationally to perform to their best ability.
According to Davidson (2011), when a novice faculty is able to take on the role of a nurse educator, at the simplest level, it means the person can successfully act the part and ‘have conformed fit’ into the expectations of the role (p. 181). In this respect, the signal to an organisation that a successful transition from clinical nurse to the role of SDN has occurred is when the transitioning SDN has reached the point of being on track.

6.4 Comparison to Relevant Theories

In this discussion of the findings, Purposeful Scaffolding theory (Sam, 2011) and transition theory (Nicholson & West, 1987) and how they relate to the lived experience of the SDN are presented. Sam’s (2011) Purposeful Scaffolding model helped to explain the key elements an organisation needs to support a nurse in transition to the SDN role. Nicholson and West’s (1988) Transition Cycle theory, derived from the business world, is considered useful for measuring change rather than explaining the meaning of change (Ashforth & Saks, 1995). Their framework for transition conditions and the patterns of response provided a useful theoretical perspective for examining the results of this study.

6.4.1 Scaffolding theory

Scaffolding theory was first introduced in the late 1950s by the cognitive psychologist Jerome Bruner; over time, different definitions of scaffolding have been formulated (Bakker, Smit, & Wegerif, 2015). Sam (2011) describes scaffolding as a meaningful metaphor that refers to the support learners get from interaction with experts, teachers and peers. The essential objectives are self-reliant learning and the achievement of competency in the subject area. It represents the temporary, but essential, assistance from a mentor or a more knowledgeable other (MKO) in order for the learner to accomplish the given task/s successfully (Sam, 2011). Sam (2011)
provides a model for different realisations of scaffolding. In her Purposeful Scaffolding model, three types of scaffolding play major roles: content scaffolding, strategic scaffolding, and procedural scaffolding (see Figure 6.2).

Figure 6.2. Removed due to copyright restrictions

The Purposeful Scaffolding model was adapted to the findings of this study demonstrating how a hospital’s SDS provides an ‘organisational’ scaffolding for SDNs that complements the vertical and horizontal scaffolding from MKOs (see Figure 6.3). Figure 6.3 presents an adaptation of Sam’s Purposeful Scaffolding to describe how the findings of this study fit this theory. In this respect, the organisation scaffolding is available for the SDN from induction and continues to be available when they reach the point of being on track. The organisational scaffolding consists of content scaffolding where the SDN is introduced to the concept of staff development through the provision of induction, professional development and mentoring, which answers the ‘what is staff development’ question for the new SDN. Procedural scaffolding provides the ‘how to’ through availability of templates, service systems and tools to complete SDN tasks. Finally, the ICIC Staff Development Framework provides strategic scaffolding, where SDNs are guided in their approach to what must be achieved.
As a result of the organisational scaffolding, over a period, the SDN transitions through stages to reach the state of ‘being on track’, when the SDN experiences seeing the big picture and becomes aware of making a difference. By providing a framework that outlines support and functions, the purposeful scaffolding by the organisation extends the range of an expert nurse to the role of an SDN, expediting the time taken for this transition; it allows accomplishments of tasks not previously known, and is used selectively by the SDN to stay on track.

6.4.2 Work-role transition theory

For expert nurse clinicians who move into educator roles, the transition to the new work role involves developing a new identity and conforming to a new set of values and rules (Anderson, 2009). Anderson (2009) describes work-role transition as the human experience associated with entering a new community of practice: a developmental process associated with emotional work, critical tasks and a diffusion through role boundaries to assume the new identity, values and knowledge base of the new role. Nicholson (1984) defined work-role transitions as any change in employment
status and formulated a theory on how work-role transitions affect both the individual and the organisation. Nicholson and West (1988) developed the Transition Cycle, a cyclic model (see Figure 6.4) for the investigation of transition in stages, exploring the perspective of the organisation and the psychosocial impact on the individual.

*Figure 6.4. Removed due to copyright restrictions.*

This theory was chosen for this study as the SDN must travel through stages of transition as they assume their new identity and gain new knowledge to enact their new role. The basic structure of the model involves four stages: preparation, encounter, adjustment and stabilisation (Nicholson & West, 1988).

The first stage, *preparation*, is also seen by Nicholson and West (1988) as the fifth stage of a preceding cycle, when a person again moves to another role. The length of these stages varies from person to person and from transition to transition, and
Nicholson and West (1988) hypothesise that each of these periods have different drawbacks and remedies. The *preparation* phase is the period of adjusting expectations. As concern turns towards developing expectations about the upcoming change, the transitioner may feel fearful, unready or reluctant to change (Nicholson & West, 1988).

The *encounter* phase is a period during the first few weeks after change that brings new and unexpected experiences; the central task for the individual at this stage is to meet challenges of sensemaking and exploration. To minimise possible negative experiences during this stage, the transitioner needs a climate of support, freedom to explore their new role or setting, and a map of where this new role fits within the formal and informal structures of the organisation (Nicholson & West, 1988).

The *adjustment* stage is the period during which a compatible relationship between the individual and their new environment is achieved. According to Nicholson and West (1988), to promote early success in the new role, performance feedback needs to be swift and reliable; it is critical to provide favourable feedback and appropriately correct performance problems as they occur. Supervisory style and support are primary determinants of success at this stage and the presence of a mentor can do much to further facilitate adjustment (Nicholson & West, 1988). Nicholson and West (1988) advise if the individual does not develop a compatibility with their new environment, the individual will not pass into the stabilisation phase, resulting in a ‘failure syndrome’.

The *stabilisation* stage is the period in which a steady state is achieved after successful adjustment (Nicholson & West, 1988). During stabilisation, people focus on the task of performing on the job and developing relationships; the goals are sustained performance and personal effectiveness (Bruce, 1991).

The Transition Cycle (Nicholson & West, 1988) is considered an appropriate theoretical framework to apply to the SDN transition experience in this study. The basis
of this thesis is that the transition of a nurse to the role of an SDN is experienced as a process, in stages, which results in achieving a state of being on track. The Transition Cycle (Nicholson & West, 1988) required adaptation to illustrate the SDN transition process in this study because although the Transition Cycle has stages, it is cyclical, whereas the participants in this study transitioned in a linear process, to an end stage of ‘being on track’. Thus, this is a process rather than a cycle (see Figure 6.5) in this study.

Figure 6.5. Nicholson and West’s (1988) Transition Cycle adapted to the SDN transition process.

At Stage 1, the SDN is stumbling in the dark trying to ‘figure out’ what the job is, and discovering expectations as they embrace their new identity, adjust to the relationship with clinical colleagues and garner an understanding of what the service expects of them. For Stage 2, SDNs encounter the organisational scaffolding; they find peer and line management support and receive instruction by attending the SDM professional study day, and are provided with the ‘map’—the ICIC Staff Development Framework. In Stage 3, the SDNs have adjusted to their role, and are able to see the big picture and how they are making a difference with their contributions.
The transition for SDNs terminates at Stage 4, when stabilisation is achieved because of the scaffolding the SDN has experienced during the transition.

6.5 Limitations

The main limitation is that this study only investigated lived experience of SDNs transitioning at one metropolitan hospital; therefore, the findings may not be transferable to other situations.

One potential limitation of this study was the participants were exclusively female. Participant recruitment was aimed at the whole population of the hospital’s SDNs; however, only female SDNs volunteered and consented to participate in the study. No male SDNs (5.7% of SDN population employed in the SDS during the study) responded to the invitation to participate. Further invitations to participate were sent out more than once; however, this did not yield a response from male SDNs. Without males in the participant group, a voice with potential valuable insight was absent, and this is a recognised potential limitation to the study.

The position of the researcher (as Director, Staff Development) may be a limitation, as I brought assumptions and biases to the study that could have potentially interfered with data collection and analysis. Reflection, memos and discussion with supervisors were strategies used to reduce researcher bias (as explained in the methodology chapter).

6.6 Chapter Summary

In this chapter, I provided a summary and discussion of the study findings and related the findings to the literature and relevant theories. Three themes culminate into an overarching theme, being on track, and depict the transition process from clinical nurse to SDN: stumbling in the dark, becoming aware of the scaffolding, and using the scaffold. The findings were then compared with those from related literature and against

This study provided findings that contribute to the current knowledge around the transition of a nurse to a hospital-based clinical nurse educator. Findings may be beneficial in improving strategies to support work-role transition of hospital-based educators, which ultimately, has the potential to improve the delivery of nursing care. These conclusions may initiate changes among staff development departments, hospital administration, clinical environments and for recipients of nursing care, and, as such, they contribute to the significance of this study. The implications of these findings and recommendations are discussed in the next chapter.
Chapter 7: Conclusion

7.1 Introduction

There is a dearth of research on the lived experience of the hospital-based SDN transitioning from the role of nurse to SDN, most of whom have no formal training or preparation for their role. In Australia, challenges for the nurse educator role have been minimally explored and there is no standardised approach to role descriptions and scope of practice, which may adversely affect role enactment (Sayers et al., 2011). Sayers et al. (2011) advise the variations in role and qualifications may complicate preparation and subsequent role development. It is therefore important that we know more about the new SDN experience so that they can be appropriately supported.

To study this topic, a qualitative approach was utilised to explore the lived experience of 10 SDNs. The literature and the researcher’s assumptions about new SDNs’ experience were used to frame the data collection and presentation of findings, as described in previous chapters. This final chapter provides implications for staff development and research, outlines recommendations for nursing education and makes suggestions for further research. The chapter concludes with a final summary of the study.

7.2 New Knowledge Generated by This Study

To date the literature on HBNEs has mostly addressed their role description and scope of practice (Sayers et al., 2011; Thornton, 2018); prior to this, there has not been a substantial study of the transition from nurse to SDN in Australia. It was not known what factors were perceived to be beneficial or seen as barriers to that transition by this population, and the participants in this study provided rich perspectives on these questions.
It is important to consider the implications of this study. This study, informed by existing literature of transition from nurse to educator and theories of transition and scaffolding, has revealed new insights into how the transition is experienced by hospital-based SDNs. The findings of this study have significant implications for SDSs, including the support of nurses during their transition to the SDN role. The contributions of this study allow those contemplating the role of SDN or administration hiring an SDN at a hospital to identify factors that enable a smooth transition. Implications of this new knowledge and recommendations for nursing education and research are presented next.

7.3 Nursing Education Implications

There is an imperative to have a hospital nursing workforce deliver safe quality patient care, and the availability of an effective clinical educator is essential to build and sustain the capability of nurses, who are faced with advancing technologies and increasing complexity in-service delivery (Keane, 2016; Thornton, 2016). Nurses coming into the role of SDN are generally not aware of what the job entails when compared with their understanding of the clinical duties and responsibilities of a bedside nurse, and have little preparation for the role. The correlation of literature and the evidence of interview statements from this research confirms that the success of the new SDN is contingent on appreciating the factors affecting the job role transition, the service model, a thorough orientation, professional development, provision of tools for the job, access to mentors/MKOs and understanding service operations and the functions of the role. The following recommendations may be drawn from the study.

7.4 Nursing Education Recommendations

These recommendations arise from the voice of the study participants, interpretation of the study findings and the literature on new educators. It remains for
the reader to determine whether the experiences of SDNs in this study and the recommendations made are relevant to other contexts. Nursing education departments in HEIs may also benefit from reading and implementing changes based on these results. SDEs, DSDs and hospital administrators may consider some of these recommendations for implementation, if what has been described resonates with their own experiences.

7.4.1 Staff development service model

Health service providers and nursing executive teams review their organisations SDS model and consider reconfiguring the service to a centralised service model. A centralised model can provide a robust line management and peer support system for nurses transitioning to the new role. A centralised service can provide a consistent approach to role orientation and the provision of support mechanisms such as professional development, access to centralised systems, templates and learning resources. Participants in this study observed that when they had access to early, efficient orientation and competent peer support, the transition to the role was smoother and shorter than for those that did not have these aspects made available early in their transition.

7.4.2 Scaffold the SDN transition

It is crucial to determine how the organisation’s model of staff development enables the organisation to scaffold an expert nurse transitioning to the role of an SDN. The scaffold to support SDN transition includes the provision of:

- induction and orientation to the role and SDS systems
- formal and informal support structure by staff development knowledgeable line managers and mentoring by competent peers
- professional development related to a body of knowledge on staff development

174
• open plan offices or near location of peers, providing peer support by close proximity

• a framework, such as the ICIC Staff Development Framework, which was implemented by the hospital in this study, outlining the functional aspects of the role and where this role fits within the structures of the organisation.

7.4.3 Recognise role transition

Education must be provided on the transition process to new SDNs and those supporting SDNs. Raising awareness of the transition process can assist to identify and utilise supportive strategies applicable to the phases of transition. Findings from this study demonstrated that there needs to be recognition of the transition process, and that the work-role transition for SDNs takes some time. New SDNs need to be sensitised to stages of role transition to counter self-limiting beliefs and expectations. By providing a depiction of the work-role transition at commencement of the role, the new SDN may gain an awareness that can result in self-advocacy with respect to their orientation and mentoring needs.

7.4.4 Orientate to the role and role supports

A formal orientation program to socialise and inform the new SDN on reporting structures, systems, processes, people, responsibilities of the role and the expectations of the SDS should be provided. Understanding the role and setting KPIs allows the new SDN to take ownership of the role, embrace their new role identity and transition smoothly to the role of SDN. The orientation process should be supported with an orientation handbook that includes the ‘how to’ of the day-to-day work and skill and knowledge ‘checklists’ that can provide the new SDN with concrete evidence of their orientation progress.
7.4.5 Provide professional development and training

A program for SDN skills development is important to address the body of knowledge that they may lack: the theory of education and training. It is recommended the combination of face-to-face training and access to learning resources (e.g., eLearning or a handbook) be made available to newly appointed SDNs at the commencement of their role or as soon as possible. Through this research study, it was determined that professional development and training specific to the SDN role was necessary for the smooth transition from expert nurse to an SDN experiencing being on track.

7.4.6 Provide tools for the job

New SDNs should be provided with the informational tools to perform in their role during the early transition phase. Study participants highlighted the importance of having available the tools for doing the job; however, too much or too little information can negatively affect the work-role transition. Therefore, the amount of information needs to be prioritised. The immediate information considered useful to include includes database use for training and recordkeeping, use of simulation equipment, document management, navigating shared drives and departmental communication methods.

7.4.7 Determine line management, mentors and networking opportunities

It is crucial to identify who is best positioned as the line manager of the SDN role; this may result in reconfiguration of line management for clinical-based educators. SDNs in this study observed that when the manager did not understand the functions of the role or staff development operations, it affected their work. The senior nurse educator as line manager was observed as a pivotal source of support by the SDNs in this study.
A formal mentor/buddy SDN should be selected and allocated to the new SDN, with selection based on experience, willingness and interpersonal skills. Peer support was evident as a significant facilitating factor in the work-role transition and it was clear that the participants valued having a ‘go to’ person that they felt safe to consult for questions or issues during their transition.

The hospital should create opportunities for new SDNs to have contact with experienced and competent peers across the organisation; this could be actioned as formal introductions and office sharing. Other actions include providing encouragement for the new SDN to engage with interested MKOs and encouraging competent peers to anticipate their new SDN colleagues’ transition needs and promote information and material sharing that might be useful. The study participants emphasised that having access to mentors and MKOs and networking were critical.

Establishing and maintaining an inclusive communication network to ensure SDNs feel part of the organisation and receive accurate and timely information relevant to their work is recommended. Study participants reported that attending regular meetings with their line manager and engaging with their peers at the ‘Town Meeting’ promoted opportunity to teamwork, reduced duplication of work and gave them a sense of community and belongingness.

### 7.4.8 Promote an understanding of staff development service and role functions

Newly appointed SDNs must be provided with a map or framework outlining the functional aspects of the role. This offers an objective mechanism to provide feedback on performance at regular intervals during their transition. A framework, as exampled in this study (the ICIC Staff Development Framework), is ideally designed and used to support the SDN achieving a state of being on track: focused on the task of performing on the job and developing relationships.
A framework can provide the scaffold to achieve and maintain the stabilisation stage of SDN transition: where sustained performance and personal effectiveness is the goal. Participants in this study reported being able to enact the SDN role was dependent on understanding the role, responsibilities and the business of staff development. Utilising the ICIC Staff Development Framework, participants planned and monitored their work performance and goals; this was deemed important to the SDNs as they were able to evaluate their performance and provide evidence of their achievements and contribution to patient care and nurse education.

7.5 Research Implications

The purpose of this qualitative study was to explore the SDN lived experience of a hospital-based SDS model. This study has addressed the research questions as outlined in Chapter 1 by:

1. describing the SDNs lived experience of a hospital’s SDS model
2. describing the context in which the SDNs commenced and transitioned to the role
3. identifying the barriers and facilitators SDNs experienced during transition to the role
4. identifying the strategies SDNs used to facilitate their transition to the role
5. devising a framework that explains transition of a nurse to an SDN.

This study identified the many factors that can affect the transition to the role of SDN from other nursing positions. Findings from the study demonstrate that success of the new SDN is contingent on organisational strategies deployed to scaffold the transition. The study was undertaken in one Australian hospital with a centralised SDS model; therefore, more research in this area is needed. Specifically, more research is
needed to explore what contributes to a successful transition to the SDN role, or what made them discontinue their role.

7.6 Research Recommendations

Prior to this study, very little was known about the lived experience of transition of a nurse to the SDN role. While this study contributes to the body of knowledge pertaining to the transition of the clinical expert to the SDN role, the findings and limitations of this study support the need for further research in the following areas:

- Investigate further the experience of nurses transitioning to hospital-based clinical educator roles—using a qualitative study to explore hospital-based clinical educators’ experiences across Australia may reveal new characteristics of importance and allow for comparison with the findings from this study.

- Replicate this study in a hospital where the nurse education service is utilising the ICIC Staff Development Framework or similar—using a qualitative study to explore the experiences of nurse educators may allow for comparison with the findings from this study and identify further development of the ICIC Staff Development Framework.

- Continue seeking out male perspectives on this topic by targeting the recruitment of male participants—creating an awareness of the need for scientific data from male study participants may improve recruitment.

- Develop a qualitative research study to examine the effectiveness and outcomes of structured orientation and mentoring programs for SDNs—a mixed methods short-term/longitudinal study could be developed using elements to measure role ambiguity, role stress and intent to stay.

- Investigate hospital-based nurse education staff, nurse unit managers and nursing executive views of KPIs for the role—using a qualitative study may
identify the characteristics of transition success and may allow for comparison with the findings from this study.

7.7 Summary

This qualitative study explored the lived experience of SDNs in an Australian hospital. Moving from the role of expert nurse to SDN involves an identity change, and achieving mastery in the role involves time and experience. The study uniquely contributes to the nurse education body of knowledge by providing a rich description of the nurse transitioning to SDN experience in the hospital setting and the factors that acted as facilitators and barriers.

The findings of this study provide insight into the process that occurs during the transition from nurse to SDN. The study explains this transition and identified an organisation’s scaffolding support for a successful role transition. Attributes of the SDN role transition were also identified.

The results of this study provide new knowledge and information useful to hospital-based educators, staff development departments and administrators, hospital nurse managers, and ultimately, the recipients of nursing care. Increased knowledge regarding transition of a nurse into an SDN role may generate new or improved organisational scaffolding strategies, resulting in an expedient, timely transition to the role. Finally, implications and recommendations from the study findings were provided for nursing education administrators as well as recommendations for further research.
Epilogue

During this study, the WA Metropolitan Health Service implemented a transformation of one of the area health services. This involved the opening of a new greenfield, quaternary-level hospital, Fiona Stanley Hospital (FSH), and the subsequent mass movement of staff and services between hospitals within the area health service.

FSH, with 750 beds and 2,000 nursing and midwifery FTE, opened with staff being transferred and recruited from other established hospitals or recruited from overseas. The new hospital’s nursing and midwifery education service was established utilising a centralised organisational model; the service consisted of nurse educators and ward-based clinical nurse educators.

The FSH nursing and midwifery education team were recruited from local hospitals across WA; all the educators had previous experience elsewhere, as either a nurse educator or SDN.

For the first part of their work over several months, the nurse education team was consumed with staff induction and orientation to a new hospital. At the same time, the nursing and midwifery education team also needed to build within the service their management relationships, systems, processes and programs. A challenge for the new team was differing ideas and experiences of nurse education. For example, many staff were unaccustomed to a centralised service and for some nurse educators, line managing a group of clinical nurse educators was a new experience. For some clinical nurse educators, it was a new experience to be working in teams and line managed centrally.

Over the initial months of working together, the educators started to find a central ground to communicate and organise their working relationships, expectations and programs. Nurse educators and clinical nurse educators previously experienced in
using the ICIC Staff Development Framework began to organically apply the language and structures to their work. Other educators were intrigued and curious about the ICIC Staff Development Framework, and soon it became the central construct for the service operations. The ICIC Staff Development Framework is now well established at FSH, a SDM professional development study day is provided on an annual basis and the orientation and mentor program for new educators is in place.

The ICIC Staff Development Framework continues today at the hospital at which this study was conducted.
References


Forbes, M. O., Hickey, M. T., & White, J. (2010). Adjunct faculty development:
Reported needs and innovative solutions. *Journal of Professional Nursing*,


http://www.academia.edu/1561689/The_use_of_semistructured_interviews_in_qualitative_research_strengths_and_weaknesses


Scotland, J. (2012). Exploring the philosophical underpinnings of research: Relating ontology and epistemology to the methodology and methods of the scientific, interpretive, and critical research paradigms. *English Language Teaching, 5*(9). http://dx.doi.org/10.5539/elt.v5n9p9


INVITATION TO PARTICIPATE

Dear Colleague,
My name is Penny Keogh and I am enrolled in a Doctor of Business Administration degree at The University of Notre Dame Australia.

I invite you to participate in a research study that concerns transition and orientation to the staff development nurse role and organisational role support for staff development nurses. The title of the study is ‘Staff development nurses lived experience of their department’s organisational model’.

I believe the findings from the study can be used to better inform an organisation as to the factors that facilitate or impede transition and orientation to the staff development nurse role and role support for staff development nurses.

The study will use a qualitative design informed by the phenomenological approach and I wish to interview nurses with more than 6 months experience in a staff development nurse role at [Insert Hospital and Health Service]. Participation is voluntary and your identity will be kept confidential. The first interview should take about 60-90 minutes of your time and we can meet at a location of your choosing and convenience. I may need to contact you again for a follow up interview.

If you are interested in volunteering to take part in this study, please email me at penny.keogh1@my.nd.edu.au and I will send you an information sheet and organise an interview with you. Prior to an interview, an informed consent document will be provided to you to sign.

If you would like to discuss the research or if you have further questions, please feel welcome to contact me on the contact details below.
Thank you for your consideration

Kind regards

Penny Keogh
DipFineArt (Painting), RN, CritCareCert., GradDipEd (Training&Dev), GradBusQual.(Leadership & Manage.), MNsg
Principal Researcher penny.keogh1@my.nd.edu.au  Tel: 0407 4

[Image]
Appendix 2 Information Sheet

Staff Development Nurses lived experience of their department’s organisational model

Dear Potential Participant,

My name is Penny Keogh and I am enrolled in a Doctor of Business Administration degree at The University of Notre Dame Australia. For my doctorate, I am required to complete a research study.

I invite you to participate in a research study that concerns transition and orientation to the staff development nurse role and organisational role support for staff development nurses. The title of the project is ‘Staff Development Nurses lived experience of their department’s organisational model’.

The Human Research Ethics Committee of the University of Notre Dame Australia has approved this study. If you decide to take part in this research study, it is important you understand the purpose of the study and what you will be asked to undergo. Please read the following, which will provide you with information about the study.

Nature and Purpose of the Study

I have asked you to participate in this study because you have six or more months experience as an acting or permanent SDN at [Hospital and Health Service] and have experienced transition to the role. The purpose of the research is to explore staff development nurses lived experience at the [Hospital and Health Service]. In undertaking this study, I hope to identify strategies to facilitate transition to the role of SDN and provide new SDNs with these strategies with an aim to minimise transition stress and, make available this information to other organisations recruiting nurses to the SDN role.

If you decide to participate in this study, you will be asked to take part in a 60-90 minute tape-recorded interview. You will be offered an interview summary, and I would be appreciative if you would comment on whether you believe we have captured your experience. I may need to contact you again for a follow up interview.

PTO
Before the interview, I will ask you to sign a consent form. Any information collected during the interview will be strictly confidential and to protect the anonymity of participants in my project, a code will be ascribed to each of the participants to minimise the risk of identification. No identifying information will be used and the results from the study will be made freely available to all participants.

Data collected will be stored securely in the University’s School of Business for five years and then destroyed. For the protection of privacy, the protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee will be adhered to and relevant sections of the Privacy Act are available at http://www.nhmrc.gov.au/

**Voluntary Participation and Withdrawal from the Study**

Participating in this study will not in any way interfere with your work at FHHS. Your participation in this study is voluntary and if you decide not to participate in this study, this will not affect your employment at the FHHS Hospital and Health Service. You may withdraw from the study at any time, for whatever reason. Such withdrawal will not in any way influence your employment at the FHHS Hospital and Health Service.

In the unlikely event the interview may raise some difficult feelings for you; you will be referred to appropriate support. You will be provided with relevant counselling information at the interview and contacted by the researcher one week afterwards.

Dr Peter Gall of the School of Business and Dr Selma Alliex are supervising this study. If you have any queries regarding the research, please contact me directly or Dr Gall by phone (08) 9433 0915 email: Peter.Gall@nd.edu.au or Dr Alliex 9433 0215 email: Selma.alliex@nd.edu.au

I thank you for your consideration and I hope you will agree to participate in this research project.

Kind regards,

Penny Keogh
Tel: 0407 43
Email: penny.keogh1@my.nd.edu.au

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au
Appendix 3 Consent Form

CONSENT FORM

Staff development nurses’ lived experience of their department’s organisational model

Informed Consent Form

I, (participant’s name) _________________________________ hereby agree to being a participant in the above research project.

- I have read and understood the Information Sheet about this project and any questions have been answered to my satisfaction.
- I understand that I may withdraw from participating in the project at any time without prejudice.
- I understand that I will be audio-taped
- I understand that all information gathered by the researcher will be treated as strictly confidential, except in instances of legal requirements such as court subpoenas, freedom of information requests, or mandated reporting by some professionals.
- Whilst the research involves small sample sizes I understand that a code will be ascribed to all participants to ensure that the risk of identification is minimised.
- I understand that the protocol adopted by the University of Notre Dame Australia Human Research Ethics Committee for the protection of privacy will be adhered to and relevant sections of the Privacy Act are available at http://www.nhmrc.gov.au/
- I agree that any research data gathered for the study may be published provided my name or other identifying information is not disclosed.

<table>
<thead>
<tr>
<th>Participant’s signature:</th>
<th>DATE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>RESEARCHER’S FULL NAME:</td>
<td>PENNY KEOGH</td>
</tr>
<tr>
<td>RESEARCHER’S SIGNATURE:</td>
<td>DATE:</td>
</tr>
</tbody>
</table>

If participants have any complaint regarding the manner in which a research project is conducted, it should be directed to the Executive Officer of the Human Research Ethics Committee, Research Office, The University of Notre Dame Australia, PO Box 1225 Fremantle WA 6959, phone (08) 9433 0943, research@nd.edu.au
Appendix 4 University Ethics Approval

13 September 2012

Dr Peter Gall
School of Business
The University of Notre Dame, Australia
Fremantle Campus

Reference Number: 012070F

Dear Peter,

I am writing to you in regards to your Low Risk Application for Ethics Clearance for your proposed research, to be undertaken as a student project at The University of Notre Dame Australia. The title of the project is: "Staff development nurses lived experience of their department's organisational model."

Your proposal has been reviewed by the University's Human Research Ethics Committee, and based on the information provided has been assessed as meeting all the requirements as mentioned in the National Statement on Ethical Conduct in Human Research (2007). Therefore, I am pleased to advise that ethical clearance has been granted for this proposed study.

All research projects are approved subject to standard conditions of approval. Please read the attached document for details of these conditions.

On behalf of the Human Research Ethics Committee, I wish you well with what promises to be a most interesting and valuable study.

Yours sincerely,

Dr Natalie Giles
Executive Officer, Human Research Ethics Committee
Research Office

cc: Prof Chris Doepel, Dean, School of Business
Appendix 5 Health Service Ethics Approval

Reference no: 2012/01
Ms Penny Keogh
Stream Leader, Education and Training
South Metropolitan Health Service,
16, Ogilvie Road,
Mt Pleasant 6153

30th October 2012

Dear Penny,

Re: Staff Development Nurses Lived Experience of a Staff Development Service Organisational Model.

Thank you for providing responses to queries raised by members of the South Metropolitan Health Service Nursing Research Review Committee. I am pleased to inform you that approval is now granted and you may commence the above study at Fremantle Hospital and Health Service.

Approval is subject to the following requirements:

- The committee is notified of any substantial changes in the protocol;
- A copy of the study's final report is provided to the SMHS Nursing Research Review Committee on completion of the study, and, if the research is not completed within 12 months you are asked to submit a brief progress report.

Please note it is the responsibility of the Chief Investigator to notify the Committee of any variation from the original proposal. Approval must be sought in writing in advance from the SMHS Nursing Research Review Committee if amendments to procedures or the sample size outlined in the original proposal are required. Should the research be discontinued you are required to inform the Committee, giving reasons for termination.

To gain access to Staff Development Nurses at Fremantle and Kaleeya Hospitals you will need to contact Carolyn Keane, Acting Nursing Director Staff Development.

I wish you well with the study and look forward to seeing the results.

Yours sincerely

[Signature]

Sunila McGowan, Adjunct Associate Professor (Curtin University)
Chairperson SMHS Nursing Research Review Committee
Director Nursing Research and Evaluation
Fremantle Hospital and Health Service

O.C Dr Peter Gall, School of Business, University of Notre Dame.
Appendix 6 Approval from Director of Nursing

Pen Keogh

From: Letts, Ruth <Ruth.Letts@health.wa.gov.au>
Sent: Wednesday, 20 June 2012 2:39 PM
To: Pen Keogh
Cc: Keogh, Penny
Subject: RE: SDN Research Project at FHHS

Thanks Penny
Happy to support
Regards
Ruth

Assoc Professor Ruth Letts
Executive Director of Nursing, Midwifery & Patient Support Services,
Fremantle Hospital & Health Service
ph. 94312651

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From: Pen Keogh [mailto:penkeogh2006@bigpond.com]
Sent: Wednesday, 20 June 2012 11:15
To: Letts, Ruth
Cc: Keogh, Penny
Subject: SDN Research Project at FHHS

Dear Ruth

Thank you for your assistance and mentor support you have provided me in undertaking my doctorate studies. As you know my interest concerns the staff development nurse and I am now ready to progress the research project regarding their experience at FHHS.

The title of the study is 'Staff development nurses lived experience of a staff development department's organisational model' and I believe the findings from the study can be used to better inform an organisation as to the factors that facilitate or impede transition to the staff development nurse role and role support for staff development nurses. Results of my study will be made available to FHHS and the participants at completion of the project.

The study will use a qualitative design and I wish to interview nurses with more than 6 months experience in a staff development nurse role at Fremantle Hospital and Health Service. Participation is voluntary and their identity will be kept confidential. The interview should take about 60-90 minutes of their time and I will meet at their convenience. There may be occasion where I need to meet again for a follow up interview.

Could you please confirm your support for the study and authorisation for me to access the FHHS SDNs by their health.gov email to invite their participation in the research?

I have attached the participant invitation letter and information sheet for your reference which explains the arrangements for ethics and project supervision. I will also be making an application to the SNAHS Nursing Research Review Committee to conduct this research at the FHHS. If you would like further details or have questions I will be delighted to follow up with you.

Many thanks for consideration of my request Ruth,

Kind regards
Appendix 7 Interview Guide

Staff Development Nurses lived experience of their department’s organisational model

Interview Guide

Date of Interview:

Time:

Introduction:

Thank you for agreeing to meet with me today. Can I please confirm that you have read the information sheets and confirm your consent to participate in this study?

I am interested in examining the experience of staff development nurses and the transition to the role. I would like to know what is helpful, and what is not. I am very interested in your experience and I encourage you to freely share with me anything that you feel will be important in helping me to understand this topic. I may ask some additional questions as we proceed in order to clarify information.

Do you have any questions before we begin?

Questions:

1. What has been your experience making the transition from bedside nurse to the SDN role at Hospital and Health Service?
   
   Can you describe any barriers to the transition to the role?
   
   Looking back, what might have assisted you?
   
   Can you describe any facilitators to the transition to the role?
   
   What strategies did you use?

2. What has been your experience of using the FHHS staff development service model?

3. Can you describe for me a typical day in the life of an SDN?

   Probes:
   
   Can you give me an example of a good day?
CONFIDENTIALITY AGREEMENT FOR TRANSCRIPTION SERVICES

I, Carol Mastick, Transcriptionist, agree to maintain full confidentiality in regards to any and all audio files and other documentation received from Penny Keogh.

Furthermore, I agree:

1. To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio interviews, or in any associated documents;

2. To not make copies of any audio file or computerized files of the transcribed interview texts, unless specifically requested to do so by Penny Keogh;

3. To store all study-related audio and materials in a safe, secure location as long as they are in my possession;

4. To delete all electronic files containing study-related documents from my computer hard drive and any backup devices upon confirmation of receipt of completed transcript by Penny Keogh.

Carol Mastick

2/12/2013

DATE

CAROL MASTICK
153 PARK PLACE DRIVE
PETALUMA, CA USA 94954
707-290-4737